EVALUATION

OF THE

ENGENDERHEALTH

COOPERATIVE AGREEMENT

1998–2003

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August 2002

Submitted by:
LTG Associates, Inc.
TvT Associates
a division of Social & Scientific Systems, Inc.

Submitted to:
The United States Agency for International Development
Under USAID Contract No. HRN–C–00–00–00007–00

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Evaluation of the EngenderHealth Cooperative Agreement, 1998–2003 was made possible through support provided by the United States Agency for International Development (USAID) under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2002–064. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACKNOWLEDGMENTS

This assessment could not have been conducted without the support of a large number of people in Washington, D.C., New York, Bangladesh, Ghana, Kenya, and the Philippines. The team would like to express its special appreciation, however, to the staff and leadership of EngenderHealth headquarters in New York. EngenderHealth leadership was eager to engage the team in productive discussions that sharpened the team's approach to the evaluation. In particular, the team wants to thank Lynn Bakamjian, senior vice president for programs, who led and managed this evaluation effort.

The team also thanks the managers and staff of EngenderHealth field offices in Bangladesh, Ghana, Kenya, and the Philippines for their cordial hospitality, openness, and enthusiasm in sharing their programs. The team was greatly impressed by their commitment and hard work.

The team would also like to acknowledge the support of the Bureau for Global Health (GH) of the United States Agency for International Development/Washington. The staff of the Service Delivery Improvement Division managed the design and groundwork for the evaluation and helped prepare the team in many ways to undertake the assignment. The team expresses its special thanks to Michelle Moloney-Kitts, the chief of this division, and Maureen Norton, senior technical advisor. In addition, the team thanks the USAID Mission staff interviewed either in person or by telephone. The views and thoughts of the Mission staff were extremely useful in understanding EngenderHealth's performance.

Finally, the team notes its appreciation for the tireless support it received from Catherine Hastings of the Population Technical Assistance Project.

ACRONYMS

AO	Administrative Order
ASP	Active Server Pages
AVSC International	Former name of EngenderHealth
CA	Cooperating agency
COPE	Client-oriented, provider-efficient services
CPR	Contraceptive prevalence rate
CYP	Couple year of protection
D&C	Dilation and curettage
DHS	Demographic and Health Survey
DMPA	Depo-Provera
DOH	Department of Health
EOC	Emergency obstetric care
FHI	Family Health International
FP	Family planning
FPAK	Family Planning Association of Kenya
FY	Fiscal year
GH	Bureau for Global Health, USAID
ICPD	International Conference on Population and Development, Cairo, 1994
IEC	Information, education and communication
IMIS	Integrated management information system
IR	Intermediate Result
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JSI	John Snow, Inc.
LAP	Laparoscopy
LGU	Local government unit
LPP	Local Government Unit Performance Project (the Philippines)
MCH	Maternal and child health
ML	Minilaparotomy
MLA	Minilaparotomy under local anesthetic
MOH	Ministry of Health
MSH	Management Sciences for Health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
NIPHP	National Integrated Population and Health Program
NSV	Nonscalpel vasectomy
PAC	Postabortion care
PHN	Population, health and nutrition
PMAC	Prevention and management of abortion and its complications
PPIUD	Postpartum intrauterine device
RH	Reproductive health
RTI	Reproductive tract infection
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization
WST	Whole-site training

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EXECUTIVE SUMMARY

This report presents the evaluation of the 1998 to 2003 cooperative agreement between the U.S. Agency for International Development (USAID) and EngenderHealth. The evaluation looks at the impact of EngenderHealth's activities on the access, quality, scaling up, and institutionalization of clinical services delivery since 1998. This includes family planning (FP) clinical services, postabortion care (PAC), voluntarism and informed choice, quality improvements, male involvement in FP, research and evaluation, and global leadership activities.

The evaluation team analyzed national Demographic and Health Survey (DHS) data (on clinical method prevalence, desire for additional children, and unmet need for limiting methods) in EngenderHealth-supported countries and available service statistics reported from EngenderHealth-affiliated project sites. The team enriched findings from the statistical data with qualitative assessments of the key project components based on

- a review of project documents,
- an appraisal of EngenderHealth's detailed background self-assessment document incorporating both quantitative and qualitative findings used to draw conclusions,
- discussions with USAID/Washington and EngenderHealth staff,
- structured interviews with knowledgeable representatives from 13 USAID Missions, and
- visits to four countries in which EngenderHealth operates (Ghana, Kenya, Philippines, and Bangladesh) to observe field activity and to discuss progress with USAID Mission and EngenderHealth in-country staff, stakeholders, and partners.

The purpose of this cooperative agreement is to provide support for voluntary sterilization and other related services in developing countries in support of USAID/Washington's Strategic Objective, "Increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and nonclinical programs." There are two levels of activity under the cooperative agreement:

- technical and programmatic assistance to country programs (field support funding) to increase availability and use of clinic-based FP services, and
- global leadership programs (core funding) to advance state-of-the-art and technical and programming guidance.

The funding ceiling for the five-year period is $137 million. EngenderHealth expects to receive $78,878,000 through June 30, 2002, of which $26,861,000 is core funding and the remainder is field support.

The project specifies six Intermediate Results (IRs) that EngenderHealth should achieve to contribute to USAID/Washington's reproductive health (RH) Strategic Objective:

- IR 1: Increased availability of quality family planning and selected reproductive health services
- IR 2: Clinical quality assurance/quality improvement systems established at the institutional level
- IR 3: Increased client satisfaction with services provided in EngenderHealth-supported programs
- IR 4: Contribution by EngenderHealth-supported programs to ensure an appropriate range of contraceptive methods and/or utilization of services within five years in selected countries
- IR 5: Increased availability of technical and programmatic guidance for clinic-based services intended to improve program sustainability and client satisfaction
- IR 6: Increased leadership, contribution to, and visibility within the international dialogue on family planning and reproductive health

ACCOMPLISHMENTS OF THE COOPERATIVE AGREEMENT

IR 1: Increased availability of quality family planning and selected reproductive health services

Long-Term and Permanent Methods

Using facility-level service statistics as the principal source of information for evaluating EngenderHealth efforts to improve the accessibility and utilization of long-term and permanent methods is a difficult proposition. Not all countries in which EngenderHealth has been working report service statistics. Only 19 of 32 countries with formal subagreements with subgrantees are required to provide service statistics to EngenderHealth. In addition, several large countries have graduated over the past three years and bilateral programs have ended in other countries. Quantitative evidence is too incomplete to reach definitive conclusions about the results achieved by EngenderHealth during the first three years of the current cooperative agreement.

From the information made available to the team, it can be concluded that whenever USAID budgets have been stable or rising, EngenderHealth has usually been able to increase access to clinical FP services. In countries where USAID funding has declined, EngenderHealth has been able, at least in the short term, to sustain access to services, largely by drawing upon other sources of funding.

Postabortion Care

PAC continues to be a major need in most of the EngenderHealth-assisted countries. EngenderHealth has been instrumental in initiating PAC services in many countries over this cooperative agreement. To date, PAC has been most effective in treating abortion complications. Because most services dealing with FP provision and counseling are generally offered in locations that are separate from obstetric and gynecology services, developing effective linkages between the two types of services has been difficult. This is an area that will need continuing attention within the PAC context.

Men as Partners

Expanding and improving men's access to RH services was a focus area during the current cooperative agreement. The number of EngenderHealth-supported sites providing male RH services rose significantly. However, only about one third of all EngenderHealth-affiliated sites offered vasectomy as part of their male RH service package. The effect of men as partners programming on acceptance of vasectomy will need to be closely monitored.

IR 2: Clinical quality assurance/quality improvement systems established at the institutional level

Quality Improvement

Quality improvement has been an area in which EngenderHealth worked extensively. EngenderHealth has a systematic approach to quality improvement. It has developed several quality improvement tools, promoted the use of these tools, and updated them continuously. The utilization of various tools has led to practices that improved the quality of services even in resource poor settings. EngenderHealth conducted a number of studies to quantify results of quality initiatives. It is important to find ways of adapting the quantitative evaluation methodologies EngenderHealth has developed in order to measure results of quality improvement tools in a variety of country settings.

Service-Based Training

EngenderHealth has trained thousands of trainers, providers, and managers in topics ranging from sterilization techniques to health care management during this cooperative agreement. Training has been a major achievement of EngenderHealth work, especially in clinical methods, counseling, and materials development. The high quality of this training has been acknowledged by host country institutions and USAID Missions. Since 1998, however, the number of training events and trainees has been declining for clinical FP (with the exception of Norplant) in favor of nonclinical training. This trend may be due to the increased number of host country institutions taking responsibility for training.

Informed Choice and Voluntarism

EngenderHealth has been scrupulous in promoting informed choice and voluntarism in all countries in which it works. It has been successful in providing leadership in identifying issues and developing strategies to transfer these concepts to the clinical level. Although there are still challenging issues, such as provider bias, EngenderHealth is well aware of these issues and has a sound strategy to deal with them.

IR 3: Increased client satisfaction with services provided in EngenderHealth-supported programs

EngenderHealth continues its commitment to being client oriented. The quality improvement tools include components that use client feedback to improve service quality. EngenderHealth also conducted several studies to examine client's perceptions and satisfaction with services provided.

IR 4: Contribution by EngenderHealth-supported programs to ensure an appropriate range of contraceptive methods and/or utilization of services within five years in selected countries

Success in improving the utilization of clinical contraceptive services (measured by the number of clients served and the number of clients served per site) has been mixed. There are notable successes (e.g., the rise in female sterilization in several Latin American countries and gains in Norplant use in Ghana), but there have also been several disappointments (e.g., reported declines in female sterilization in Nepal and reductions in the number of intrauterine device [IUD] clients served in Nepal and Tanzania).

Among countries reporting service statistics, there have also been declines in the average number of clients served per EngenderHealth-supported site. Unfortunately, it is often not possible to determine the extent to which this trend is due to compositional change in the countries in which EngenderHealth has been working, recent realignments of country program activities, altered service statistics reporting requirements, or underlying change in program performance. However, on an annualized basis, long-term and permanent method client loads per site are often quite low, particularly in such countries as Nepal, Kenya, and Nigeria.

IR 5: Increased availability of technical and programmatic guidance for clinic-based services intended to improve program sustainability and client satisfaction

While many aspects of sustainability in developing country settings are beyond EngenderHealth's control, it has paid attention to issues of scaling up, institutionalization, and sustainability. The extent of EngenderHealth's contribution to sustainable clinical FP services is different in individual countries. There is a need to compare approaches across countries, identify best practices and lessons learned, and ensure that these results are widely disseminated, both within EngenderHealth and among other countries.

IR 6: Increased leadership, contribution to, and visibility within the international dialogue on family planning and reproductive health

Leadership

EngenderHealth has proven to be a leader in addressing technical issues in clinical FP and other related areas, such as PAC, through country programs and the development of guidelines and standards. In many countries, EngenderHealth also has been a leader in policy development to support the availability and accessibility of clinical FP services. Because of EngenderHealth's rich experience throughout the world, it could strongly advocate for clinical FP services as an essential RH service.

Research

EngenderHealth has implemented a substantial research program. There are many examples of research results leading to program improvements. Key research themes have been reproductive health for men, clinical studies on vasectomy techniques, and

PAC. It is notable that research has often been directed towards the development of new clinical procedures and quality assurance tools. While much research is also focused on clinical FP issues, EngenderHealth has not used research to address broad global issues, such as determining the reasons for the worldwide plateau of voluntary sterilization levels, institutionalization/sustainability, and how to address remaining barriers to acceptance.

Other Key Findings and Conclusions

National Level Trends in EngenderHealth-Assisted Countries

While it is not feasible to relate EngenderHealth project activities to national-level trends in program performance, the analysis of DHS data offers a useful contextual introduction for this evaluation. The analysis reveals that while female sterilization prevalence has been increasing in many Latin American countries, few Asian and African countries have reported substantial gains in this method. Male sterilization continues to be a much underutilized FP method. IUD prevalence has either been constant or following a downward trend in most developing countries, and Norplant still is not a major method in most developing countries.

Current and Future Demand for Clinical Contraception

Many women want to limit their fertility in countries in which EngenderHealth has been working. The percentage of currently married women who are not using contraception and do not want any more children is still high in many of these countries. In addition, many women not currently using FP report that clinical contraceptive methods are their preferred future methods.

Monitoring and Evaluation System

Over the past three years of this cooperative agreement, EngenderHealth has expended considerable effort to improve its monitoring and evaluation system. A new Results Framework was developed, including a set of indicators to measure progress in achieving results. It has also developed an integrated management information system (IMIS) for the timely collection and analyses of data. However, problems remain with the monitoring and evaluation system. The number of selected indicators is excessive. Some are difficult to collect and others do not necessarily measure intended results. Consequently, they do not always provide valuable information to EngenderHealth or USAID for measuring performance and making management decisions.

Program Focus

Despite the common vision of EngenderHealth's mandate expressed by its staff, EngenderHealth may be having difficulty maintaining its focus on clinical contraception. This concern is supported by EngenderHealth's apparent lack of urgency in dealing with low, and in some countries declining, trends in sterilization prevalence. EngenderHealth's current research agenda does little to address such global programmatic concerns. In addition, the team observed that EngenderHealth staff was interested in new non–family planning initiatives. While these initiatives are very

important for overall public health improvement, it is questionable whether they are the most central activities for meeting the unmet demand for clinical FP services.

Organization and Staffing

EngenderHealth has undergone a major reorganization and consolidation in 2001 in order to facilitate coordination of project activities. EngenderHealth's reorganization is a positive step towards integrating the work of separate divisions and will have a positive impact on field operations. EngenderHealth headquarters and field office staffs are highly qualified.

Relations with USAID Missions

All of the USAID Missions visited or interviewed during the evaluation have a good relationship with EngenderHealth; it is a partner highly valued by all. Missions stated that they are satisfied with the contributions of EngenderHealth, in particular with technical assistance delivered, productive working relationships, and EngenderHealth's responsiveness to Mission requests.

Funding Environment

Fluctuations in Mission use of field support funding reflect both changing Mission priorities and concerns about managing a large number of cooperating agencies (CAs). Several Missions have shifted to bilateral projects using consortia. The uncertainty of field support levels and countries from year to year affects the way EngenderHealth conducts its business. The strategic framework, developed with the assumption that recipient countries and field support levels would remain constant over the period of the agreement, is not able to provide a clear picture of achievement because that assumption has not proven valid.

Cost Sharing

EngenderHealth reached its cost share or exceeded it every year of the agreement. This requirement has enabled EngenderHealth to diversify its funding base and has been an important vehicle for promoting greater marketing and institutional development efforts.

Coordination and Collaboration

EngenderHealth works collaboratively and productively with a number of other CAs, such as Johns Hopkins University (JHU), JHPIEGO, PATH, PRIME, and the Population Council, in a number of countries. EngenderHealth and JHPIEGO, the primary USAID CAs involved in training in clinical contraception, are generally able to work out divisions of responsibility amicably in most countries where both CAs work.

KEY RECOMMENDATIONS FOR THE REMAINDER OF THE COOPERATIVE AGREEMENT

The following provides a list of summary recommendations for the remainder of the cooperative agreement. The recommendations are presented in priority order.

Continue to focus on clinical contraception.

Analysis of the DHS demonstrates that clinical contraception deserves high priority in the future. There is still considerable unmet demand in the countries in which EngenderHealth has been working. While expanding its scope to cover broader areas of health care, EngenderHealth has to be cautious to maintain its focus on clinical FP.

Improve the monitoring and evaluation system.

EngenderHealth should reduce the number of indicators used in its framework and collect only essential statistics on accessibility and use in all countries in which EngenderHealth is assisting with clinical services. EngenderHealth should also continue to improve the IMIS by upgrading accessibility and training of staff in its use.

Focus additional attention on sustainability.

EngenderHealth has considerable experience with promoting sustainability and institutionalization issues and it is in a strong position to inform the field of sustainability. EngenderHealth should review its worldwide experience in sustainability of services and identify/develop approaches and guidelines to foster sustainable program gains and to help promote increased understanding of the issues surrounding this work.

Increase advocacy efforts to promote clinical contraception.

EngenderHealth should strengthen its global efforts to have a focused advocacy role in promoting clinical FP services and to promote the mobilization of global resources for clinical contraception.

Continue to focus on postabortion care.

EngenderHealth should continue its focus to expand PAC. Because of the difficulties associated with developing linkages to integrate FP counseling and services to other reproductive health services, EngenderHealth should continue its efforts to strengthen this area within the PAC context. EngenderHealth should also track the percentage of PAC clients who accept a FP method in the sites it serves.

Develop a systematic approach to show results of quality improvement tools.

EngenderHealth has evidence that in some countries, the use of quality improvement tools has improved the quality of services. EngenderHealth should adapt the methodologies it has developed in these countries for evaluating quality improvement tools and use them for wide-scale assessment of these tools.

Maintain focus and document the effectiveness of clinical training.

EngenderHealth should maintain its focus on clinical training. The shortage of trained providers continues to be a priority issue in most EngenderHealth-assisted countries. EngenderHealth should also establish a systematic evaluation of its training activities to document the success and depth of its efforts in training.

Conduct research to address key programming issues.

EngenderHealth should revise its research agenda to address some key programming questions. EngenderHealth should also find ways to disseminate research results, best practices, and lessons learned effectively so that country programs in different regions are informed by these results.

Devote additional attention to the promotion of vasectomy.

Only one third of EngenderHealth-supported sites offering male RH care provide vasectomy services. Vasectomy services should be promoted more widely as part of men as partners programs.

Conduct qualitative research on client wants and needs.

EngenderHealth should enhance its understanding of client needs and wants, particularly in countries where clinical FP service utilization is stagnant or declining, by conducting research on client wants and needs.

I. BACKGROUND

EngenderHealth is a nonprofit organization that works to improve reproductive health (RH) services worldwide. Since 1971, EngenderHealth has taken the lead under agreements with the U.S. Agency for International Development (USAID) for making safe, high-quality, voluntary sterilization services and other clinical family planning (FP) methods available throughout the developing world.

This evaluation assesses contributions of EngenderHealth to improving clinical reproductive health services worldwide under its cooperative agreement, Program for Voluntary Surgical Contraception and Related Services, with USAID/Washington's Bureau for Global Health (GH), and makes recommendations to guide GH in designing future interventions for clinical reproductive health services. Specifically, the impact of EngenderHealth's activities on the access, quality, scaling up, and institutionalization of clinical services delivery since 1998 is evaluated. This includes FP clinical services, postabortion care (PAC), voluntarism and informed choice, quality improvements, male involvement in FP, research and evaluation, and global leadership activities.

METHODOLOGY

The evaluation team consisted of a medical doctor with 12 years experience in managing USAID's health and FP programs in Turkey; a demographer and statistician with experience in both managing and evaluating USAID family planning programs; a nurse with a specialization in public health, reproductive health, and population planning who has implemented and evaluated clinical services in the U.S. and in many other countries; and an economist with 20 years experience in USAID program management positions, including Mission director. The evaluation took place from May 28 to August 30, 2002.

The team selected its focus areas from a matrix of key questions included in the evaluation scope of work based on the cooperative agreement's strategic framework and other issues of concern to USAID/Washington (see appendix A). In particular, USAID/Washington wished to know to what extent field support contributed to the RH Strategic Objectives of USAID country programs and whether activities under core funding responded to the needs of country programs.

The evaluation team analyzed national Demographic and Health Survey (DHS) data (on clinical method prevalence, desire for additional children, and unmet need for limiting methods) in EngenderHealth-supported countries and available service statistics reported from EngenderHealth-affiliated project sites. The team enriched findings from the statistical data with qualitative assessments of the key project components based on

- a review of project documents, particularly those produced since the last project evaluation in 1998, including a comprehensive self-assessment prepared by EngenderHealth;

- discussions with USAID/Washington and EngenderHealth staff;

- structured interviews with knowledgeable representatives from 13 USAID Missions; and

- visits to four countries in which EngenderHealth operates (Ghana, Kenya, Bangladesh, and the Philippines) to observe field activity and to discuss progress with USAID Mission and EngenderHealth in-country staffs, stakeholders, and partners.

The four countries visited engaged the cooperative agreement in different ways. In Ghana, two thirds of the cost of EngenderHealth activity is funded from a bilateral cooperative agreement, supplemented with field support. The program in Kenya employs a bilaterally funded consortium, of which EngenderHealth is the lead partner, but also uses core funds for research with applications broader than Kenya. Bangladesh, which had a bilateral consortium project involving EngenderHealth in the past and a bilateral cooperative agreement for quality improvement, currently has only field support. The Philippines program has relied exclusively on field support, with no bilateral funds.

Appendix B is a list of persons contacted and appendix C lists the sites visited. Summaries of the findings from the four countries visited are in appendix D, while appendix E contains questions and responses from 12 of the 13 USAID Missions queried. The final appendix is a list of assignment references.

CONTEXTUAL ENVIRONMENT FOR FAMILY PLANNING AND POPULATION PROGRAMMING

In assessing EngenderHealth's ability to achieve its objectives for increasing the use of FP and RH services, it is important to understand the environment in which the programs carried out under this cooperative agreement operate. Three major factors were identified that affect the availability of funds for clinical FP services and the interest and ability of donors to support them.

First and perhaps most importantly, the International Conference on Population and Development (ICPD) in Cairo in 1994 resulted in a paradigm shift in perspective of population programming needs. This conference condemned programming with a population reduction focus and expanded the field to a broader set of issues. By the time the first evaluation of EngenderHealth's program was conducted in 1998, the effects of this shift were underway.

The ICPD Plan of Action spelled out the resources that would be required in order to fulfill the ambitious program of expanded reproductive services. Unfortunately, most donor countries were not able to provide the resources required. Some leaders in the population field are concerned that insufficient resources and an expanded scope of expectations have resulted in declines in the availability of FP services. At the 2002 Expert Group Meeting on Completing the Fertility Transition, sponsored by the Population Division of the United Nations, the post-Cairo impacts were discussed by eminent population specialists. Caldwell stated, "The present is unexpectedly a critical time for population change and policy. We are little more than halfway through the great population growth spurt that began in the middle of the twentieth century, but developed-

country governments seem to be losing interest in the issue."[1] To some extent, leaders in the population field held the view that by improving educational opportunities for women, FP use would increase as a natural outgrowth. Attention shifted from direct FP services to new areas of concern about RH, including attention to men as partners and broader areas of sexuality, education, and health.

Issues of gender equity, education and empowerment of women, and reproductive rights are important policy directions and are complementary in nature to policies for FP and reproductive health. They help to create a conducive and enabling environment but do not substitute for FP and RH programs. Indeed, there is a need to be increasingly concerned that basic FP services are included in development priorities.

A second factor is concern about sustainability. Donor countries want to believe that short to mid-term aid will result in recipient countries gaining the capacity and locating the resources to manage programs and/or services without continuing donor support. Certainly it seems to be an important goal for both donors and recipients. Nevertheless, there are few clear guidelines concerning the steps that lead to sustainability and the amount of human and material resources needed. The situation is complicated by the efforts of governments in many developing countries to carry out health care financing reforms, which can compromise the reliability of resource allocations to service sites. The study of sustainability requires the review not only of organizations and programs but also of political and governance issues within operating environments.

A third important factor is the reduction in the size of government. Over the last decade, support to population programs has declined as have the numbers of technical staff supported by USAID. USAID Missions are turning to large consortia as a means of reducing their administrative burden. Consortia attempt to meld objectives of competing organizations to manage the design, operations, and results expected. These arrangements mix individual organizational objectives with those of funding sources. As Missions try to find increasingly efficient ways of managing reduced population resources with fewer staff, some are moving away from using single-purpose FP cooperating agencies in favor of consortia or other broader mechanisms.

In reviewing the findings of this evaluation, the impact of these three global factors (broadened definition of population planning without commensurate resources, ill-defined emphasis on sustainability with unclear timeframes, and the declining ability of USAID to manage diverse single-purpose grantees) on the environment in which EngenderHealth is implementing its cooperative agreement should be kept in mind.

[1] Caldwell, John C., "The Contemporary Population Challenge," UN/POP/CFT/2002/BP/1.

II. PROGRAM DESCRIPTION

The project began in 1993 with a five-year cooperative agreement that was renewed for an additional five years in 1998. Under this second cooperative agreement, the project purpose is to provide support for voluntary sterilization and other related services in developing countries in support of USAID/Washington's Strategic Objective, "Increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and nonclinical programs." The project focuses on providing global leadership in voluntary sterilizations, other long-term methods (Norplant, injectable contraceptives, intrauterine devices [IUDs]) and PAC, and on increasing the availability and use of clinic-based FP services in about 40 countries. There are two levels of activity:

- **technical and programmatic assistance to country programs (field support)** to increase the availability and use of clinic-based FP services and to increase the capacity of host country institutions to manage service delivery efforts; USAID Mission requests determine the location, the issues, and the funding level at which EngenderHealth works; and

- **global leadership programs (core funding)** to advance state-of-the-art and technical and programming guidance on voluntary sterilization, clinic-based reproductive health services, PAC, informed choice, meeting the needs of special client populations, and quality improvement. Research topics are suggested by EngenderHealth or USAID, often based on issues that emerge from field support programs. EngenderHealth and USAID/Washington agree on work plans annually.

The project specifies six Intermediate Results (IRs) that EngenderHealth should achieve to contribute to USAID/Washington's reproductive health Strategic Objective:

IR 1: Increased availability of quality family planning and selected reproductive health services
IR 2: Clinical quality assurance/quality improvement systems established at the institutional level
IR 3: Increased client satisfaction with services provided in EngenderHealth-supported programs
IR 4: Contribution by EngenderHealth-supported programs to ensure an appropriate range of contraceptive methods and/or utilization of services within five years in selected countries
IR 5: Increased availability of technical and programmatic guidance for clinic-based services intended to improve program sustainability and client satisfaction
IR 6: Increased leadership, contribution to, and visibility within the international dialogue on family planning and reproductive health

The funding ceiling for the five-year cooperative agreement period is $137 million. EngenderHealth expects to receive $78,878,000 through June 30, 2002, of which $26,861,000 is core (global leadership) funding and the remainder is field support. To foster sustainability, the project calls for cost sharing by other funding sources to reach 25 percent of the total cost of project activity by 2003.

III. CLINICAL CONTRACEPTION TRENDS IN ENGENDERHEALTH–ASSISTED COUNTRIES

During the period of EngenderHealth's cooperative agreement with USAID, project activities have been undertaken in 32 countries (see table 1). Projects are executed through formal subagreements with subgrantees (usually the case with field support) or through other contractual mechanisms. This distinction is important in that EngenderHealth has no legal leverage to require that service statistics be reported on project performance in countries without subagreements.

As shown in table 1, not all countries in which EngenderHealth has been working since 1998 have received USAID funding. EngenderHealth technical support in Colombia, Pakistan, Moldova, Myanmar, Mongolia, and Ethiopia has been implemented with funds from other donors. In other countries, certain program areas are funded with non–USAID resources (e.g., startup PAC activities in Indonesia and the Philippines). Since projects funded by other donors count as part of the 25 percent cost-share component of the USAID cooperative agreement, they are included (when data are available) in this evaluation of EngenderHealth's field activities.

Table 1
Countries with EngenderHealth Assistance by Subagreement Status, 1998–2003

Countries With Subagreements		Countries Without Subagreements	
Asia and Near East		**Asia and Near East**	
Cambodia*	Nepal	Bangladesh	Mongolia*
Indonesia	Pakistan*	India	Turkey
Jordan	Philippines	Kyrgyzstan	Uzbekistan
		Myanmar*	
Africa		**Africa**	
Ghana	Nigeria	Ethiopia*	
Guinea	Tanzania	South Africa	
Kenya	Uganda	Senegal	
Malawi			
Latin America		**Latin America**	
Bolivia	Guatemala	Honduras	
Colombia*	Paraguay	Mexico	
Dominican Republic			
Europe		**Europe**	
NA		Russia	Moldova*

*Country activities supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau for Global Health.

This review uses data from DHS implemented by ORC/Macro International and the Centers for Disease Control (for Honduras). Countries selected for this review are EngenderHealth countries in which more than one DHS has been undertaken since 1990. This criterion allows for the assessment of national trends in clinical contraception for many countries in which EngenderHealth has been working during the current cooperative agreement (the major omission being Mexico). Unfortunately, most of the countries under review have not had a DHS since 1998, particularly in the Asia/Near East and Africa regions, so the examination of national trends is of limited value in evaluating

the performance of EngenderHealth-supported countries during the period of its current cooperative agreement.

This analysis was conducted in order to provide a context for EngenderHealth's activities and programs. The presentation of such national-level DHS data is not meant to imply that the outcome of EngenderHealth's project-level activities should have been expected to have a major influence upon national-level outcomes. Nor are trends in DHS data necessarily valid indicators of DHS performance. It is not feasible to identify the extent to which national-level performance can be ascribed to the number of clients served by EngenderHealth-supported facilities.

FEMALE STERILIZATION

Figures 1 through 3 provide information on levels and trends in female sterilization for countries having had support from EngenderHealth during the current cooperative agreement. The percentage of currently married women aged 15–49 using female sterilization has not increased substantially in most of these countries since 1990. In the Asia and Near East region, only India and Nepal have registered gains in female sterilization over the past decade. In Bangladesh, female sterilization has continued to fall during the 1990s, although the biggest declines occurred between 1985 and 1991. Female sterilization has remained low in Indonesia, the Philippines, Jordan, and Turkey since 1990.

In Africa, Malawi experienced a sizable gain in female sterilization between 1992 and 2000 (with prevalence rising from 1.7 percent to 4.7 percent). While these performance levels are still low, they do present an encouraging upward trend. In Kenya, the use of sterilization is somewhat higher than in Malawi, but there were only modest gains in prevalence between 1993 and 1999. Other African countries in which EngenderHealth has been working report low levels of use with little evidence of any sizable upward trend.

Over the past decade, EngenderHealth countries in Latin America have been emerging as success stories. Bolivia, Colombia, the Dominican Republic, and Guatemala have all recorded improvements in female sterilization use since 1990. Female sterilization is also a major method in Honduras and has been an important component of that country's successful FP effort (the Honduras contraceptive prevalence rate [CPR] has increased from 50.0 percent to 61.8 percent between 1996 and 2001).

Figure 1
Percentage of Currently Married Women Aged 15–49 Currently Using Female Sterilization
(Asia and Near East, 1990 to 2001)

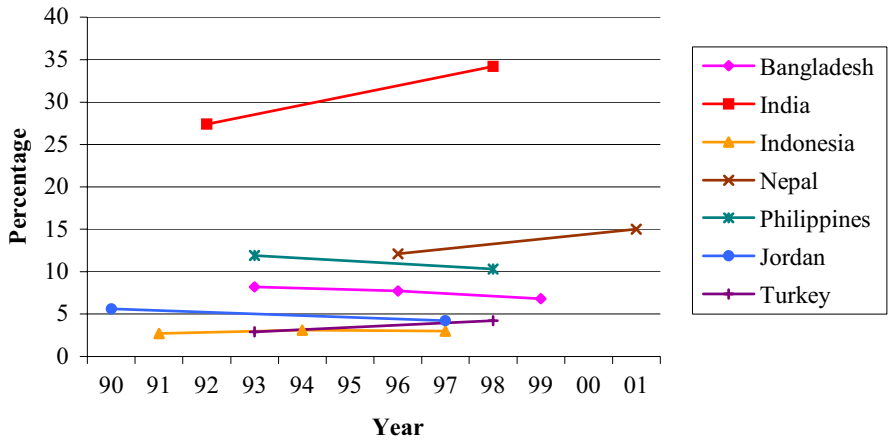


Figure 2
Percentage of Currently Married Women Aged 15–49 Currently Using Female Sterilization
(Africa, 1990 to 2001)

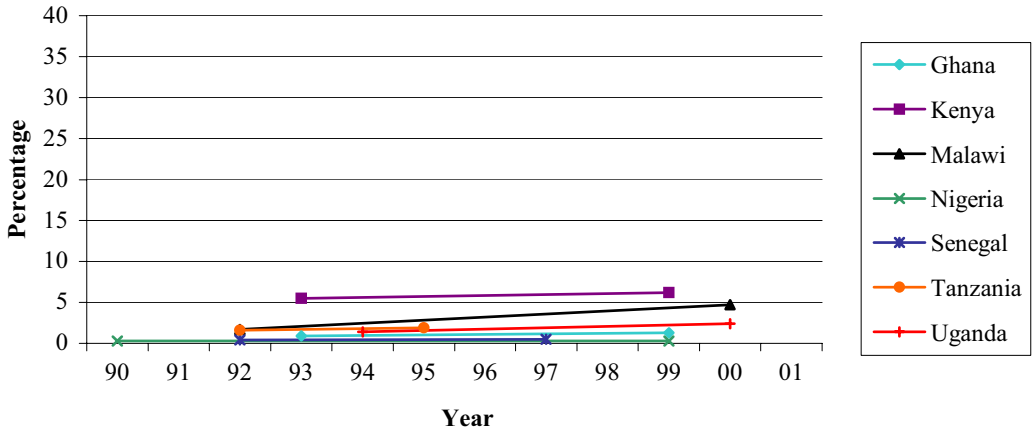
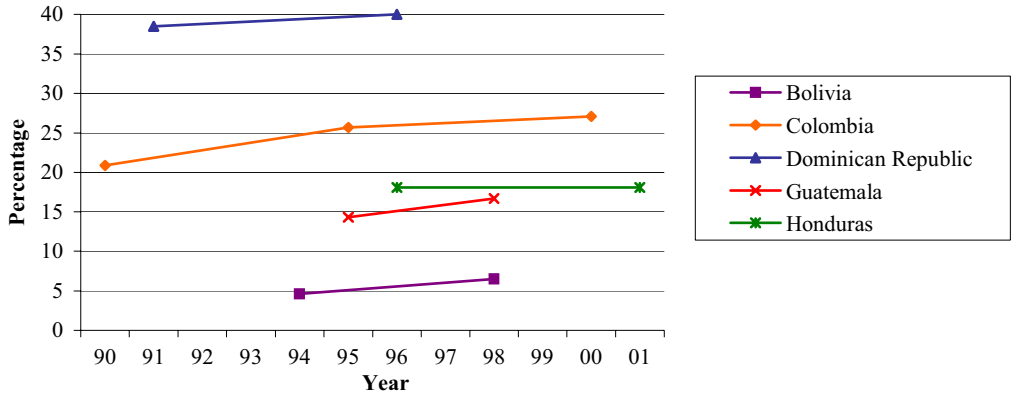


Figure 3
Percentage of Currently Married Women Aged 15–49 Currently Using Female Sterilization
(Latin America, 1990 to 2001)

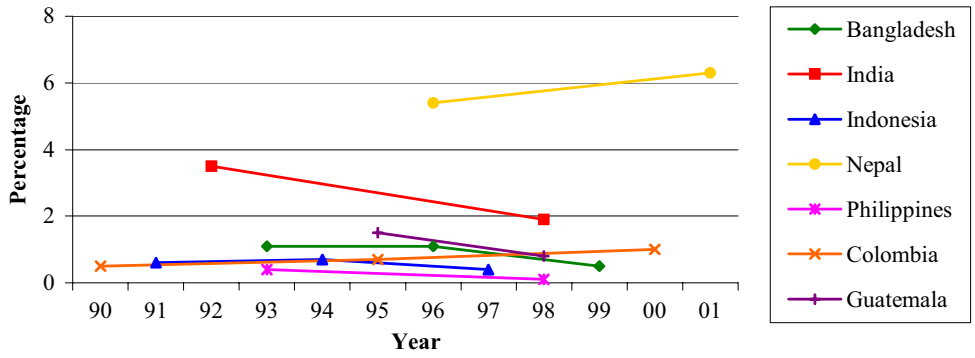


MALE STERILIZATION

Throughout the 1990s, male sterilization continued to be a much underutilized FP method. In most EngenderHealth countries, male sterilization simply does not register as a method of contraception in national Demographic and Health Surveys.

Figure 4 presents information on male sterilization in countries with measurable levels of use. Nepal is the only EngenderHealth country in which more than 5 percent of all currently married women aged 15–49 report that their husbands had a vasectomy. Nepal and Colombia are the only countries that have reported any increase in vasectomy since 1990. This disappointing outcome is accentuated by the fact that male sterilization prevalence fell in India from 3.5 percent to 1.9 percent over the seven-year period from 1992 to 1998.

Figure 4
Percentage of Currently Married Women Aged 15–49 Reporting Husband's Use of Male Sterilization
(Selected Countries, 1990 to 2001)



INTRAUTERINE DEVICES

Figures 5 though 7 provide information on regional levels and trends in IUD use. While the IUD continued to be a major method in several Asia/Near East and Latin American countries, IUD prevalence has been either constant or in a downward trend in most EngenderHealth countries over the past decade. Jordan, Turkey, Bolivia, and the Dominican Republic are positive exceptions to this generally gloomy picture. While IUD prevalence in Colombia has been above 10 percent since 1990, there was no rise in the use of IUDs between 1990 and 2000.

Recent trends in IUD prevalence in Indonesia and Kenya have been less encouraging. IUD use in Indonesia fell from 13.3 percent to 8.1 percent between 1991 and 1997, and in Kenya from 4.2 percent to 2.7 percent from 1993 to 1998. During the 1990s, low levels of IUD use in South Asia either continued to decline (Bangladesh and India) or remained at nearly imperceptible levels (Nepal). It is also disappointing to note that Kenya is the only EngenderHealth country in Africa that has been able to attain IUD prevalence above 2 percent.

Figure 5
Percentage of Currently Married Women Aged 15–49 Currently Using IUDs
(Asia and Near East, 1990 to 2001)

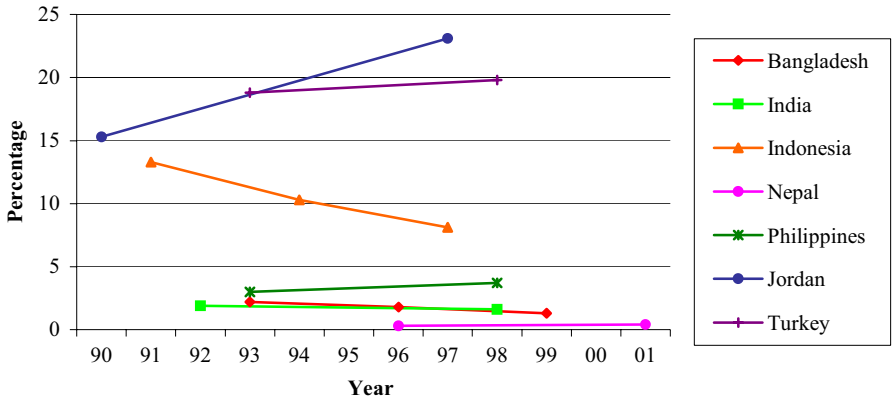


Figure 6
Percentage of Currently Married Women Aged 15–49 Currently Using IUDs
(Africa, 1990 to 2001)

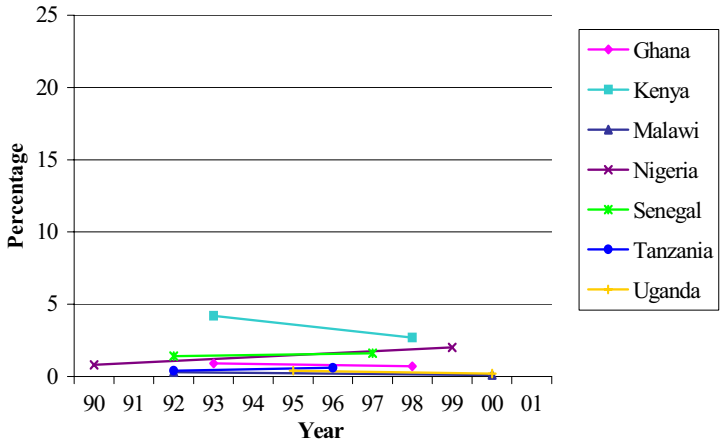
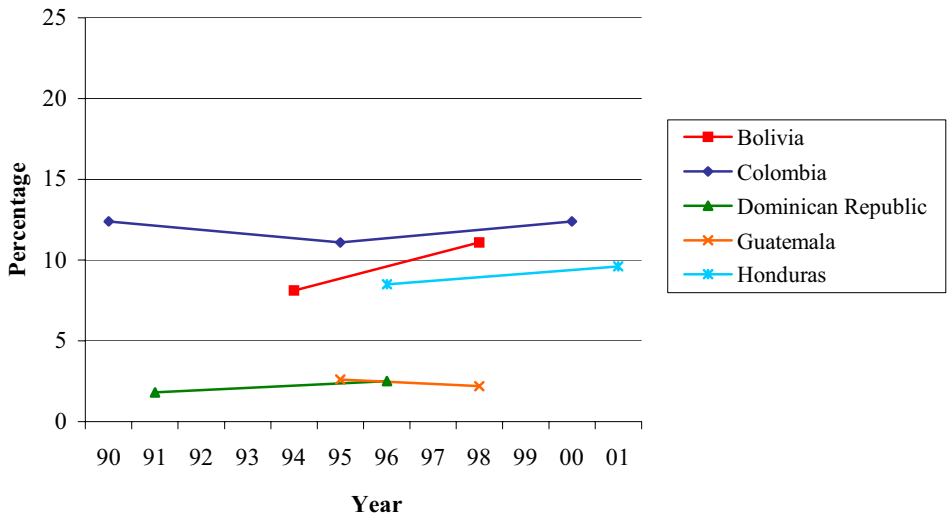


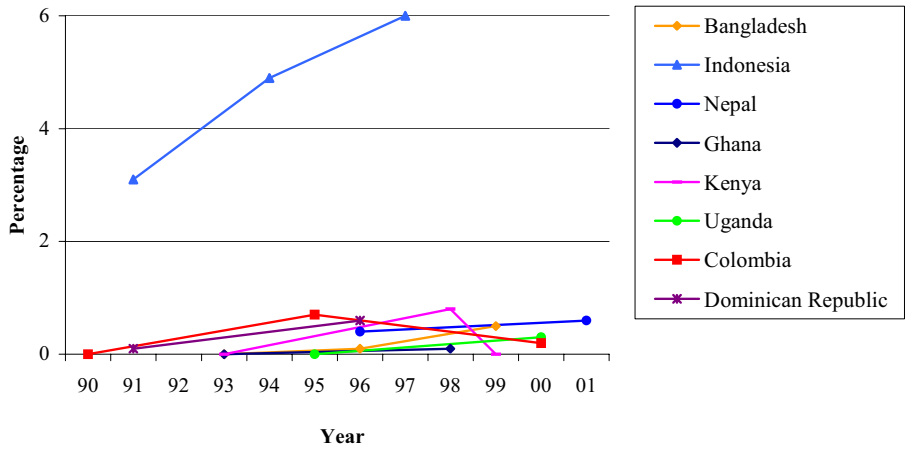
Figure 7
Percentage of Currently Married Women Aged 15–49 Currently Using IUDs
(Latin America, 1990 to 2001)



NORPLANT

Norplant is still not a major method in most developing countries. The cost of the method combined with the need for substantial clinical support and follow up have probably slowed the acceptance of Norplant. Figure 8 indicates that Norplant prevalence has not risen above 1 percent in most EngenderHealth countries. Before the onset of the 1997–98 economic crises, Indonesia had been the one remarkable success story, with Norplant prevalence reaching 6 percent in 1997. More recently there has been concern that the rising cost of Norplant (a price rise triggered largely by the collapse of the Indonesian rupiah) might inhibit the continued growth of the method. However, reports of rising Norplant use in Ghana over the past two to three years were encouraging.

Figure 8
Percentage of Currently Married Women Aged15–49 Using Norplant
(Selected Countries, 1990 to 2001)



DEMAND FOR LONG–TERM AND PERMANENT FAMILY PLANNING METHODS

The demand for contraceptive methods that allow women to limit their fertility is high in countries in which EngenderHealth has been working. Table 2 shows that the percentage of currently married women between the ages of 15–49 who want no more children ranges from 49.6 percent to 66.3 percent in Asia and the Near East, 19.4 percent to 53.3 percent in Africa, and 58.4 percent to 71.3 percent in Latin America. The percentage of currently married women who are not using contraception and who do not want any more children (unmet limiting need) is still substantial in such countries as Bolivia (19.3 percent), Nepal (16.4 percent), Uganda (13.9 percent), Malawi (12.5 percent), and Ghana (11.8 percent). These findings demonstrate that clinical contraception offering long-term and permanent protection from unwanted fertility deserves high priority in the future.

Table 2
Percentage of Currently Married Women Who Want No More Children (Desire to Limit) or Who Are Not Currently Using Contraception and Want No More Children (Unmet Limiting Need)

Country*	Desire to Limit	Unmet Limiting Need
Asia and Near East		
Bangladesh, 1999	58.9	7.3
India, 1998	63.6	7.5
Indonesia, 1998	49.6	4.9
Nepal, 2001	65.6	16.4
Philippines, 1998	61.9	10.6
Jordan, 1997	51.2	6.8
Turkey, 1998	66.3	6.3
Africa		
Ghana, 1999	35.0	11.8
Kenya, 1999	53.3	9.9
Malawi, 2000	42.3	12.5
Nigeria, 1999	19.4	4.5
Senegal, 1997	23.0	9.4
Tanzania, 1995	29.9	8.5
Uganda, 2000	38.5	13.9
Latin America		
Bolivia, 1998	71.3	19.3
Colombia, 2000	69.5	3.5
Dominican Republic, 2000	62.6	5.3
Guatemala, 1998	58.4	11.3
Honduras, 2001	57.1	

*Indicates latest year available
Source: DHS and CDC (Honduras) data for various years

PREFERRED CLINICAL METHOD FOR FUTURE USE

Clinical contraceptive methods are often identified as preferred future methods by women not currently using contraception. Table 3 on the following page indicates that female sterilization and IUDs are preferred future methods in many countries in which EngenderHealth has been working. Women in India, the Dominican Republic, and Nepal are most likely to prefer female sterilization, but other Latin American countries (Colombia and Guatemala) also report substantial future preference for this method. However, there appears to be little interest in male sterilization outside Nepal.

Table 3
Percentage of Currently Married Women Not Currently Using Contraception but Who Intend To Use a Clinical Method

Country*	Sterilization		IUDs	Norplant
	Female	Male		
Asia and Near East				
Bangladesh, 1999	2.3	0.1	0.6	1.0
India, 1998	65.2	0.7	3.2	0.0
Indonesia, 1998	2.1	0.1	7.1	7.6
Nepal, 2001	31.7	8.4	0.8	3.4
Philippines, 1998	8.7	0.1	9.3	0
Jordan, 1997	4.0	0.1	48.1	0.7
Turkey, 1998	6.4	0.4	36.5	0.1
Africa				
Ghana, 1999	3.4	0	2.1	3.6
Kenya, 1999	9.9	0	2.2	4.1
Malawi, 2000	9.9	0.1	1.4	1.4
Nigeria, 1999	2.5	0	8.6	0.9
Senegal, 1997	2.2	0	7.0	10.0
Tanzania, 1995	6.2	0	2.4	1.8
Uganda, 2000	6.4	0.1	0.7	3.3
Latin America				
Bolivia, 1998	5.3	0.2	30.5	0.4
Colombia, 2000	29.2	0.8	17.6	7.3
Dominican Republic, 2000	33.2	0.2	5.0	7.1
Guatemala, 1998	22.9	0	3.6	0
Honduras, 2001	20.4	0	10.3	0

*Indicates latest year available
Source: DHS and CDC (Honduras) data for various years

Future preference for IUDs tends to be concentrated in the Middle East (Jordan and Turkey) and in Latin America (Bolivia, Colombia, and Honduras). An increased number of women are now identifying Norplant as a preferred future method in recent surveys. Norplant appears particularly attractive to women in Senegal, Indonesia (prior to its economic crisis), Colombia, and the Dominican Republic.

These estimates underscore the need to improve the accessibility and quality of clinical FP methods in future years. It is quite likely that even more women and men will prefer clinical contraception once they are better informed about the advantages of long-term and permanent methods and come to trust the quality of service provision in their communities.

IV. FINDINGS

Principal findings for this evaluation draw upon a wide range of data sources. They include reviewing a large number of documents, visits to four country programs, interviews with USAID field Missions, and interviews of USAID/Washington and EngenderHealth staff. In addition, analyses of relevant DHS and EngenderHealth service statistics were conducted.

The findings address 15 separate areas of project performance encompassed by the cooperative agreement and the Results Framework: accessibility of clinical contraceptive services, utilization of clinical FP methods, monitoring and evaluation, PAC, men as partners, quality improvement, service improvement, voluntary and informed choice, client perspectives and satisfaction, scaling up and sustainability, leadership, research, collaboration and complementarity, program management, and funding issues.

CONSTRAINTS ON SERVICE STATISTICS DATA

Findings on the accessibility of clinical contraceptive services and utilization of clinical FP methods address IR 1 (Increased availability of quality family planning and selected reproductive health services) and IR 4 (Contribution by EngenderHealth-supported programs to ensure an appropriate range of contraceptive methods and/or utilization of services within five years in selected countries). These results rely on reported service statistics and constitute an important source of information for evaluating EngenderHealth project activities.

These service statistics are only reported for countries in which EngenderHealth operates through formal subagreements with subgrantees. During the period of USAID's current cooperative agreement, 19 of 32 EngenderHealth countries have been reporting service statistics through subagreements. Since some countries have been graduated by USAID (thereby ending EngenderHealth's in-country presence) and others have switched from field support to bilateral funding (thereby curtailing the ability to report service statistics), not all of the 19 countries under review report results for the three-year period from fiscal year[2] (FY) 1998/99 to FY 2000/01. For this reason, over 40 percent of EngenderHealth-supported sites do not report service utilization data to EngenderHealth. It is also important to note that countries that have been added to the EngenderHealth portfolio in recent years (e.g., Bolivia, Cambodia, Guinea, Jordan, and Malawi) tend to have smaller potential client populations and therefore report fewer numbers of sites and clients served. Findings from countries reporting performance information on service accessibility and utilization through subagreements are described in detail in appendix F.

ACCESSIBILITY OF LONG-TERM AND PERMANENT METHODS

Since FY 1998/99, the total number of facilities affiliated with EngenderHealth has fallen by 24 percent, as several large countries have been graduated (Mexico and Turkey), bilateral programs ended (e.g., Indonesia), or project activities were reconstituted and phased down (e.g., Kenya and the Philippines). However, discounting the two countries (Mexico and Turkey) in which EngenderHealth ceased operations because USAID

[2]Effective in fiscal year 1999/2000, AVSC International changed its fiscal year to end on June 30.

phased out its assistance, the number of EngenderHealth-affiliated service sites rose 94 percent during the first three years of the cooperative agreement.

Owing largely to the conclusion of technical assistance for sterilization in Indonesia and the phaseout of program support for the Local Government Unit Performance Project (LPP) in the Philippines, the total number of EngenderHealth-assisted sites offering female sterilization declined by 18 percent between FY 1999/00 and FY 2000/01.

In other countries, the number of sites providing sterilization tended to rise, most notably in Nepal. The number of EngenderHealth-affiliated facilities offering male RH services increased by 37 percent since FY 1999/00. Site expansion occurred most dramatically in Nepal and India. The number of sites offering male RH services in other countries tends to be low and is not usually sufficient to influence national vasectomy prevalence.

THE UTILIZATION OF LONG–TERM AND PERMANENT METHODS

It is difficult to provide meaningful quantitative estimates of contraceptive utilization in EngenderHealth-supported sites. As noted previously, trend data based on multicountry aggregates are virtually meaningless since the total number and identity of countries changed significantly over the period. In addition, data are unavailable from more than 40 percent of supported sites in which EngenderHealth operates without formal subagreements. Of the 32 countries assisted through the cooperative agreement, even partial utilization data are only available for 17 countries. The USAID budget for EngenderHealth activities declined or went to zero in 11 of these 17 countries. These caveats need to be kept in mind in interpreting the utilization data reported below.

Between FY 1998/99 and FY 2000/01, the number of clients obtaining female sterilization, male sterilization, IUDs, and Norplant from EngenderHealth-affiliated sites fell from 111,911 to 71,706. This decline was largely due to the conclusion or recasting of program activities in such countries as Guatemala, Indonesia, Kenya, Mexico, the Philippines, Turkey, and Uganda. In countries continuing to report service statistics to EngenderHealth, there have been some gains in service provision (e.g., in the Dominican Republic, Ghana, Jordan, Malawi).

The number of clients obtaining female sterilization care in EngenderHealth-affiliated facilities fell from 73,518 in FY 1998/99 to 38,152 in FY 2000/01. Much of this decline was due to a change in the composition of countries in which EngenderHealth has been working and realignment of country programs (e.g., in Kenya and the Philippines). In Nepal, the decline in clients is unexpected given the reported increase (by 54.7 percent) since FY 1999/2000 in the number of facilities providing female sterilization. On a more positive note, several countries in Latin America appear to be emerging as female sterilization success stories—most notably, Bolivia, Guatemala, and the Dominican Republic.

There is also evidence to suggest that there has been some decline in sterilization services provided during the postpartum period. Since FY 1998/99, the number of postpartum minilaparotomy (ML) clients fell from 32,866 to 7,644, a decline which is disproportionate to reductions in interval minilaparotomy, laparoscopy (LAP), and Caesarean-section minilaparotomy. It is again important to note that these declines may

again be largely due to the compositional change in the number of countries (and distribution of affiliated service sites) in which EngenderHealth has been working.

The number of vasectomy clients served by EngenderHealth affiliated sites rose from 4,564 to 6,059 between FY 1998/99 and FY 2000/01. Much of this increase occurred in Nepal. The number of vasectomy clients reported through subagreements in other EngenderHealth countries is very low.

The number of IUD clients served by EngenderHealth-affiliated sites fell from 15,589 to 7,881 between FY 1998/99 and FY 2000/01. While the evolving composition of EngenderHealth's country portfolio accounts for much of this decline, these trends may also partly reflect global declines in IUD use as reported by national-level survey data. However, some countries in which EngenderHealth has been working report gains in IUD use, that is, Colombia, Honduras, Jordan, and Turkey.

There is no clear trend in the number of Norplant clients served by EngenderHealth-affiliated sites since FY 1998/99. The number of Norplant insertions decreased in Nepal and Kenya. Public sector funding cuts combined with the hesitancy of private sector doctors to report client data can account for part of this decline in Nepal. Norplant declines in Kenya have been attributed to the lack of trained staff and recent commodity shortages. However, EngenderHealth does appear to be achieving some success with Norplant in several African countries (Ghana, Tanzania, and Malawi) as well as Colombia and the Dominican Republic.

Results suggest that the average number of long-term and permanent method clients per site has been falling over the past three years of the cooperative agreement. In FY 1998/99, 138 long-term and permanent method clients were served per site. This figure declined to 59.8 clients per site by FY 2000/01. There were also declines in the average number of sterilization clients served per site between FY 1999/2000 and FY 2000/01. While these trends may imply that there have been declines in cooperating agency (CA) performance, they also certainly reflect change in the number and number composition of countries reporting results since FY 1998/99 (e.g., countries with relatively high client loads per site such as Indonesia, Uganda, and Guatemala stopped reporting results in FY 2000/01) and change in the distribution of sites within countries (e.g., Kenya and the Philippines).

While trends in the average number of clients served per site are difficult to interpret, it is clear that client loads at EngenderHealth-supported facilities are quite low on an annualized basis. For example, there were 71 female sterilization clients served per site in FY 2000/01. This works out to only 5.9 female sterilization clients per site per month. In the same fiscal year, there were only 1.2 vasectomies performed per site per month. These performance levels vary considerably across countries. For example, in FY 2000/01, the Dominican Republic and the Philippines reported high female sterilization client loads per site (312.7 and 385.1 clients, respectively) while facilities in Nepal, Kenya, and Nigeria performed at substantially lower levels.

Quantitative evidence is too incomplete and fragmentary to reach definitive conclusions about overall results pertaining to accessibility and utilization of clinical FP methods during the first three years of the current cooperative agreement. However, it is possible

to draw some conclusions about country-level performance from available service statistics. Based on this evidence, country-level performance has been mixed. There are notable successes to report over the past three years (e.g., the rise in female sterilization in several Latin American countries and gains in Norplant use in Ghana) but also some discouraging results (e.g., declines in female sterilization in Nepal and reductions in the number of IUD clients served in Nepal and Tanzania).

Despite the mixed picture presented by EngenderHealth's service statistics, Mission representatives interviewed by the team were definitive in their belief that EngenderHealth has contributed to the achievement of their Strategic Objectives and Intermediate Results related to the expansion of FP services. Of the 13 Missions interviewed, 11 stated that EngenderHealth had been a major contributor to increased access to quality FP services and/or to increased utilization of services. Most reported that there are data to support these claims. The two Missions that did not view EngenderHealth as having made a major contribution to increased services had explanations pertaining to cultural and religious issues surrounding surgical contraception that greatly dampened demand (although IUD use is on the rise) and to EngenderHealth's focus being on quality improvements rather than on expansion of services (and EngenderHealth succeeded in improving quality).

MONITORING AND EVALUATION

The Integrated Management Information System

During the period of EngenderHealth's current cooperative agreement with USAID, it has made substantial efforts to improve monitoring and evaluation. The centerpiece of this effort has been the development of an impressive new integrated management information system (IMIS). The IMIS is an Intranet database powered through Citrix Systems hardware and Active Server Pages (ASP) software technologies that can be accessed by EngenderHealth staff working at headquarters in New York, regional offices, and country program offices.

Four types of data are maintained in the IMIS: financial records, medical monitoring data, administrative/programmatic information, and service statistics. For projects that are implemented through subagreements, information is sent to the IMIS in New York on a quarterly or periodic basis through seven standardized reporting forms (see table 4). These forms are not submitted on a routine basis when project activities are not programmed through subagreements.

Since the IMIS was only developed in 1998, its full potential as a monitoring and evaluation tool has yet to be realized. At the present time, the IMIS is used primarily to prepare annual work plans and budgets as well as to compile project performance data submitted by regional and country offices. Currently, the IMIS does not appear to be used as extensively as it could be to troubleshoot program implementation issues or guide management decision-making. As additional staff members are trained in IMIS protocols and Internet connectivity difficulties between New York and the field are gradually resolved, the IMIS should live up to its considerable potential.

Table 4
Reporting Forms Employed by EngenderHealth's IMIS

Financial Data
Form 1: Financial Report
(1–A Status of Local Funds and 1–B Budget and Expenditures)
Programmatic Data
Form 2: Narrative Progress Report
Form 4: Training Event Report
Form 5: Summary Training Report
Service Statistics
Form 3: Service Statistics Report
Medical Data
Form 6: Report for complications or pregnancy related to contraception or other reproductive health procedure
Form 7: Report for death related to contraception or other reproductive health procedure

When visiting EngenderHealth offices in the four countries visited, the team observed the ease of access and use of the IMIS. It was easily accessible in Ghana and Kenya using the ASP format. However, the excruciatingly slow Internet connection speed in Bangladesh made the IMIS cumbersome and frustrating to use. Until connectivity problems are resolved, the IMIS will likely be underutilized in the field.

Additional information technology technical support from headquarters and regional offices would likely help strengthen IMIS utilization. EngenderHealth's regional information technology support person, based in Bangkok, only visited Bangladesh (on average) for a few days once every 3 months. This visitation schedule may be suboptimal given the connectivity troubles at the Bangladesh country office.

Quality and Usefulness of the Results Framework

EngenderHealth is currently reporting a wide array of performance indicators (listed in table 5 on the following page) that are tied to the six Intermediate Results (IRs) specified in EngenderHealth's cooperative agreement. Clearly, EngenderHealth has made a good effort to be responsive to the reporting requirements stipulated in the agreement. However, an effective and easy-to-use monitoring and evaluation system should employ a more limited range of indicators that track only essential core activities. These indicators should be easy to collect on a routine basis, provide valid measures of project activities, and qualify as robust measures of program performance.

Many of the current indicators do not share these characteristics. Consequently, they do not always provide valuable management information to EngenderHealth or USAID. EngenderHealth has been attempting to record performance data (sites served and service statistics data [Indicators 1.1 through 1.5 and indicator 4.1]) from all EngenderHealth projects, regardless of the source of donor support. However, it has only been possible to consistently compile service statistics from project sites supported by subagreements with EngenderHealth. Since data are often incomplete or of questionable reliability, they do not provide a clear picture of program activity. In addition, as EngenderHealth phases out service delivery activities in one country and phases into another, the number of

countries and sites upon which service statistics are based is highly variable from year to year.

Table 5
Core Performance Indicators Incorporated in EngenderHealth's IMIS

1.1:	Number and type of service delivery sites supported by EngenderHealth
1.2:	Number and type of service delivery sites providing quality postabortion care services
1.3:	Number of sites providing contraceptive services to postpartum women
1.4:	Number of service delivery sites providing services to men with EngenderHealth support
1.5:	Number of service delivery sites providing female sterilization services
1.6:	Number of training events supported by EngenderHealth programs by topic
1.7:	Number of persons trained in EngenderHealth support programs by content area
2.1:	Number of EngenderHealth-supported institutions in which EngenderHealth is supporting the strengthening of quality assurance/quality improvement systems
2.2:	Number of EngenderHealth-supported service delivery sites implementing quality insurance approaches/guidelines by approach
2.3:	Number of organizations that have adopted or adapted EngenderHealth quality improvement approaches or tools (in whole or in part)
3.1:	Number of EngenderHealth-supported studies on client satisfaction
4.1:	Number of clients served at EngenderHealth-supported programs by service, method (where applicable), and timing of service provision (i.e., postpartum)
5.1:	Number of service delivery or clinical evaluation for research studies designed, implemented, and completed to improve service delivery
5.2:	Number of EngenderHealth programs utilizing the results from EngenderHealth-sponsored or other research and/or evaluation to improve services
5.3:	Number of technical and programmatic approaches, guidelines, and/or other reference documents produced for clinic-based FP and reproductive health service delivery
5.3.A:	State-of-the-art-publication
5.3.B:	Job aids
5.3.C:	Reports
5.3.D:	Translations
6.1:	Number of countries where EngenderHealth has worked to influence national policy related to FP and reproductive health issues
6.2:	Number of country, regional, or international meetings or panels sponsored by EngenderHealth to address special issues
6.3:	Number of professional papers published in peer-reviewed journals (international and country specific; includes working papers)

EngenderHealth is aware of the weakness of the current Results Framework, as reported in its self-assessment. In putting together its annual report for 2000–01, EngenderHealth developed a better understanding of the flaws in its reporting system (attributable to the Results Framework, the changing role of technical assistance and consequent funding mechanisms, and changes in USAID Mission strategies and USAID procedures). EngenderHealth has embarked on a process to correct this situation, including investigating data quality in key countries, developing an alternative methodology for estimating service trends that does not rely exclusively on quarterly subagreement reports, and modifying its data collection systems.

The indicators related to quality assurance, client satisfaction, programmatic guidance, and leadership are measures of output, but what is really needed for decision-making in these areas are indications of the *impact* of these outputs. The current indicators for these IRs are little more than lists of studies completed, guidelines or documents compiled, publications and reports produced, international meetings attended, and professional papers presented. They are lists of outputs, not measures of effectiveness or impact.

Consequently, they do not really measure whether indicators were achieved and are not particularly useful for assessing EngenderHealth performance.

As presently constituted, the number of indicators incorporated in the Results Framework is excessive. Specifically, there is little practical benefit for USAID/Washington or EngenderHealth in obtaining information from indicators 2.1, 3.1, 5.1, 5.2, 5.3, 5.3.A, 5.3.B, 5.3.C, 5.3.D, 6.1, 6.2, and 6.3. Rather than having EngenderHealth commit valuable staff time compiling indicators of little utility to program management, efforts should be focused on

- ensuring the completeness and reliability of essential program indicators,
- improving the reporting of key service statistics from project sites not supported through formal project subagreements, and
- undertaking targeted evaluative studies to determine the reasons for unfavorable trends in long-term and permanent method use and to assess the impact and institutionalization of key quality improvement and technical tools.

In addition to streamlining the reporting of results (i.e., reducing the number of indicators) and upgrading the accessibility and functionality of the IMIS, additional full-time staff should be assigned to managing the monitoring and evaluation system. This is particularly true for field staff that must often report different performance indicators for the cooperative agreement, bilateral contracts implemented through USAID field Missions, and other donor funding. Rather than placing more responsibility for monitoring and evaluation on New York headquarters personnel, priority should be given to upgrading data management and information technology skills of field staff.

Internal Evaluation

The team identified internal evaluations of EngenderHealth-supported country programs in Egypt, Ghana, Guatemala, Kenya, Mexico and Tanzania (excluding evaluations carried out through bilateral projects) and reviewed evaluations for Ghana, Kenya, and Bangladesh. In addition, the Ghana EngenderHealth country director and West Africa regional director briefed the team on the sentinel sites survey carried out there.

Based on this limited review, the evaluations were found to be comprehensive and candid in identifying areas in need of improvement. In Ghana, information gleaned from the evaluation and the sentinel sites survey resulted in retraining in infection prevention at some sites. The Kenya end-of-project evaluation pointed out problems in project design that had greatly limited potential for institutionalization and financial sustainability of the government program. The follow-on bilateral project, AMKENI, is addressing these issues by working directly with the central Ministry on supervision and training and by incorporating a strong policy component to the project.

Internal evaluations are very useful, particularly when the overall Results Framework is flawed as a means of identifying best practices and lessons learned that could have broad application in more than one country. It was surprising that internal country evaluations

have been used so infrequently. In its self-assessment report, EngenderHealth identified several factors that may have inhibited the use of internal evaluations: differing agendas and strategies of USAID Missions, the shift towards bilateral country programs, and fluctuations in field support.

POSTABORTION CARE

PAC is a relatively new program area for EngenderHealth. In the past three years, EngenderHealth has expanded PAC programs to 20 countries. EngenderHealth directly funded PAC service sites in 12 countries. In FY 2000/01, about 27,600 PAC clients were served through EngenderHealth-affiliated facilities. The number of facilities offering PAC services increased from 122 to 201 sites over the two-year period (shown in table 3 in appendix F). Much of this increase occurred in Indonesia and Russia.

EngenderHealth has worked to expand PAC services in Bangladesh, the Philippines, Ghana, and Kenya. Given the high need in many countries for expanded PAC services, this program area should be given greater attention in the future. Most Missions interviewed gave little attention to the PAC work of EngenderHealth (the Philippines, Tanzania, and Kenya were the exceptions).

Dilation and curettage (D&C) is still the main procedure employed for PAC in most sites supported by EngenderHealth (around 17,600 women had D&C in FY 2000/01). However, the use of manual vacuum aspiration (MVA) is increasing rapidly; about 7,600 patients were treated using MVA in FY 2000/01. MVA procedures are expected to spread widely as additional service providers are trained in MVA and the advantages of this method become apparent. MVA is safer and less costly for both the woman and the health facility than traditional D&C.

In two of the four countries visited, success in PAC is greatest in the first component: treatment of abortion complications. In Ghana and Kenya, trained nurse-midwives were allowed to provide MVA, thus expanding access to the community level. In Kenya, evidence was available of declines in hospital admissions for abortion complications and declines in hospital maternal mortality.

Family planning counseling and service delivery is included in all EngenderHealth standards and training for PAC. However, during the African field trips, the team observed that the second component of PAC—family planning counseling and services—is not as strong as the first component and needs to be strengthened. Data on FP acceptance were only available for the Philippines, Uganda, and the Dominican Republic.

The linkage with other reproductive health services within PAC is very weak. While there are some examples to link with other services, such as diagnosis and treatment of sexually transmitted infections (STIs), this component has received insufficient attention. There has been almost no data collection on the success of PAC counseling in leading to client acceptance of an FP method.

In the Philippines, the team observed that EngenderHealth had made good inroads on training physicians as well as linking to FP services. Training materials and agendas paid careful attention to needs for counseling clients and integrating them into other needed

services. Another achievement in the Philippines is the inclusion and institutionalization of PAC counseling into preservice training for nurses and midwives.

EngenderHealth should continue to strengthen its focus on expanding PAC services. Family planning counseling and services are often in locations that are separate, making linkages to other RH services difficult. There is, therefore, a special need to continue to focus on strengthening these linkages within the PAC context. Further, EngenderHealth should keep track of the number/percent of PAC clients who accept an FP method. Although EngenderHealth believes that this would be difficult to do, if PAC clients have the opportunity to accept an FP method before they leave the clinic, clinic staff should be able to keep records of those clients accepting methods.

MEN AS PARTNERS

Men as partners has been one of the priority initiatives under EngenderHealth programming since 1996. The concept stems from the rationale that women carry a disproportionate responsibility for RH and family size while men often hold the decision-making power over these issues. EngenderHealth recognizes the need to reach out to men with services and education to enable them to share the responsibility for RH.

EngenderHealth's program goals for men as partners are to increase men's

- awareness of and support for RH choices,
- awareness for prevention of sexually transmitted diseases, and
- access to comprehensive RH services, including contraceptive methods.

EngenderHealth believes that the overall effectiveness of its programs depends to a great extent on the involvement of both men and women. EngenderHealth has developed programs that not only deal with men's RH needs but also acknowledge men's power and influence over RH services for women.

Great attention was given to men as partners initiatives in EngenderHealth/New York and in reports of specific country and international activities to addressing men as partners programs. In the field, however, the team observed little activity regarding this initiative. According to service statistics, services for men have been extended to 19 countries since 1996. The number of EngenderHealth-supported sites providing male RH care rose from 815 to 1,114 (a 36.7 percent increase) between FY 1999/2000 and FY 2000/01. Table 13 (in appendix F) indicates that much of this increase has been due to growth in new male RH services (e.g., the treatment and diagnosis of sexually transmitted diseases) and counseling programs designed to better inform men about RH options. In fact, in FY 2000/01, only 31.8 percent of all EngenderHealth-affiliated sites operating through subagreements offered vasectomy services as part of their male RH service. However, since 1998/99, the number of sites offering vasectomy has doubled in Bangladesh (through private sector facilities supported by the National Integrated Population and Health Program [NIPHP]), and has risen somewhat in Kenya, Malawi, Nepal, and Nigeria.

While it is important to address men's RH issues (specifically vasectomy) as well as their support for women's RH, distraction from other goals might result from this process.

EngenderHealth should increase its efforts to incorporate vasectomy as an essential RH service for men. The extent to which EngenderHealth activities with men as partners programs contribute to increasing vasectomy services as well as increasing female access to FP should be monitored.

QUALITY IMPROVEMENT

Quality improvement is made up of a set of elements that deal with technical competence, provider/client interrelationships, information provided to clients, informed choice, service mix availability, continuity, and follow up. There is widespread acceptance that if service sites address quality issues, they will provide services that are safe, effective, and capable of being sustained.

Infection prevention is often dealt with as a distinct area of quality because it needs high priority attention in developing countries. Many educational programs for medical doctors and other health personnel throughout the world graduate people with very limited knowledge of infection control or practical application of procedures for maintaining universal precautions to prevent infections. Because universal infection prevention procedures are not routine within medical colleges, it is a major challenge for training and inservice educators. This need for augmenting practical knowledge and skills of service providers is accompanied by the need to establish clear responsibilities for site supervision to assure safety in service delivery systems. Scarcity of water, chlorine, soaps, and sterilization equipment frequently compound existing problems.

There is no standard method for establishing quality of care in FP services. EngenderHealth has developed a variety of quality improvement tools to identify the most critical steps and training needed to develop the required knowledge and skills. A review of quality improvement tools and approaches developed by EngenderHealth is found in appendix G.

Of the 13 USAID Missions interviewed for this evaluation, 11 cited medical quality assurance and quality improvements among the most important technical contributions of EngenderHealth. Bangladesh, Senegal, and Paraguay considered quality improvement to be EngenderHealth's greatest achievement.

During the field trips, the evaluation team observed practices in clinics as well as reviewed client records and reports of services and activities. Observations included clinical FP procedures for Norplant insertions and minilaparotomies as well as counseling and provider/client interactions. Operating rooms and clinical sites examined showed consistent attention to appropriate infection prevention procedures and adequacy of equipment and supplies.

Quality improvement concepts and skills have been successfully applied to FP services and in many sites; managers were able to provide examples of how these tools improved the quality of services. Quality improvement tools were also applied to a number of service areas beyond FP, including child health, maternal health, and community partnerships. Other departments of hospitals and outpatient clinics are learning and applying infection prevention and quality-of-care procedures to other service areas (obstetric care, for example).

EngenderHealth identified the dilemma of needing to quantify the quality work it was undertaking beyond the quality-measuring tool already in use. A number of different approaches were tested, including one in Bangladesh and one in Ghana. The Quality Improvement Project supported by USAID funding in Bangladesh from 1998 to 2002 is unique in that it included "quality compliance coefficients of composite indicators." Once the measurement tools were refined, a 2–person review team took 2 days per site and derived numbers that resulted in a composite score. Within the life of the project, sites were measured from 2–4 times and scores compared. In almost all instances, there was substantial improvement over time.

Ghana was one of three sites chosen to pilot a sentinel sites survey methodology that has many of the same attributes as the Bangladesh Quality Improvement Project. Special teams visited each site, giving a numerical grade to each of a checklist of indicators for key quality components. Although the exercise proved too resource intensive to carry out in full for a second year, the Ghana EngenderHealth office and USAID Mission were sufficiently pleased with results to carry the evaluation out annually at a reduced number of service sites. Comparison of results between year 1 and year 2 indicated a decline in the quality of infection prevention at certain sites, leading EngenderHealth to initiate a program of retraining in infection prevention. These methodologies, while too complex and expensive to use everywhere, should be adapted and streamlined so that they can be used by recipient programs to monitor progress and identify areas that need additional work.

Following the 1998 evaluation of the USAID cooperative agreement that discussed the need for better understanding of training and its impact, EngenderHealth recognized that a comparative evaluation of whole site training and centralized training would add to the state of knowledge of training methodology. However, EngenderHealth could not find both another CA partner to undertake such a review and Mission support to undertake the work.

EngenderHealth has consistently demonstrated a high level of leadership and accomplishment in actions resulting in improved quality of clinical FP and RH services. Its reach has been comprehensive and effective, making service delivery safer for both clients and health care providers. The greatest emphasis has been directed toward FP counseling and infection prevention. Quality work in FP services has led the way for similar improvements to a broad array of health services.

EngenderHealth should continue its efforts to quantify and document results of quality improvement tools and activities. Also, more effective use should be made of medical monitoring by focusing on specific clinical problems, which tend to be common across sites and across countries, and the types of solutions derived to ameliorate the problems. Documentation of experiences would benefit a broader population. Strengthening lessons learned across countries and regions also would be useful.

SERVICE–BASED TRAINING

Since FY 1998/99, EngenderHealth has conducted 7,122 training events, either through its cooperative agreement with USAID or by using other donor funding. The number of training events by skill area is shown in table 6. In FY 2000/01, 16 percent of all training

events focused on quality improvement, 14 percent on female and male sterilization, 14 percent on instruction in FP counseling and informed choice, 12 percent on infection prevention, and 9 percent on PAC.

Table 6
Number of Training Events Supported by EngenderHealth by Skill Area and Fiscal Year

Skills Area	1998/99	1999/2000	2000/01	Totals
Minilaparotomy (ML)	238	176	86	500
Laparoscopy (LAP)	36	17	0	53
Nonscalpel Vasectomy (NSV)	142	71	46	259
Assist ML	122	67	54	243
Assist LAP	4	16	23	43
Assist NSV	90	4	25	119
Implants	94	85	80	259
IUD	105	72	30	207
Postpartum IUD (PPIUD)	1	43	23	67
Injectable Contraceptives	10	19	3	32
MVA	NA[o]	10	74	84
STDs/RTIs*	16	69	43	128
FP Counseling	373	323	105	801
FP General	170	149	91	410
STD Counseling	128	72	29	229
PAC Counseling	32	260	74	366
Infection Prevention	364	305	190	859
IEC**	13	57	39	109
Medical Monitoring	97	344	27	468
COPE***	130	273	192	595
Facilitative Supervision	19	41	43	103
Health Management/MIS	NA	61	231	292
Men as Partners	NA	42	19	61
Informed Choice	NA	10	39	49
Other	334	387	65	786
Totals	**2,518**	**2,973**	**1,631**	**7,122**

*Sexually transmitted diseases/reproductive tract infections
**Information, education and communication
***Client-oriented, provider-efficient services
[o]Not applicable; data for that category were not collected in specified year

Table 7 and figure 9 show that nearly 79,000 people attended training programs over the past three years of the USAID cooperative agreement. Providers that have had contact with EngenderHealth training events have concentrated on FP counseling (17.6 percent), infection prevention (17.4 percent), and COPE (9.4 percent). MVA training, postabortion counseling, and COPE have experienced the most rapid gains among the skill areas taught to providers.

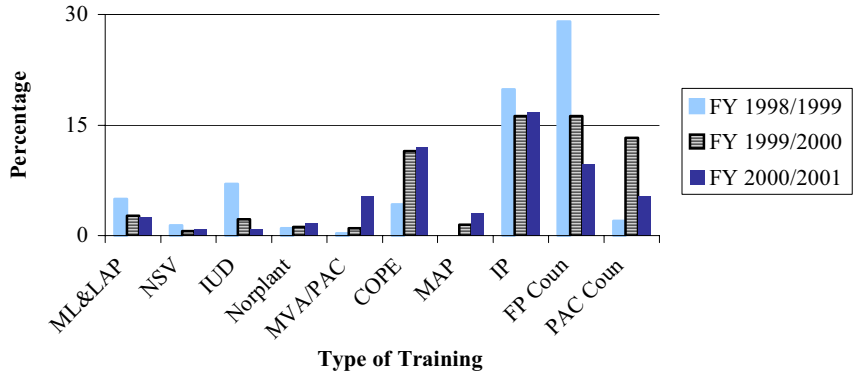
It is important to note that rates of training in female and male sterilization and IUD insertion appears to have declined substantially over this same three-year period (see table 7 and figure 9). While this decline largely reflects compositional change in the number of countries and sites in which EngenderHealth has been working since FY 1998/99, it also tends to suggest that training in clinical FP methods may have declined somewhat in order of importance during the current cooperative agreement.

Table 7
Number of Providers Trained by EngenderHealth by Skill Area and Fiscal Year*

Skill Area	1998/99	1999/2000	2000/01	Totals
ML	589	561	187	1,337
LAP	328	115	0	443
NSV	212	210	117	539
Assist ML	257	195	133	585
Assist LAP	0	101	154	255
Assist NSV	118	6	44	168
Implants	232	421	311	964
IUD	1,652	615	108	2,375
PPIUD	24	177	67	268
Injectable Contraceptives	232	581	81	894
MVA	76	361	1029	1,466
STDs/RTIs	1,517	949	654	3,120
FP Counseling	6,902	5,143	1,863	13,908
FP General	359	1,978	1930	4267
STD Counseling	1,210	1,316	412	2,938
PAC Counseling	474	4,806	1,029	6,309
Infection Prevention	4,718	5,869	3,202	1,789
IEC	1085	1,209	329	2,623
Medical Monitoring/Supervision	85	842	405	1,332
COPE	1,007	4,159	2,291	7,457
Facilitative Supervision	239	541	667	1,447
Health Management/MIS	NA°	2,648	920	3,568
Men as Partners	NA	525	585	1,110
Informed Choice	NA	176	1,417	1,593
Other	2,433	2,696	1,063	6,192
Total	**23,749**	**36,200**	**18,998**	**78,947**

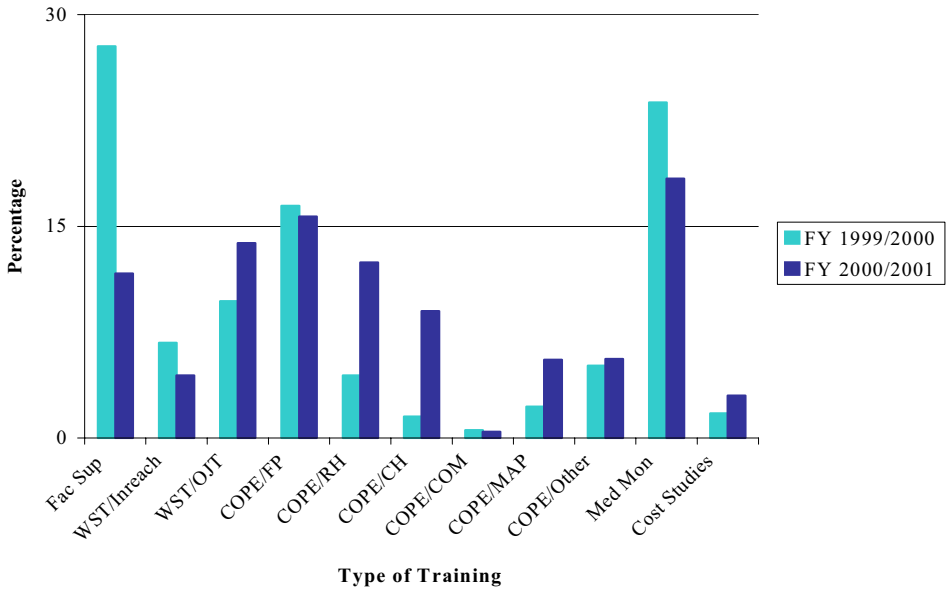
* Note: Since providers are frequently trained in more than one skill area, one provider can be counted several times in this table.
°Not applicable; data for that category were not collected in specified year

Figure 9
Percentage of Providers Trained by EngenderHealth by Skill Area
FYs 1998 to 2001



Many of the training programs that were carried out by EngenderHealth have dealt with subjects beyond clinical FP methods and delivery setting issues. EngenderHealth has led the way in developing PAC training materials, as well as in other reproductive health areas, such as maternal and child health, sexually transmitted diseases, and HIV/AIDS. As can be seen in figure 10, the range of quality improvement training has been extensive under this cooperative agreement. In FY 2000/01, medical monitoring (18.4 percent), COPE training in FP (15.7 percent), COPE training in RH (12.4 percent), and on-the-job whole-site training (13.8 percent) have been the major quality improvement elements implemented by EngenderHealth. (Additional detail on EngenderHealth quality-improvement tools is provided in appendix G.)

Figure 10
Quality Improvement Training in EngenderHealth-Supported Facilities
FYs 1999 to 2001



EngenderHealth is using the Internet as a means of promoting education about FP, infection prevention, sexuality, and other RH topics. Individuals logging on to EngenderHealth's web site have free access to these educational modules. This is a new area for training and educational programming and one that has broad potential for application for the future. Many Asian countries have a great deal of technical sophistication, while other countries are learning at a very rapid pace. The challenge is how to make Internet sources both easy to use and a source of documenting learning impact.

Training has been a major achievement of EngenderHealth's work especially in clinical methods, counseling, and materials development. Training materials are modified to be appropriate for individual countries. Concepts of infection prevention, for example, are included and involve the appropriate participants in the training. EngenderHealth has sought to institutionalize training skills through such techniques as on-the-job training and facilitative supervision.

Three of the Missions interviewed noted that EngenderHealth had successfully established governmental training institutes that now take the major responsibility for clinical FP training without further EngenderHealth assistance in Jordan, Guatemala, and Senegal.

EngenderHealth could further document the overall experience and lessons learned with clinical training. By drawing together a definitive paper on training, EngenderHealth could inform a broader audience in the problems, issues, and solutions for increasing the effectiveness of training. The number of people trained that become lost to the service settings or transferred to non–family planning locations would be important to track. While there are case studies of training programs and anecdotal evidence that training makes a difference, more systematic evaluation of training activities would help inform the program. To date, there has not been enough systematic research to assess the effectiveness of EngenderHealth training.

INFORMED CHOICE AND VOLUNTARISM

Assuring that all clients that avail themselves of FP services have been given adequate levels of information about services to make an informed choice is not an easy proposition. There are numerous reasons why clients may be provided with services without adequate communication and discussion with providers. It is a major challenge to assure that clients have been properly counseled and know exactly what they are choosing from the range of method choices. One of the advantages of whole-site training is that the various roles of different staff members become highlighted and the mechanisms through which clients receive information and counseling in the service setting can be determined.

Both Missions interviewed and USAID/Washington informants praised EngenderHealth for its work on voluntarism and informed choice. EngenderHealth has taken the lead on providing consultation to others (including USAID Mission staff) on the requirements of the Tiahrt Amendment. A number of activities took place as global program activities with specific adaptations within various countries for strategy development and development of leadership initiatives in choice (Uganda, Bolivia, and Bangladesh).

With respect to informed choice, EngenderHealth recognizes that a wide gap still exists between rhetoric and reality at service delivery facilities, and that the issue of client rights needs to receive increased attention. In 1998, EngenderHealth developed a tool kit for expanding the conceptual framework for informed and voluntary decision-making. It includes concrete indicators that could be used to determine the extent to which these concepts are operating. Tool kits that were originally developed for FP have been modified to deal with other service-specific needs.

While it is important to set standards for voluntary and informed choice, there is also a need to be pragmatic in expectations for applying these important concepts. In many parts of the world, service delivery constraints need to be modified through training and facilitative supervision to promote acceptance and application of voluntary and informed consent.

EngenderHealth has been scrupulous in promoting voluntarism and informed choice, is aware of remaining problems and challenges, and continues to find ways of enhancing informed choice, such as the tool kit described above.

CLIENT PERSPECTIVES AND SATISFACTION

EngenderHealth has a strong and long-term commitment to client focus and recognizes that clients are at the center of its programming framework. Its quality improvement package has components to use client feedback to improve service quality. In addition, EngenderHealth has a strong research capability to study client perspectives.

EngenderHealth's work is structured around the quality improvement framework that outlines client rights and provider needs as it is reflected in the COPE tool. COPE is an effective approach to encourage and enable local service providers to assess their own work in order to identify problems and find effective solutions in their own facilities. The tool uses client exit surveys to provide input from clients on their satisfaction with services. Client interviews focus on the following issues:

- Do the clients receive the services they seek?
- Do they receive information related to the care they receive?
- Do they feel comfortable and respected at the facility?
- What do they like best about the facility?
- What do they like least about the facility?
- What are their suggestions for improving the services?

While COPE incorporates client views and helps providers be aware of client rights, it is not an instrument to explore client needs and wants; it is essentially a provider tool. Identifying client's true values, needs and wants is a separate process that requires the use of qualitative data-gathering techniques, such as focus groups or indepth interviews with a small sample of clients.

Over the course of the cooperative agreement, EngenderHealth has conducted numerous studies with a client focus. The majority have explored client information, attitudes, and behavior related to RH services, while there are some focusing on client perspectives and needs. Table 8 presents a summary of these studies, their findings, and how the results were applied to improve service quality.

The studies conducted in Cambodia, Nepal, and Ukraine examined client satisfaction with the services provided. Clients were asked to evaluate the quality of services based on whether they received the services they came for, their level of comfort at the facility, their feelings about the clinical procedures, and what they liked and did not like about the facility. The Colombian study was designed differently. It looked into what men think, want, and need in terms of their sexual and reproductive health. Findings from these studies were used in establishing programming priorities and designing training and services. The director of the Office of Population and Health at USAID/Nepal highlighted the important role EngenderHealth has had in evaluation and research in client-focused services.

Table 8
EngenderHealth Research on Client Perspectives and Satisfaction (1998–2001)

Study	Findings	Application of Results
Client Exit Interviews in Bakan District, Cambodia, 2000	In general, clients express satisfaction with health services.	For baseline for COPE evaluation
Men's Sexual and Reproductive Health: What do Colombians Think and Want, 2000	Men want more than just information about health. Services should address men's needs holistically and identify diverse education and communication strategies.	To develop strategies for pilot services in men's reproductive health in three sites in Bogota, Cali, and Medellin
Clients' Views Toward Services at FP Service Sites in Nepal, 2001	Seventy-three percent of clients were satisfied with the providers' attitudes and service delivery procedures. Common complaints included inadequate facilities and clinic hours, waste management, and lack of privacy.	To establish program priorities, design training, and provide client-oriented services
Enhanced Monitoring of Mobile Outreach Sterilization Services: Client Perspectives	Respondents experienced difficulties during the pelvic examination, experienced pain following the operation, and expressed feelings of embarrassment when visiting the mobile unit.	To establish program priorities, design training, and provide client-oriented services
Creating Youth-Friendly Adolescent Health Services in Ukraine: A Model for Change	Assessed adolescents' reproductive health care needs and concerns and the degree to which they are addressed.	To design an adolescent service delivery training curriculum
Client Exit Interviews in Kralanh District in Cambodia	In progress	
Improving PAC Services for Adolescents in the Dominican Republic	In progress	
Client Experiences with Norplant and Depo-Provera (DMPA)	In progress	

While client satisfaction studies are extremely helpful in providing information on clients' views of the services provided to them, they may fall short in understanding clients' true wants and needs. Satisfaction studies tell the providers and managers how the clients *react* to the existing services, but not necessarily what the clients *want* from the services nor their actual *needs*. Client value is defined as the client's perception of what they want to have happen with the help of a service or product offering, in order to accomplish a desired purpose or a goal.[3] In contrast, client satisfaction is a client's positive or negative feeling about the product or services received from an organization. While these two concepts are closely related and complementary, they are not synonymous. Client values tell an organization what to do to satisfy its clients and give it direction, while client satisfaction tells the organization how it is doing.

As a key service delivery and quality improvement agency, EngenderHealth is committed to being client oriented and client focused. While the quality improvement tools and

[3] Woodruff, Robert and Sarah Gardial, *Know your Customer: New Approaches to Understanding Customer Value and Satisfaction*, 1996, MA.

client satisfaction studies research are highly valuable in understanding client perspectives, additional work is needed to identify client needs, wants, and values. EngenderHealth should strengthen its strategies to enhance its understanding of client values, particularly in countries where FP service utilization is stagnant or declining. For example, an understanding of client values may identify the reasons for biases against certain FP methods in specific countries and help managers develop new strategies for service delivery programs.

SCALING UP, SUSTAINABILITY, AND INSTITUTIONALIZATION

Scaling Up

EngenderHealth recognizes that capacity building is needed across the public and private sectors. Most EngenderHealth programming is within the public sector but it has also worked with private and nongovernmental services. EngenderHealth aims to scale up in all countries through incremental pilot testing and dialogue based on trusted relationships with key decision-makers.

The EngenderHealth self-assessment report has a careful treatment of scaling-up issues, using PAC as an example. Characteristics and inputs are listed in three stages: introduction, expansion, and institutionalization. There are also examples of countries that are at various stages in their programming and a series of case studies. Some countries have had program elements that are considered institutionalized (e.g., Mexico for clinical FP services and Turkey for PAC and clinical contraception).

The extent of scaling up varies by individual countries and program components. For example, in the Philippines, EngenderHealth has successfully introduced PAC and the government needs to be able to procure and supply MVA kits. With respect to FP, the government would like to be able to scale up more but they are having difficulty with supplies, number of personnel, and equipment. In Ghana, where program continuity resulted in a significant expansion in services, the country has had greater access to female sterilization and Norplant services.

Most USAID Missions interviewed indicated that EngenderHealth had effectively scaled up services (i.e., expanded services to the extent that they have an influence on national prevalence data) in their countries: Bolivia, Guatemala, the Dominican Republic, Honduras, Kenya, Ghana, Senegal, and the Philippines for clinical services, and Paraguay and Bangladesh for quality improvements.

There are a number of institutional issues, however, that may affect the ability of these countries to maintain scaled-up services countrywide. These include the loss of trained medical personnel and insufficient financial resources to keep essential equipment and supplies flowing to all sites.

Financial Sustainability

In most countries, financial sustainability is a long-term issue that applies to the entire health care system. Health sector reform has had a major negative impact on clinical services, especially in Africa. In Kenya, for example, in response to inadequate budgetary

resources, fees had to be charged for FP services. Such fees were in some cases well beyond the means of many clients, thereby reducing their accessibility to needed services.

Policy dialogue can help, however, to ensure that financial inputs are in place to meet key needs, and EngenderHealth has made some inroads in that area. For example, in Tanzania, a memorandum of understanding between EngenderHealth and the Ministry of Health (MOH) on long-term and permanent programming, including PAC, is a clear indication that EngenderHealth will be part of the general MOH program. In Kenya, EngenderHealth discussions with the Ministry of Health led to the inclusion of MVA on the essential services list, assuring financing for needed commodities.

Institutionalization

EngenderHealth's executive director discussed its main goal of "making family planning available to people in the kindest way with the most choice." She mentioned to the team that the biggest issue is what access means and what needs to be done to maintain CPR momentum and to expand FP services into institutional status. There will be a need to promote new technical innovations, such as the procedure for transcervical tubal ligation. She also identified the need for commodities and supplies along with trained providers and safe clinical sites. In countries where there is no health care infrastructure, a great deal of capacity development is required.

EngenderHealth aims to focus on establishing clinical quality assurance/quality improvement systems at the institutional level. EngenderHealth provides leadership within a range of development activities (policy dialogue, knowledge, and skill development through training and other related support) to create the capacity within countries to achieve an appropriate range of contraceptive methods and increased availability of technical and programmatic guidance. Achieving institutionalization may take many years as well as program continuity. EngenderHealth sees the need to build technical depth with a vision to institutionalize. USAID has allowed EngenderHealth to achieve this goal in a number of countries because of the relationships that have been developed over the years.

Influencing government policy is an important means to achieving institutionalization. EngenderHealth states that it provides policy advice on standards or guidelines for ministries of health and other institutions in about two dozen countries. In Kenya, for example, EngenderHealth promoted Norplant service delivery by nurse-midwives. This approach improves options for sustainability because nurse-midwives are less likely to leave than physicians. In the Philippines, EngenderHealth is successfully working with professional associations for integrating PAC into nursing and midwifery curricula. In Bolivia, EngenderHealth helped create national norms and technical procedures for each clinical method.

Building training capacity is another approach used by EngenderHealth for institutionalization. Mission interviewees in Jordan, Honduras, and Senegal spoke of the importance of local training institutions and a cadre of trainers that were put in place by EngenderHealth for both ensuring sufficient numbers of trained personnel and maintaining program momentum.

Kenya is a good case study of institutionalization. After many years of field support focusing on national-level scaling up of permanent and long-term methods, USAID shifted focus to an intensive program in two provinces. Sites in other provinces that had enjoyed EngenderHealth support for many years were left on their own. In the last year that the cooperative agreement operated, USAID advised EngenderHealth to cease reimbursing clinics for costs of expendable supplies for voluntary sterilization and Norplant. The team noted a number of changes since EngenderHealth assistance ended. Abrupt withdrawal of reimbursements left many clinics unprepared and unable to finance these costs. In addition, the MOH never formally recognized the regional supervisory system used under the cooperative agreement. When the cooperative agreement ended, this system was not formally accepted by the government. As a result, funds were not allocated to allow supervisory trips to continue. Quality improvement tools had been widely used in sites that received EngenderHealth support, but once the assistance ended, some sites ceased using these tools. Because of substantial changes in personnel at each site, gains made through the past use of quality improvement tools are being lost. It should be noted that under the new bilateral program for which EngenderHealth is the lead partner, many of these problems are resolved. The new program recognizes the need for policy-level discussions and buy-in from the central MOH. The project works directly with the ministry on supervision, training, and policy issues.

The Ghana program is in an earlier stage of development and EngenderHealth has made a similar decision, using separate subagreements with each province rather than an agreement with the central government. It should be noted that there are substantial differences in government commitment between Ghana and Kenya. In Ghana, health sector reform has reportedly been implemented more successfully, with more effective implementation of decentralization of responsibilities and funds to the provincial level than in Kenya. In addition, EngenderHealth notes that the central level has full knowledge, support, and involvement in the program. Nonetheless, use of separate subagreements sets up a parallel system to that of the normal MOH system. While it provides timely flow of funds for scaling-up services, it will require careful coordination and policy discussion with the MOH to ensure that this flow of funds continues once the project ends.

Some Missions interviewed cited problems with the supervisory system that inhibited institutionalization, while others believe their systems are sustainable. Clearly, there is value in examining what techniques have proven successful in promoting institutionalization.

There appear to be different interpretations within USAID of terms such as "institutionalization" and "sustainability." Without a shared USAID strategy regarding these concepts, potential for progress, or overall importance, USAID cannot have realistic performance expectations for EngenderHealth or other cooperating agencies.

While some aspects of sustainability in developing country settings are beyond EngenderHealth's control, it has substantial experience in its promotion. EngenderHealth is in a position to draw together the lessons learned over time and to provide important substance to policy guidance as well as the research base dealing with sustainability and institutionalization issues. EngenderHealth should review its worldwide experience in the sustainability of services and identify/develop approaches and guidelines to foster

sustainable program gains and to help promote greater understanding of the issues surrounding this work. EngenderHealth should build on the techniques that it has already used successfully to promote institutionalization and sustainability: policy dialogue with host countries and building of host country training capacity.

LEADERSHIP

Expectations about leadership in the clinical FP field extend from the basis of the proposal associated with this agreement to include global and site-specific objectives:

> This agreement will support ongoing family planning activities with a primary focus on providing global leadership in voluntary sterilization, other long-term methods (Norplant, IUDs) and PAC, as well as increasing the availability and use of hospital and clinic-based family planning services in approximately 40 countries.
>
> AVSC undertakes global leadership activities to support efforts at the country level and to address issues of emerging importance to country program implementation through pilot programs and/or operations research. These activities result in the development of guidelines, standards, and materials that can be adapted and used by AVSC country and other CA programs. In addition, AVSC will continue to provide USAID with factual and strategic support on policy issues in particular with regard to informed choice and other controversies in service delivery.[4]

This statement declares strong ideas for providing leadership both to USAID and to partner countries.

The fact that EngenderHealth won the United Nations Population Award as the major contributing organization to population goals in 2002 highlighted the regard in which the organization is held.

Leadership is shown by the ways in which the organization is managed at all levels. It was reported, for example, that within EngenderHealth, communication with staff is excellent and transparency is not an abstraction. The high level of satisfaction that USAID Missions express about EngenderHealth shows that organizational leadership is effective and demonstrable. The team has also observed that EngenderHealth staff is involved in planning at all levels.

As noted in the self-assessment report, identifying "champions" creates a more receptive environment for PAC or other areas of programming. These are individuals identified by EngenderHealth as being able to lead the way in new programming development and to influence others. These have been facility administrators, trained providers, or policymakers who contribute to the development of norms and guidelines as well as assistance in leveraging other funds. EngenderHealth has supported their participation in such activities as conferences, media events, policy dialogue, and training.

Leadership in technical fields is also a strength within EngenderHealth. It has supported high-level technical staff and consultants. Technical leadership is required with respect to promoting the state-of-the-art with respect to new contraceptive technology. This includes promoting policy dialogue with countries on new and upcoming methods and

[4] Proposal for cooperative agreement between the USAID and AVSC International, 1998 to 2003, September 16, 1998.

what will be required in the way of approvals to introduce them. New methods include various types of implants with fewer rods and new methods of hormonal delivery (skin patches, vaginal rings, and IUDs).

The following are examples of EngenderHealth leadership in policy development:

- In the Philippines, EngenderHealth worked with officials at the national and regional levels to develop a number of Administrative Orders (AO), which became national health policy. One AO mandates that a minimum number of 40 interval minilaparotomy under local anesthetic (MLA) cases be added as a completion requirement for all physicians undertaking the obstetrics/ gynecology residency training. Another AO established goals, objectives, components, activities, and guidelines for a program on the prevention and management of abortion and its complications (PMAC) throughout the country.

- EngenderHealth institutionalized PMAC counseling in the preservice training for nurses and midwives in the Philippines. To achieve this major change, EngenderHealth worked with professional organizations to develop a curriculum that was field tested in schools of nursing and midwifery.

- EngenderHealth is involved with national consultative meetings with Department of Health officials and other key leaders in the Philippines. These meetings serve as important communication vehicles for professionals to exchange experiences and ideas as well as to promote the service goals needed for the country.

- In Bangladesh, EngenderHealth worked with a variety of national committees to develop strategic policy directions and products. The manual on technical standard and service delivery guidelines on PAC is an excellent example of a high-quality publication. The content is impressive in its detailed attention to procedures, equipment, infection prevention, counseling, FP, and linkages to other RH services.

- In Kenya, EngenderHealth obtained approval to allow nurses and physician assistants to insert and remove Norplant, which was previously restricted to physicians. As a result, Norplant is much more widely available, including at health centers where no physician is assigned.

- Because of PAC workshops and PAC gaps analysis, the Ministry of Health of Kenya agreed to include MVA among essential services and to include MVA on the list of essential medical items. The ministry also agreed to allow nurse-midwives to provide PAC services.

- In Tanzania, the government has agreed to allow physician assistants and nurse-midwives to perform MLAs.

- In Bolivia, an important milestone was the development of national norms for FP, including male surgical contraception, implemented through a ministerial

resolution that legalizes the procedures to be implemented in public and private services nationwide.

On a different note, the team observed that within country programs, EngenderHealth has local professional employees that are extremely competent and articulate about the importance and the details of their work. It may be possible in the future to utilize some of these employees to help disseminate information about the work of EngenderHealth throughout the world.

EngenderHealth has proven to be a leader in addressing technical issues in long-term and permanent methods and other related areas, such as PAC, through country program implementation and the development of guidelines and standards. In many countries, EngenderHealth also has been a leader in policy development to support availability and accessibility of clinical FP services.

In all of the countries visited, the team observed that there is a need for a more focused advocacy effort to promote clinical FP services and to mobilize additional resources for clinical contraception. EngenderHealth is in a unique position to advocate throughout the world for mobilization of resources for clinical FP services and research.

RESEARCH

EngenderHealth has carried out a large program of research, evaluative studies, and technical guidance since 1998, much of it (but not all) listed in the appendix to the self-assessment. Some of this research was funded from outside this cooperative agreement. The discussion below relates only to research activity funded by the cooperative agreement.

Subject areas for these studies arise from the identification of needs by global, regional, or country managers. It appears that EngenderHealth also tends to conduct additional research in countries that have bilateral programs to share the cost; Cambodia, Kenya, Nepal, and Ghana have been the locales for a large number of studies. An exception is Tanzania, which relies on field support. Tanzania may have been selected for a large number of studies because of its strong central government commitment to the program and an MOH memorandum of understanding with EngenderHealth that creates an excellent environment for researching and testing new concepts.

Appropriateness of Research Areas

Although the subject matter of research conducted during this period is broad, there are some key themes. Reproductive health for men and men as partners has been the subject of studies carried out in Colombia, Ghana, Honduras, Kenya, South Africa, Paraguay, Tanzania, and Turkey, as well as clinical studies on vasectomy techniques. Similarly, PAC has been a priority. Adolescent services are an emerging issue for study in Latin America and Eurasia. Knowledge, attitude, and practice studies of both clients and health workers, particularly related to long-term and permanent methods, have been carried out in several regions.

Research projects most central to EngenderHealth's leadership in clinical family services, and which EngenderHealth considers its most important, include the following:

- publication of *Contraceptive Sterilization: Global Trends and Issues*, the most comprehensive compendium of current information on sterilization;

- research on clinical vasectomy, notably the fascial interposition study, the cautery study, and the study of vasectomy utilization; and

- joint hosting with the World Health Organization (WHO) and the Reproductive Health Alliance of a meeting on research on male contraceptive technology and its implications for program design.

Among those interviewed for this evaluation and most knowledgeable about this research work and its potential application for their programs were EngenderHealth's country and regional staffs. USAID informants gave favorable reviews to EngenderHealth's work in PAC, men as partners, quality improvement, and counseling, all of which are included in EngenderHealth's research agenda.

EngenderHealth field staff was clear about how work conducted under core funding enriches country programs. Some examples include the following:

- The Ghana program has adopted EngenderHealth's infection prevention curriculum, the curriculum to integrate sexually transmitted infection (STI) and HIV into FP counseling, the PAC curriculum, and the men as partners programming guide. A core study planned for 2002, stemming from a question raised by the country director, will seek to find out why Norplant is so popular in Ghana. The core-funded sentinel sites monitoring system has been adapted and now receives support from the bilateral cooperative agreement.

- The Kenya program has benefited from a core-supported study analyzing the gaps in PAC, using its findings to convince the Kenyan government of some important policy changes, such as listing MVA among essential public health services, allowing nurse-midwives to take responsibility for PAC, and developing a national PAC curriculum.

- In the Philippines, EngenderHealth has been instrumental in promoting research studies as a feature of obstetrics/gynecology residencies. In Pangasinan, for example, four obstetrics/gynecology residents had prepared research studies on various aspects of PAC. They were rewarded in their work by presenting their findings to a professional meeting organized by EngenderHealth in collaboration with the Department of Health.

The evidence indicates that EngenderHealth's research agenda is of value for improving its field programs, and that it does help EngenderHealth attain leadership in emerging programming areas, such as PAC and men as partners. With due recognition for this good work, there are some core questions that EngenderHealth should be trying to answer

if it is to maintain its leadership role in promoting and institutionalizing clinical FP services, including the following:

- Contraceptive prevalence from long-term and permanent methods is stagnating or declining in many countries. Why? What can be done about it?

- How sustainable are the gains in clinical FP made through EngenderHealth's training, technical assistance, and tools? There are several countries that have now graduated from EngenderHealth assistance. To what extent is the quality of services and counseling institutionalized in these countries, and how can the likelihood of institutionalization in other countries be improved?

- The purpose of quality improvement tools is to improve clinical services. Ultimately, if services are improved, this should result in an increase in clients. Are the quality improvement tools making any discernible difference in the acceptance of long-term and permanent methods?

- What are the remaining barriers in accessing contraceptive services? How can access be improved?

EngenderHealth's research agenda includes studies that examine some of these issues. For example, the 2000 study of sterilization services in Bangladesh made a careful examination of supply, demand, training, and medical quality, including demand factors. Results of that study fed into the new strengthening sterilization services in Bangladesh project, which is having considerable early success. In its 2002–2003 work plan, EngenderHealth has proposed carrying out studies of scaling up in four countries and a study of long-term sustainability in one country in which EngenderHealth no longer works (e.g., Mexico). However, there is much more to be done to answer these basic questions.

EngenderHealth staff reported that research ideas that emerge from within EngenderHealth are likely to be implemented faster than studies that result from outside evaluations. Two of the findings from the 1998 external evaluation of AVSC International that have not to date received much attention:

- **Ensure that health resource (quality improvement) tools are tested in the public sector before scaling up.** EngenderHealth argues that its evaluation of COPE for child health in Guinea and Kenya demonstrates the value of COPE. This was a good evaluation that showed improved performance on a variety of indicators comparing COPE sites with control sites. The real test for scaling up, however, should be whether the COPE process or other quality improvement processes will be sustained when EngenderHealth is no longer providing regular monitoring and support. That type of evaluation has not yet been conducted.

- **Improve perioperative pain management for MLA**. EngenderHealth staff provided several explanations about why it has taken EngenderHealth four years to come up with a concept paper to study this issue. The team also understands EngenderHealth's dilemma that once medical practitioners have

been trained, EngenderHealth has no control over what they actually do. Nonetheless, on an issue as important as this one seems to be, EngenderHealth should be doing all it can to make sure that training includes exercises addressing pain management and to discuss with recipient governments the incorporation of pain management standards into training curricula.

EngenderHealth should revise its research agenda to address some key programming questions.

Dissemination of Lessons Learned

EngenderHealth is concerned that important findings from research and evaluation are not being disseminated widely enough to inform EngenderHealth programs outside the region where the research was conducted. For example, several Missions noted problems in the supervisory structure of EngenderHealth's programs that hampered institutionalization efforts. For example, the 1999 internal evaluation of the Kenya program found that the system of regional supervisory teams had failed because they were never integrated within the ministry's formal supervisory structure. This has been corrected in the new bilateral project as well as in the flagship Tanzania program. A different model (secondment of a senior MOH official to the EngenderHealth project for one year) was used in Bangladesh, which could have application to both Kenya and Ghana. But the team is not aware that EngenderHealth has undertaken a systematic effort to discuss with field staff worldwide what factors need to be in place to institutionalize improved supervisory techniques.

EngenderHealth may be doing more to disseminate findings than the team was able to discern during its relatively quick review. Nonetheless, EngenderHealth recognizes in its self-assessment and in the 2001 management review that its methods of disseminating research results are inadequate and it is trying some new approaches. EngenderHealth also notes that its staff is focused on implementation and does not have time to think about larger development issues. Although field staff sometimes participates in global teams to consider particular issues, based on discussions with field staff, these opportunities should be expanded. EngenderHealth should examine its information dissemination methods to ensure that its own technical staff, as well as others in the RH field, is informed about research results and the experiences of EngenderHealth programs in other countries.

COLLABORATION AND COMPLEMENTARITY

Collaboration can occur in several ways: formal partnerships in consortia arrangements, subcontracts or joint plans of action, small grants, interagency working groups, and informal consultation among agencies on shared interests and programs. EngenderHealth is involved in all of these forms of collaboration, as outlined in its self-assessment. The vast majority of them are partnerships and contractual relationships that define the role of each participating agency and formalize reporting and coordination mechanisms. EngenderHealth headquarters staff notes that in consortium arrangements, it must make significant investments in management, communications, and conflict resolution among

partners with similar areas of expertise. None of the interviewed USAID Missions, EngenderHealth field staff, or other CAs noted that this had been a major problem.

Most core-funded research is conducted in collaboration with other organizations (e.g., the vasectomy research with Family Health International [FHI]), as are some of the workshops (e.g., the Mombasa PAC workshop with Ipas). For service delivery activities (field support), it appears that most collaboration occurs through participation in country-level or regional meetings or working groups.

EngenderHealth and JHPIEGO are the primary USAID CAs involved with training health personnel in clinical FP methods, and while their work sometimes overlaps, they are able to work out divisions of responsibility amicably. In most countries where both CAs work, JHPIEGO has taken responsibility for preservice training, leaving inservice training and supervision to EngenderHealth. In recent years, as CAs have broadened their scopes, there are more and more areas of potential overlap. Among some country programs, these areas include

- clinical FP training (EngenderHealth, JHPIEGO);
- infection prevention (PRIME, JHPIEGO, EngenderHealth);
- quality assurance tools (Pathfinder, John Snow, Inc. [JSI], EngenderHealth, University Research Co., LLC [URC], Family Health International [FHI]);
- development of inservice training guides (JHPIEGO, URC, EngenderHealth);
- PAC (PRIME, EngenderHealth, Pathfinder, JHPIEGO);
- HIV/AIDS counseling (EngenderHealth, JHPIEGO, FHI); and
- cost analysis/pricing (POLICY, EngenderHealth, Management Sciences for Health [MSH], FHI).

USAID Missions surveyed were quite satisfied with EngenderHealth's collaboration and coordination efforts. USAID Missions take some responsibility for coordination by holding regular CA meetings and by approving work plans. Governments also have a coordinating role (e.g., Kenya has a national PAC working group to which all relevant CAs belong). Workshops, such as EngenderHealth has sponsored on PAC, are a valuable way to exchange knowledge and encourage communication about work on similar activities among CAs and other organizations. The level of collaboration varies from country to country, depending on the nature of the program, the number of CAs, and the role of the Mission in coordinating their work.

There are good examples of collaboration that demonstrate how valuable it can be, including the following:

- **Social Marketing**: In Ghana, EngenderHealth took Johns Hopkins University (JHU) personnel to clinic sites to see client load and observe

facilities, then helped develop IEC materials for JHU's successful life choices campaign.

- **Infection Prevention**: In Ghana, EngenderHealth conducts assessments for each site to ensure that staff has not been trained by another CA before beginning infection prevention training under PRIME.

- **Demand Generation**: In Malawi, EngenderHealth is developing a subagreement under field support with PATH to work on demand generation.

- **Operating Procedures for Opening and Closing Offices**: EngenderHealth New York is developing such procedures because fluctuations in field support funding make it necessary to open and close offices unexpectedly, and has shared its work with the Population Council and PRIME.

- **MIS**: EngenderHealth New York is also providing assistance to other organizations on establishing Internet-based interactive management systems.

- **Service Delivery**: Through collaboration with CARE in Bolivia, EngenderHealth and CARE were both able to serve a larger area.

Collaboration is becoming a more important issue than in the past as CAs expand their services into new and overlapping areas. Collaboration is also increasing as an issue for EngenderHealth as an organization, now that it is becoming involved in large consortium projects with a number of partners. Collaboration allows CAs to engage in new areas or more integrated efforts without losing their focus on their core area of expertise and should be encouraged.

PROGRAM MANAGEMENT

EngenderHealth's Mission

Formerly known as AVSC International, EngenderHealth changed its name in March 2001 to better reflect a broadened and more comprehensive approach to FP and RH services. EngenderHealth states that its name has changed but its mission statement remains the same. EngenderHealth works worldwide to improve the lives of individuals by making reproductive health services safe, available, and sustainable. EngenderHealth provides technical assistance, training, and information, with a focus on practical solutions that improve services where resources are scarce. EngenderHealth believes that individuals have the right to make informed decisions about their reproductive health and to receive care that meets their needs. It works in partnerships with governments, institutions, and health care professionals to make this a reality.

Organization and Staffing

In 2001, EngenderHealth reorganized its structure and created an integrated program division with the responsibility of overseeing and supporting field-based and global programs, including clinical and knowledge management oversight. A 6–person program management team leads the program division. The management team includes

- the senior vice president for programs, who is responsible for development, implementation, and evaluation of field programs and global leadership activities and serves as the project director for the cooperative agreement;

- the director of field operations, who is based in Bangkok and has the responsibility for the strategic and operational oversight of regional and country programs;

- the director of global programs, who is responsible for oversight of the global leadership programs;

- the deputy director of global programs/director of research and development, who has the added role of overseeing the development of new content and approaches through global research and pilot program activities;

- the medical director, who is responsible for the strategic oversight of medical affairs and clinical monitoring; and

- the director of evaluation and monitoring, who is responsible for planning and evaluating programs and sharing the findings to improve future programs.

The reorganization also consolidated field operations into five regions, each covering four to seven countries led by a regional director. The regions are Asia/Near East, The Americas, West Africa, East and Southern Africa, and Eastern Europe/Central Asia.

Through the realignment, EngenderHealth restructured its global program teams. Currently the agency has seven global teams: FP, maternity/PAC, HIV/STI, research and development, informed choice, men as partners, and quality improvement. Overall, the agency believes that the consolidation will facilitate the coordination of activities, which had previously been managed out of separately led divisions.

EngenderHealth continues to decentralize its operations and relocate technical staff in field offices. The current field to headquarters staff ratio is close to 1:3. There are about 100 staff members at headquarters and 270 at the field offices.

With strengthened regional offices, EngenderHealth country programs are able to respond more quickly to Mission requests. Although a few of the Missions interviewed for last year's management review were critical of slow response time from the EngenderHealth country offices, none of the Missions interviewed for this evaluation had such a complaint. All were satisfied with the responsiveness and professionalism of their country EngenderHealth offices. EngenderHealth's reorganization and consolidation is a positive step toward integrating the work of separate divisions and will have a positive impact on field operations. EngenderHealth should continue decentralization efforts.

EngenderHealth's Comparative Advantage and Mandate

EngenderHealth's comparative advantage is establishing and improving the quality of clinic-based FP services in large service delivery systems. EngenderHealth also has a comparative advantage in promoting informed choice and voluntary participation in FP.

While EngenderHealth brings these advantages to the cooperative agreement with USAID, it also applies its capacities more broadly through other funding and donor support.

There have been extensive discussions between USAID and EngenderHealth regarding the strategic value to USAID of EngenderHealth maintaining a well-defined niche in clinical service delivery. USAID feels that there is an important need for continued focus on sterilization quality and access. It also recognizes that there is a conflict between maintaining a niche when there is an increasing trend towards consolidation and one-stop shopping at the field level.

EngenderHealth staff, both at headquarters and in the field, held a common vision of EngenderHealth's mandate: that its core focus remains in FP, and its strength is in the clinic. But FP services cannot be entirely vertical. For example, it would be unconscionable to allow a mother to die because of inadequate services in the same clinic where FP services are being offered. Similarly, one cannot restrict infection prevention improvements to FP only in clinics offering other services. However, EngenderHealth only diversifies into new areas when these areas have a clear link to FP.

This is considered to be a very reasonable approach, and one that continues to give top priority to the core focus area of FP. In fact, it can expand access to FP if the new services have a strong FP component. Success of this approach really depends on maintaining an appropriate balance and on constantly questioning how this service can be used to increase access to clinical FP services.

Unfortunately, there are many factors that mitigate against maintaining this balance. There has been a change in emphasis since the ICPD in Cairo, which has tended to relegate FP service delivery to a less important role than the broader issues of gender equity and maternal and child health. There is donor and government fatigue about FP promotion after so many years of effort, when other important health interventions (e.g., HIV/AIDS) have global appeal and more readily generate substantial donor funds. Key EngenderHealth partners, including host governments and USAID Missions, want to apply EngenderHealth's renowned, trusted skills in the clinic to non–family planning areas like maternal health. (Family planning is an essential part of maternal health, but not all other aspects of maternal health are directly related to FP). Another factor is the difficulty in making the linkage between other services and FP in individual country settings. Without clear government policies on linking FP and other services (e.g., PAC), it is a huge task for EngenderHealth to negotiate these changes on a clinic-by-clinic basis, especially when it is scaling up. For maternal health services, the problem is more difficult, because host country staff is likely to view FP linkage as nonessential. The executive director mentioned this challenge, saying that in too many countries, providing a range of maternal health activities (e.g., AIDS testing) at FP clinics has not increased access.

Despite the common vision of EngenderHealth's mandate expressed by its staff, EngenderHealth may be having difficulty maintaining its focus on clinical FP when faced with the barriers noted above. Some of these concerns are the apparent lack of urgency to change worldwide trends, a research agenda that does not address global questions, interest by EngenderHealth staff in engaging in new areas, and training trends.

Apparent Lack of Urgency to Change Worldwide Trends

Sterilization levels have been reaching a plateau worldwide for various reasons, including increasing the focus on private sector and temporary methods, health sector reform, increased prevalence, lack of government support, and changes in USAID Mission strategies. The overall trends did not appear to be of great concern to EngenderHealth as an issue for policy discussion with USAID or host country partners.

Research Agenda That Does Not Address Global Questions

There has been insufficient research concerning broad factors limiting the use of clinical contraception—information that is vital in carrying out a global policy discussion with donors and governments about the need to refocus attention on the unmet need for these services. For example, EngenderHealth's family planning/clinical services team stated, "It is logical that sterilization figures will go down as choice increases. We should be measuring the percent of women over 35 who use sterilization." The team is not aware, however, that EngenderHealth is conducting this type of analysis or has suggested to USAID that this should be a research topic.

Interest by EngenderHealth Staff in Engaging in New Areas

EngenderHealth staff members interviewed were very enthusiastic about new initiatives, such as the application of COPE and other quality improvement methods to new areas (child health and community), men as partners, HIV/AIDS integration, maternal health, and applying informed consent to non–family planning areas of reproductive health. As one senior field manager noted, one has to be concerned about giving staff assignments that will be interesting and exciting to them. His staff was eager to work on broader maternal health issues, and this was an area that could easily be moved into because of existing competence in the surgical area. Yet, important as these initiatives are for overall health improvement, it is questionable whether they are the most central activities for meeting the unmet demand for clinical FP services.

Training Trends

Service-based training statistics also show changing trends, with declines in clinical services training and increases in quality improvement training, MVA training, PAC, and men as partners. EngenderHealth has been the leader in creating training materials for maternal and child health, sexually transmitted diseases (STDs) and HIV/AIDS. While recognizing their importance, there remains a great need for clinical services training.

Any one of these observations alone would not be cause for concern, but taken together, EngenderHealth is risking the dilution of its focus on clinical FP services. While expanding its scope, EngenderHealth has to be cautious to maintain its focus in clinical FP, since this area is still its niche and biggest strength.

Relationships with USAID

Thirteen Missions were interviewed about their relationships with EngenderHealth. (A consolidated matrix of Mission responses is in appendix E.) All the Missions interviewed and those visited (Ghana, Kenya, Bangladesh, and Philippines) have good relationships with EngenderHealth. Almost all of the Missions stated that they are satisfied with the contributions of EngenderHealth, in particular with technical assistance delivered and productive working relationships. Many noted EngenderHealth's responsiveness to Mission requests. EngenderHealth was clearly valued as a partner by all.

However, some uneasiness was observed in EngenderHealth's relations with USAID/Washington, mostly due to the anxiety of an uncertain future. Many things have been changing in the operating environment. USAID Missions now tend to prefer bilateral agreements rather than field support mechanisms, with the result that funding levels have been fluctuating more than in the past. In addition, USAID/Washington has announced that noncompeted cooperative agreements have come to an end. Additional funding uncertainty has been introduced by growing competition from large consortium projects that provide one-stop shopping for USAID Missions and host country governments. Inadequate and unclear strategic guidance from USAID/Washington may have also been a source of difficulty. All of these factors seem to have contributed to tensions between USAID/Washington and EngenderHealth.

FUNDING ISSUES

Funding Trends

Fluctuations in Mission use of field support reflect both changing Mission priorities and concerns about managing a large number of CAs, each operating vertical projects. Several Missions have shifted to bilateral projects using a consortium with one lead agency to reduce USAID's coordination burden and to increase Mission control over activities. Based on interviews with Missions, it appears that many Missions continue to view support for clinic-based FP services as a high-priority need.

As noted in earlier sections of this report, the uncertainty of field support levels and countries from year to year affects the way EngenderHealth conducts its business.

- To ensure EngenderHealth program continuity in individual countries, EngenderHealth needs to diversify its donor base. It is doing so by joining consortia to bid on USAID bilateral programs and by seeking out funding from other donors. USAID Mission and other donor interests are rarely limited to clinical FP services, so EngenderHealth needs to broaden its proposals to related areas in order to successfully compete for these new funding sources.

- EngenderHealth has reorganized to place increased emphasis on external marketing and the development of new donor resources, and it has set ambitious goals for broadening its financial base.

- EngenderHealth is developing operating procedures for opening and closing country offices, and is placing human resources staff at the regional offices so

that as funding levels fluctuate, required changes in country presence can be made with minimal disruption.

- The strategic framework, developed with an assumption that recipient countries for field support would remain stable over the period of the agreement, is not able to provide a clear picture of achievements in service delivery because that assumption has not proven valid.

EngenderHealth's efforts to diversify its funding base and to join consortia in bidding on bilateral projects are healthy developments since they reduce EngenderHealth's dependency on funding from the cooperative agreement. To diversify successfully, however, EngenderHealth does have to broaden its focus. With funding outside the cooperative agreement, it has worked on cervical cancer screening and adolescent and child health, for example. By broadening its scope and engaging in marketing, EngenderHealth has succeeded in reducing its USAID dependency. The cooperative agreement now accounts for about 50 percent of EngenderHealth's total funding—compared with 75 percent in 1998–99.

Cost Sharing

In the first three years, EngenderHealth's cost share from other sources was $18 million. With an expected level of expenditures from the cooperative agreement over five years of $78 million, the 25 percent cost-share requirement will be about $19.5 million. EngenderHealth is on track to meet that requirement.

In the 2001 management review, EngenderHealth provided a number of examples of activities funded by the cost share in Pakistan, Ethiopia, Nigeria, Honduras, and Guatemala that will contribute to the CA's Strategic Objective. EngenderHealth staff noted, however, that other donors prefer doing unique work rather than supporting another donor's goals and objectives. However, few other donors are interested in supporting clinical FP services. This means that EngenderHealth needs to put much effort into designing programs that relate to its core mandate under the CA but are different enough to attract other resources. Country and regional directors now have to include marketing among their responsibilities.

Based on discussions with USAID, it appears that the primary rationale for cost sharing was to have EngenderHealth become less dependent on GH. The cost-share requirement was a reminder to EngenderHealth about the need to diversify its resources, and that message was reinforced with field support fluctuations. (Field support jumped from $12 million to $16 million from 1998 to 1999, but then fell back to $12 million in 2000.) Cost share has been an important vehicle for promoting additional marketing and institutional development efforts at EngenderHealth. A side effect, however, has been encouraging EngenderHealth to broaden its mandate, undertaking activities that are not directly supportive of the CA's objective.

V. SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

NATIONAL–LEVEL TRENDS IN THE USE AND FUTURE DEMAND FOR CLINICAL CONTRACEPTION IN ENGENDERHEALTH COUNTRIES

DHS data report that the use of sterilization and other clinical contraceptive methods has varied considerably over the past decade across the regions and countries in which EngenderHealth has been working.

- In Asia and the Near East, only India and Nepal have reported substantial gains in female sterilization. African countries generally report low levels of sterilization use, but Kenya and Malawi have recorded modest gains in female sterilization prevalence between 1993 and 1999. EngenderHealth countries in Latin America appear to be emerging as success stories (e.g., Bolivia, Colombia, the Dominican Republic, Guatemala, and Honduras). Male sterilization continued to be a much underutilized FP method.

- IUD prevalence has either been constant or decreasing in most countries. The only countries that have seen a rise in IUD use are Jordan, Turkey, and Bolivia. With the exception of Indonesia, Norplant is still not a major method in most developing countries.

- Analysis of DHS data shows that many women want to limit their fertility in countries in which EngenderHealth has been working. The percentage of currently married women who are not using contraception and who do not want any more children is still high in many EngenderHealth countries, particularly in Bolivia, Nepal, Uganda, Malawi, and Ghana.

- Many women not currently using FP report that clinical contraceptive methods are preferred future methods. Women in India, Nepal, Colombia, the Dominican Republic, and Guatemala are likely to prefer female sterilization. With the exception of Nepal, future preference for male sterilization is universally low. IUD preference is concentrated in Jordan, Turkey, Bolivia, Colombia, and Honduras. More women in Nepal, Indonesia, Colombia, and the Dominican Republic are expressing future preferences for Norplant.

Conclusion: Clinical contraception offering long-term and permanent protection from unwanted fertility deserves high priority in the future. There is still considerable unrealized potential and unmet demand for clinical contraception in many developing countries.

ENGENDERHEALTH PERFORMANCE ASSESSED THROUGH SITE–SPECIFIC SERVICE STATISTICS

Facility-level service statistics are the principal source of information for evaluating EngenderHealth project performance pertaining to the accessibility and utilization of clinical FP methods. Unfortunately, not all countries in which EngenderHealth has been working during this cooperative agreement report service statistics. Any country whose

program is funded through formal subagreements with subgrantees is required to provide service statistics to EngenderHealth. Only 59.4 percent (19/32) of countries in which EngenderHealth operates report service statistics through subagreements. Therefore, service statistics compiled by EngenderHealth do not provide a complete accounting of EngenderHealth achievements.

The number of countries reporting service statistics through subagreements has been declining as the ratio of field support to bilateral funding has dropped. Since 1998, EngenderHealth funding ended under the CA in five countries that switched to bilateral programs (Kenya, Uganda, Indonesia, Guatemala, Paraguay, and the Philippines). By FY 2000/01, Uganda, Indonesia, Guatemala, and Paraguay no longer reported service statistics to EngenderHealth. Also complicating the assessment of EngenderHealth performance is the fact that several large countries (e.g., Mexico and Turkey) have been graduated by USAID. Countries that have been added to the EngenderHealth portfolio in recent years (e.g., Bolivia, Cambodia, Guinea, Jordan, and Malawi) tend to have smaller potential client populations and lower prevalence levels, which also serves to depress total EngenderHealth performance under the cooperative agreement.

While overall trends in accessibility and utilization are difficult to determine from available EngenderHealth service statistics, it is possible to draw several conclusions about country-level outcomes.

- There has been an increase in the number of EngenderHealth-supported sites offering clinical RH services. The most dramatic increases have occurred in Bangladesh, Bolivia, Cambodia, Ghana, India, Jordan, and Nepal.

- The number of long-term and permanent method clients served also has increased in the Dominican Republic, Ghana, Guatemala, Jordan, and Malawi and fallen in Bolivia, Kenya, Nepal, and Tanzania.

- The current analysis, based upon incomplete evidence, concludes that whenever USAID budgets have been stable or rising, EngenderHealth has usually been able to increase access to clinical FP services. In countries where USAID funding has declined, EngenderHealth has been able (at least in the short term) to sustain access to services, largely by drawing upon other sources of funding.

- The use of female sterilization has risen in Bolivia, Cambodia, the Dominican Republic, Guatemala, and Jordan. Declines in other settings (e.g., Kenya and the Philippines) can be largely attributed to change in the distribution and number of in-country regions and sites in which EngenderHealth has been assigned to work.

- Male sterilization continues to be an underutilized method in most EngenderHealth-supported countries. Nepal is the only EngenderHealth country that registered a substantial gain in vasectomy over the past three years.

- IUD use is mixed in EngenderHealth-assisted countries. While some countries have seen IUD use expand in recent years (e.g., the Dominican Republic and Guatemala), others report less encouraging trends (e.g., Kenya, Nepal, Nigeria, and Tanzania).

- With the exception of Indonesia, Norplant is still not a widely used method in EngenderHealth-supported countries. However, Ghana and Tanzania both report substantial gains in Norplant use since FY 1998/99.

- There also have been declines in the average number of clients served per EngenderHealth-supported site over the past three years. Unfortunately, it is not possible to determine the extent to which this trend is due to compositional change in the countries in which EngenderHealth has been working, recent realignments of country program activities, altered service statistics reporting requirements, or underlying change in program performance. However, on an annualized basis, long-term and permanent method client loads per site are often quite low, particularly in such countries as Nepal, Kenya, and Nigeria.

Conclusion: Based upon evidence from individual countries, country-level performance has been mixed. There are notable successes (e.g., the rise in female sterilization in several Latin American countries and gains in Norplant use in Ghana), but also some disappointments (e.g., declines in female sterilization in Nepal and reductions in the number of IUD clients served in Nepal and Tanzania). Overall, the quantitative evidence made available to the team is too incomplete and fragmentary to reach definitive conclusions about trends in accessibility and utilization of clinical methods.

POSTABORTION CARE

PAC continues to be a major need in most of the EngenderHealth-assisted countries. EngenderHealth has been instrumental in initiating PAC services in many countries over this cooperative agreement. Since FY 1998/99, PAC services have expanded to 20 countries, or about 27,600 clients. The number of facilities offering PAC services rose from 122 to 201 sites. While D&C is still the main procedure employed for PAC, MVA procedures are expected to spread more widely once additional providers are trained in MVA and the advantages of this method become more apparent.

To date, PAC has been most effective in treating abortion complications. Because most FP provision and counseling services are generally offered in locations that are separate from obstetric and gynecology services, developing effective linkages between the two types of services has been difficult. This is an area that will need continuing attention within the PAC context.

Recommendation: EngenderHealth should continue its focus to expand PAC, particularly by strengthening linkages to integrate FP counseling and services to other RH services. EngenderHealth should also track the percentage of PAC clients who accept a FP method in the sites it serves.

MEN AS PARTNERS

Expanding and improving men's access to reproductive health services was a focus area during the current cooperative agreement. The number of EngenderHealth-supported sites providing male RH services rose significantly. However, only about one third of all EngenderHealth-affiliated sites offered vasectomy as part of their male RH service package. The effect of men as partners programming on acceptance of vasectomy will need to be closely monitored.

Recommendation: While it is important to address men's RH issues as well as their support for women's RH, distraction from other goals might result in this process. EngenderHealth should increase its efforts to incorporate vasectomy as an essential RH service for men. The extent to which EngenderHealth activities with men as partners contribute to increasing vasectomy services as well as increasing female access to FP should be monitored.

QUALITY IMPROVEMENT TOOLS AND APPROACHES

Quality improvement has been an area in which EngenderHealth worked extensively. EngenderHealth has a systematic approach to quality improvement; it has developed several quality improvement tools, promoted the use of these tools, and updated them continuously. The utilization of various tools has led to practices that improved the quality of services, even in resource-poor settings. EngenderHealth conducted a number of studies to quantify results of quality initiatives. It is important to find ways of adapting the quantitative evaluation methodologies EngenderHealth has developed in order to measure results of quality improvement tools in a variety of country settings.

Recommendation: EngenderHealth needs to continue to develop a more efficient and systematic approach for quantifying achievements to show results of activities and tools over time. The Bangladesh evaluation and Ghana sentinel sites survey are valuable models that could be streamlined and simplified for broad use. Also, more effective use should be made of medical monitoring by focusing on specific clinical problems, which tend to be common across sites and across countries and the types of solutions derived to ameliorate the problems.

SERVICE–BASED TRAINING

Training has been a major achievement of EngenderHealth work; thousands of trainers, providers, and managers have been trained in topics ranging from sterilization techniques to health care management during this cooperative agreement. The quality of training has been highly acknowledged by host country institutions and USAID Missions. Since 1998, however, the number of training events and trainees has been declining for clinical FP efforts (with the exception of Norplant) in favor of nonclinical training. This trend may be due to the increased number of host institutions taking over the training responsibility. In addition, there has been insufficient evaluation of training activities to determine the success and depth of efforts in this area.

Recommendations: EngenderHealth should maintain its focus on clinical training. The shortage of trained providers continues to be a priority issue in most EngenderHealth-

assisted countries. EngenderHealth should also establish a systematic evaluation of its training activities to document the success and depth of its efforts in training.

INFORMED CHOICE AND VOLUNTARISM

EngenderHealth has been scrupulous in promoting informed choice and voluntarism in all of the countries in which it works. It has been successful in providing leadership in identifying issues and developing strategies to transfer these concepts to the clinical level. Although there are still challenging issues, such as provider bias, EngenderHealth is well aware of these issues and has a sound strategy to deal with them.

SUSTAINABILITY

While many aspects of sustainability in developing country settings are beyond EngenderHealth's control, EngenderHealth has been concerned with issues of scaling up, institutionalization, and sustainability. The extent of EngenderHealth's contribution to sustainable clinical FP services is different in individual countries. In some countries, EngenderHealth seems to use more effective approaches and support policies to sustain the gains of its programs than in other countries. There is a need to compare approaches across countries, identify best practices and lessons learned, and ensure that these results receive wide dissemination both within EngenderHealth and among other countries.

Recommendation: EngenderHealth has considerable experience with promoting sustainability and institutionalization issues and it is in a strong position to inform the field of sustainability. EngenderHealth should review its worldwide experience in the sustainability of services and identify/develop approaches and guidelines to foster sustainable program gains and to help promote greater understanding of the issues surrounding this work.

CLIENT PERSPECTIVES AND SATISFACTION

EngenderHealth is committed to being client oriented. The quality improvement tools include components to use client feedback to improve service quality. EngenderHealth also conducted several studies to examine client perceptions and satisfaction with the services provided. While the quality improvement tools and client satisfaction studies are highly valuable in understanding client perspectives, additional work is needed to identify client values, needs, and wants.

Recommendation: EngenderHealth should enhance its understanding of client needs and wants, particularly in countries where clinical FP service utilization is stagnant or declining, by conducting research on client wants and needs.

LEADERSHIP

EngenderHealth has proven to be a leader in addressing technical issues in clinical FP and other related areas, such as PAC, through country programs and the development of guidelines and standards. In many countries EngenderHealth also has been a leader in policy development to support the availability and accessibility of clinical FP services.

Because of EngenderHealth's rich experience throughout the world, it could advocate more than it does for clinical FP services as an essential RH service.

Recommendation: EngenderHealth should use its unique experience base to strengthen its global efforts to assume a focused advocacy role in promoting clinical FP services and to effectively mobilize global resources for clinical contraception.

RESEARCH

EngenderHealth has implemented a substantial research program. There are many examples of research results leading to program improvements. Key research themes have been RH for men, clinical studies on vasectomy techniques, and PAC. It is notable that research often has been directed toward development of new clinical procedures and quality assurance tools. While much research is also focused on clinical FP issues, EngenderHealth has not used research to address broader global issues, such as determining the reasons for worldwide leveling of voluntary sterilization levels, institutionalization/sustainability issues, and addressing the remaining barriers to acceptance.

Recommendation: EngenderHealth should revise its research agenda to address some key programming questions. EngenderHealth should also find ways of disseminating research results, best practices, and lessons learned effectively so that country programs in different regions are informed by these results.

MONITORING AND EVALUATION

Over the past three years of this cooperative agreement, EngenderHealth has expended considerable effort to improve its monitoring and evaluation system. A new results framework was developed, including a set of indicators to measure progress in achieving results. EngenderHealth has also developed an IMIS for the timely collection and analyses of data. However, problems remain with the monitoring and evaluation system. The number of selected indicators is excessive, some are difficult to collect, and others do not necessarily measure intended results. Consequently, they do not always provide valuable information to EngenderHealth or USAID for measuring performance and making management decisions.

Recommendations: EngenderHealth should reduce the number of indicators used in its framework and collect only essential statistics on accessibility and use in all countries in which EngenderHealth is assisting with clinical services. EngenderHealth should also devote additional resources to improve its monitoring and evaluation system and to continue to improve the IMIS by upgrading accessibility and training of staff in its use.

ORGANIZATION AND STAFFING

EngenderHealth has undergone a major reorganization and consolidation in 2001 to facilitate the coordination of project activities. EngenderHealth's reorganization is a positive step toward integrating the work of separate divisions and will have a positive impact on field operations. EngenderHealth staff at both the New York headquarters and the field offices are highly qualified.

ENGENDERHEALTH COMPARATIVE ADVANTAGE AND PROGRAM FOCUS

EngenderHealth's comparative advantage has been in establishing and improving the quality of clinic-based FP services and in ensuring informed choice and voluntary participation in FP. Recently, EngenderHealth has considerably expanded its core competencies to cover broader areas of health care. The shift has been a response to the requests from host country institutions, USAID Missions, and other donor organizations and is a good strategic move to remain competitive within the community of USAID CAs.

Despite the common vision of EngenderHealth's mandate expressed by its staff, EngenderHealth may be having difficulty maintaining its focus on clinical contraception. There is an apparent lack of urgency by EngenderHealth in dealing with low, and in some countries declining, trends in sterilization prevalence. EngenderHealth's current research agenda does little to address such global programmatic concerns. In addition, EngenderHealth staff was interested in new non–family planning initiatives. While these initiatives are very important for overall public health improvement, it is questionable whether they are the most central activities for meeting the unmet demand for clinical FP services.

Recommendation: While expanding its scope to cover broader areas of health care, EngenderHealth has to be cautious to maintain its focus on clinical FP.

RELATIONSHIPS WITH USAID MISSIONS

All the USAID Missions visited or interviewed have a good relationship with EngenderHealth. EngenderHealth is a highly valued partner by all. Missions stated that they are satisfied with the contributions of EngenderHealth, in particular with technical assistance delivered, productive working relationships, and EngenderHealth's responsiveness to Mission requests.

FUNDING ENVIRONMENT

Fluctuations in Mission use of field support funding reflect both changing Mission priorities and concerns about managing a large number of CAs. Several Missions have shifted to bilateral projects using consortia. The uncertainty of field support levels and countries from year to year affects the way EngenderHealth conducts its business. The strategic framework, developed with the assumption that recipient countries and field support levels would remain constant over the period of the agreement, does not provide a clear understanding of achievement because that assumption has not proven valid.

COST SHARING

EngenderHealth reached its cost share or exceeded it every year of the agreement. This requirement has enabled EngenderHealth to diversify its funding base and has been an important vehicle for promoting increased marketing and institutional development efforts.

COORDINATION AND COLLABORATION

EngenderHealth works collaboratively and productively with a number of other CAs, such as JHU, JHPIEGO, PATH, PRIME, and the Population Council, in a number of countries. EngenderHealth and JHPIEGO, the primary USAID CAs involved in training in clinical contraception, are generally able to work out divisions of responsibility amicably in most countries in which both CAs work.

These appendices are part of the
Evaluation of the EngenderHealth Cooperative Agreement 1998–2003
Report No. 2002-064-009, produced by the Population Technical Assistance Project
August 2002

APPENDICES

A: Scope of Work

B: Persons Contacted

C: Sites Visited

D: Summaries of Country Findings

E: Mission Interviews and Responses

F: Analysis of EngenderHealth Service Statistics

G: Review of Quality Improvement Tools and Approaches

H: References

APPENDIX A

SCOPE OF WORK
(from USAID)

SCOPE OF WORK
Final Evaluation of EngenderHealth

Identification of Task

The assignment under this Scope of Work (SOW) is to assist the USAID Bureau for Global Health's Family Planning Services Division (FPSD) in conducting a final evaluation of the Program for Voluntary Surgical Contraception and Related Services, a cooperative agreement with EngenderHealth.

The anticipated start and completion dates for the assignment are May and September 2002, respectively. A draft report will be due in mid-August 2002.

Project Information

Project Name and Number	Program for Voluntary Surgical Contraception and Related Services (936-3068)
Agreement Number	HRN-A-00-98-00042-00
Cooperating Agency	EngenderHealth (formerly named AVSC International)
Agreement Ceiling	$137,673,774
Obligations to Date	$74,970,000
PACD	September 30, 2003

Background

In 1993, USAID R&D/POP authorized the Program for Voluntary Surgical Contraception Project to introduce, expand and improve voluntary surgical contraception services and other long-term contraceptive methods. This authorization supports USAID's collaborative relationship with EngenderHealth (at that time named Association for Voluntary Surgical Contraception, or AVSC), a nonprofit organization recognized as a worldwide leader in the field of voluntary surgical contraception. USAID support began in 1972 and has continued through the present.

The current activity has a planned project life of ten years with an estimated PACD of September 2003. In 1993, USAID awarded the first non-competitive five-year cooperative agreement to EngenderHealth under the current authorization. In 1998, USAID awarded the second non-competitive five-year cooperative agreement to EngenderHealth.

The original emphases under this project authorization included: (1) medical quality assurance; (2) voluntarism and well-informed clients; (3) client-centered service systems; (4) service-based training; (5) vasectomy and male involvement in family planning; (6) postpartum and postabortion family planning services; (7) social marketing; (8) sustainable and cost-effective services; and (9) evaluation and research.

After the Cairo ICPD in 1994 and the April 1998 evaluation of the EngenderHealth cooperative agreement, USAID and EngenderHealth agreed to minor modifications in the emphases of this activity. Under the current cooperative agreement, EngenderHealth contributes to achieving results under the FPSD Services Activities' Strategic Objective (SO): *Increased use of sustainable, quality family planning and reproductive services and healthy practices through clinical and non-clinical programs.* The emphasis for EngenderHealth is limited to clinic-based programs and healthy practices related to family planning.

The Intermediate Results (IRs) specified in the current EngenderHealth cooperative agreement are:

IR1: Increased availability of quality family planning and selected reproductive health services.

IR2: Clinical quality assurance/quality improvement systems established at the institutional level.

IR3: Increased client satisfaction with services provided in EngenderHealth-supported programs.

IR4: Contribution by EngenderHealth-supported programs to ensure an appropriate range of contraceptive methods and/or utilization of services within 5 years in selected countries.

IR5: Increased availability of technical and programmatic guidance for clinic-based services intended to improve program sustainability and client satisfaction.

IR6: Increased leadership, contribution to and visibility within the international dialogue on family planning and reproductive health.

The project activities aimed at accomplishing the strategic objective and intermediate results can be grouped into the following technical components:

- postpartum and postabortion FP services
- postabortion emergency treatment
- vasectomy and male involvement in FP
- client-centered service system strengthening
- sustainable and cost-effective services
- voluntarism and informed choice
- service-based training
- medical quality assurance
- evaluation and research

Purpose of the Assignment

This project is nearing the end of the planned ten-year project life. A new activity may be designed to expand the quality and availability of family planning services and systems. The main focus of the evaluation is to assess EngenderHealth's contributions to improving clinical services worldwide, with special emphasis on countries where they have put in considerable effort and have received large amounts of resources both from field support and core.

The Evaluation Team will look retrospectively at the EngenderHealth cooperative agreement and is expected to answer the principal question: What is the impact of EngenderHealth's activities on the access, quality, scaling up and institutionalization of clinical services delivery?

Access can be defined broadly as the ability of clients as individuals to be able to utilize services. Quality encompasses such variables as provider competence, client satisfaction, logistical support, quality assurance monitoring. Scaling-up refers to the percent of the population that is covered by these services (and the underlying reasonable costs involved in expansion, including human as well as financial costs). And institutionalization is defined as the ability of the local institutions to carry on with the services without further technical assistance from EngenderHealth.

The purpose of this final evaluation is to:

- Assess the results achieved based on the cooperative agreement's SO and IRs framework.
- Assess the strengths and weaknesses of the EngenderHealth activity, from both technical and management standpoints, identifying what has been particularly effective and what has been ineffective, and why.
- Identify gaps in project design or results both retrospectively and prospectively.
- Recommend design changes and possible new directions for any future activity.

The following areas should also be addressed:

- Progress towards the strategic objective and results achieved under each IR.
- Advances in the state of the art for each of the technical components in the cooperative agreement. How well are these innovations recognized and used by EngenderHealth's programs worldwide, by other CAs and programs, and by other donors?
- Partnerships with other CAs, and local organizations including ministries of health.
- USAID Mission views on results achieved and quality/value of this centrally managed activity.
- Findings from country and technical evaluations.
- Is there a Monitoring and Evaluation framework and plan in place? How have they used the data generated by this system for programmatic decision-making and program improvement?

Annex I presents the Results Framework for the project and illustrative detailed questions by IR. This Annex is useful for a better understanding of the project and provides a starting point from which the Team should develop other questions as appropriate. The Team, however, is not expected to answer all the questions listed in Annex I.

The Evaluation Team will also look prospectively at emerging issues and challenges in expanding the quality and availability of family planning services and systems and future needs to achieve this Strategic Objective.

Methodology

A. Approach

The Evaluation Team will consist of a Team Leader and three other members, and will be supported by POPTECH and EngenderHealth staff persons. The evaluation process will be conducted in two phases, described as follows.

Phase I - Background Review

The Background Review will be carried out by one Evaluation Team member, and supported by one EngenderHealth staff person and one POPTECH staff person. The Review team will travel to New York City to interview EngenderHealth representatives. They will identify data that address as many questions in Annex 1 as possible and will clarify the issues identified in Annex 1 that need to be addressed by the Evaluation Team in the field. Based on the work in New York, the team will produce an outline that includes the data gathered to date, and a one or two page summary of the issues and concerns to be addressed. The team will also develop a draft questionnaire to be sent out in advance to select missions for use during the subsequent telephone interviews. The POPTECH staff person will provide broad support to the team, including scheduling interviews with key informants for the Evaluation Team. The EngenderHealth staff person will facilitate data collection, arrange for contacts with appropriate EngenderHealth staff, both in New York and the field, and guide the organization's self-assessment.

Phase II – Field Work/Report Preparation

The complete Evaluation Team will then meet in Washington, D.C. to produce an Action Plan, conduct phone interviews and prepare for their field work. The team will also travel to New York City for three days of interviews at EngenderHealth. Interviews with key informants outside of Washington, D.C. and New York City may be conducted by telephone or videoconference, as appropriate. The team will then divide up into two pairs, each of which will travel to two different key countries in order to interview USAID Mission and EngenderHealth field staff, in-country stakeholders and implementing partners, and make site visits.

Interviews with Missions, stakeholders and implementing partner organizations in key field-supported programs will focus on: (1) country-level results; (2) the quality, responsiveness and value of EngenderHealth technical assistance and the present centrally-funded mechanism; (3) the technical components selected and why; and (4)

identification of service delivery needs, in order to inform development of future activity and strategy.

B. Information Sources

Documents that the Evaluation Team will review for this assignment include but are not limited to:

Project Authorization for the Program for Voluntary Surgical Contraception

Final Evaluation of AVSC International Cooperative Agreement dated April 1998

EngenderHealth Cooperative Agreement including the Proposal dated September 1998

EngenderHealth Annual Workplans

EngenderHealth Annual Reports

EngenderHealth service statistics reports

EngenderHealth Management Reviews dated November 2000 and October 2001

EngenderHealth Working Papers

EngenderHealth Works-in-Progress

EngenderHealth Country Program Evaluations

The Sterilization Fact Book available May 2002 from EngenderHealth

Special Studies completed by EngenderHealth since September 1998

Papers published and other reports completed by EngenderHealth since October 1998

Mission Responses to Recent Management Assessment

The EngenderHealth Self-Assessment Paper.

EngenderHealth will provide the Evaluation Team with one copy of the above documents.

C. Data Collection

The Evaluation Team will use a variety of methods to collect, analyze and synthesize information. Sources of information will include a review of EngenderHealth documents

and evaluation reports; interviews with key informants; and analysis of service statistic trends in priority EngenderHealth countries.

The one Evaluation consultant on the Background Review will:

- Review relevant background documents.
- Identify/organize the data that address the SO and IR questions in Annex 1.
- Interview EngenderHealth staff.
- Prepare an outline for the Evaluation Report using information available at EngenderHealth headquarters and data related to the SO and IR achievements. EngenderHealth will contribute by preparing a self-assessment paper.
- Develop a draft standardized questionnaire for use in gathering information from Missions. The draft questionnaire should be reviewed and revised by the other three team members before being sent to the FPSD Division Chief and EngenderHealth CTO for final approval. The selected missions will receive them a week prior to their scheduled phone interviews.

The POPTECH staff person on the Background Review will:

- Assist in data collection and scheduling interviews with key informants for the Evaluation Team.

The EngenderHealth staff person on the Background Review will:

- Oversee the organization's self-assessment, facilitate the preparation of the outline for the evaluation report to be produced at EngenderHealth headquarters, and coordinate the Evaluation Team's country visits with EngenderHealth field staff.

The Evaluation Team will:

- Review relevant key documents, surveys of missions and implementing partners and the outline for the evaluation report.
- Conduct interviews with EngenderHealth staff, USAID/W staff and USAID field staff where EngenderHealth is currently working or has worked in the recent past. To facilitate the interviewing process, the Evaluation Team will use the standard questionnaire developed for this purpose. The majority of interviews will be conducted by telephone or videoconference.
- Conduct site visits to four priority field-supported programs. The Evaluation Team will use the standard questionnaire to interview USAID Mission and implementing partner staff.

D. Analysis, Report Writing and Presentation

The Evaluation Team will:

- Prepare a series of discreet analyses to assess the results achieved, based on the areas of clinical services, MAQ and PAC as described above, as well as the Intermediate

Results (IR) framework, and to answer questions set forth in Table 1. For each question, the Team is to draw on data identified (including interview data) and clearly state the key findings, conclusions and recommendations. All findings should reference the supporting data. The Evaluation Team is encouraged to consider presenting responses in bullet or table format, to the extent possible, in order to aid in understanding the large volume of information that is anticipated. For each of the Intermediate Results, the Team will describe the type of activities undertaken (inputs), countries where the activities have been implemented, the size of the investment and the results achieved. USAID is particularly interested in the evidence-based state of the art approaches that EngenderHealth has developed and the Team's assessment of EngenderHealth's contribution to the state of the art in clinic-based family planning and reproductive health services. Factors that have contributed to the success or failure to achieve the strategic objective and Intermediate Results should also be addressed.

- Synthesize information to identify results and gaps in the current EngenderHealth program. The Final Report should include recommendations regarding future field needs and activities as well as alternative funding/programming mechanisms.
- The Team will give an oral presentation and written summary of the findings to the Family Planning Services Division, other interested parties within USAID, and EngenderHealth on August 1, 2002.
- Submit deliverables following the schedule agreed to with USAID. The draft report should be submitted to FPSD on August 12, 2002. Following comments and revision(s), the draft will be submitted in final for editing by POPTECH around August 30, 2002.

Team Composition

The evaluation will require a team of four consultants:

1. Team Leader

    - Experience in strategic design of family planning/reproductive health programs, particularly with regard to institutionalization and capacity building, implementation and evaluation.
    - Demonstrated skill in written and oral communication
    - Demonstrated knowledge of USAID policies and procedures

2. Analytical Expert
    - Knowledge and ability to interpret and analyze family planning service statistics

3. Clinician
    - 5-10 years of experience in clinic-based family planning service systems in more than one developing country
    - Experience in medical monitoring/medical quality assurance, informed choice and client-provider interactions, sustainable provider training methodologies, postpartum and postabortion service delivery

4. Family Planning/Reproductive Health Training Expert
    - 5-10 years of experience in clinic-based family planning service systems in more than one developing country

- Quality improvement/quality assurance related to clinic-based FP/RH service delivery systems
- Experience in maternal health, training, sterilization and other areas linked to reproductive health.

In addition, a USAID/W staff member may participate in the evaluation as an observer.

Duration and Timing of the Evaluation

The evaluation will begin on/around May 22, 2002 with the Background Review team; the field work will begin around July 5, 2002. Team members should read documents provided by EngenderHealth prior to the June 25 Team Planning Meeting. Consultants on the Evaluation Team will be approved to work six-day weeks.
The approximate timeline and Level of Effort envisioned is as follows:

May 22-31	Background Review (Analytical Expert – 6 days each of LOE)
June 3-21	Background Reading for other two team members (2 days each and 1 day for Analytical Expert)
June 24-July 4	Travel to WDC and NYC, Team Planning Meeting, Interviews, Prep work for field visits (10 days LOE each member)
July 5-20	Field Work and travel (team – 14 days of LOE each member)
July 22-26	Report Writing at Home (5 days each member)
July 29-August 2	Travel to Washington for more Report Preparation and Debriefing (entire team – 5 days LOE each member)
August 5-9	Team completes Draft Report and submits it to USAID on August 12 (5 days of LOE for team)
August 12-23	USAID reads and comments on draft report, comments due to TL on Aug. 26.
August 26–28	Team Leader revises report and submits the Final Report to POPTECH and USAID (2 days of LOE, 1 day LOE for others).
August 29–Sept. 19	POPTECH has 3 weeks for editing the document. Clearance Copy sent to USAID by Sept. 20 . Once approved, POPTECH will print copies.

Total LOE for Team Leader =	46 days
Total LOE for Analytical Expert =	45 days
Total LOE for Clinical team member =	40 days
Total LOE for Training Expert =	37 days

Deliverables

The Evaluation Team will deliver:

1. Action Plan for the Evaluation Team including a proposed Table of Contents and preliminary outline for the Evaluation Report with Executive Summary, due after Team Planning Meeting.
2. A list of all documents reviewed and all individuals interviewed, including their affiliation and interview questions.

3. Summaries of findings, recommendations and any key decisions from internal or external meetings with findings supported by reference to the evidence.
4. Debriefing meeting with FPSD and EngenderHealth staff, including a PowerPoint presentation.
5. Draft report submitted for review and comment by USAID and by EngenderHealth. This report should answer the questions in Annex I, including, to the extent possible, data presented in matrices and/or tables and findings (analyses of the data), conclusions and recommendations presented in bullet format.
6. Final Report incorporating USAID and EngenderHealth comments.

Focus	Overarching Question	Data Sources	Sub-Questions
USAID/FPSD Strategic Objective: Increased use of sustainable, quality family planning and reproductive services through clinic-based programs.			
	What have been clinical FP/RH utilization trends in EngenderHealth-supported countries between 1993-2001?	DHS; Sterilization Fact Book	Based on DHS, what are the family planning acceptor numbers and trends? Is there evidence that EngenderHealth has contributed to these trends, directly/indirectly, in select countries? What external factors outside of EngenderHealth's control have also contributed to these trends?
IR1: Increased availability of family planning and selected reproductive health services.			
Long-term and Permanent Methods	How and to what extent have EngenderHealth activities contributed to an increase in the number of sites offering long-term and permanent contraception?	EngenderHealth Annual Reports; program data	Since 1998, to how many new service delivery sites have long-term and permanent contraceptive methods been expanded? Disaggregate by method type and where possible if the service is offered as interval or postpartum/postabortion. What evidence is there that new service delivery sites increase utilization of family planning services? e.g. Ghana
Postabortion Care	How and to what extent have EngenderHealth activities contributed to an increased number of sites offering PAC services?	EngenderHealth program data; special studies; reports to the Packard Foundation; case study designs	What has been the growth in the number of sites offering PAC services? What approaches have been used to introduce and scale up PAC services in different country settings? Are different approaches more appropriate to different country contexts? Where have these activities resulted in new or expanded PAC service availability, what is the magnitude and nature of increases in service availability (e.g., emergency treatment/FP counseling/FP commodities/referrals; new sites/expanded hours/more providers)? To the extent possible, present evidence that all three components of PAC have been implemented. e.g. Philippines, Turkey
Men As Partners (MAP) & Vasectomy	How and to what extent have EngenderHealth activities contributed to increased number of sites offering reproductive health services for men and/or vasectomy?	EngenderHealth program data; special studies	What has been the growth in the number of sites offering men's reproductive health services and/or vasectomy? What approaches have been used to increase the availability of reproductive health services for men and to involve men in RH in different country settings? What lessons have been learned about involving men in reproductive health? What evidence is there (if any) that MAP programs increase men's support for their partners' use of FP? What evidence is there that MAP programs increase use of other FP/RH services, including vasectomy? e.g. South Africa
Scaling Up Services	How and to what extent have FP/RH services been taken to scale?	EngenderHealth program data; special studies	In which countries has Engenderhealth been asked to take services to scale? Which specific services does this include? What approaches have been used to scale up services? Does this differ by type of service, development level of the health infrastructure or other identifiable variables? What evidence is there to demonstrate that services have been scaled up? Is there any country where scaled up services had had a national impact? e.g. Ghana (PLT), Turkey (PAC)
Service-based Training	How and to what extent have service-based training activities contributed to an increased availability of FP and selected RH svcs?	EngenderHealth Annual Reports; Annual Workplans; evaluations of training activities and tools and approaches	How many providers have been trained (disaggregate by cadre and service where possible)? At what level were EH trainers involved -- provider training, TOT, technical support only? What advances have been made in training service providers? Where possible, show how the focus of provider training has changed over time (1993 to present) in specific countries and/or for the global agreements as a whole. In selected countries, how has this training led to improved or expanded services? e.g. Turkey, India, Nepal, Tanzania

Focus	Overarching Question	Data Sources	Sub-Questions
IR2: Clinical quality assurance/quality improvement systems established at the institutional level.			
Service System Strengthening	How and to what extent has EngenderHealth been able to build capacity to assess and improve quality at the institutional level?	Special studies; Mission and implementing agency questionnaires and interviews; country evaluations; program data	What functional areas of local capacity building have been emphasized (problem solving, supervision, medical monitoring etc.)? Are these areas appropriate for this agreement and to the country context where they have been used? What evidence is there that local capacity has been strengthened? What evidence is there that these functional capacities have been institutionalized by local partners? e.g. Tanzania, Nepal, Senegal, Guinea, Mongolia, Bolivia
Medical Quality Assurance	How and to what extent have medical monitoring activities contributed to establishing quality assurance systems at the institutional level?	Existence of EngenderHealth medical monitoring checklist prototypes; key informant interviews	What is EngenderHealth's approach to: (i) medical quality assurance (medical monitoring) and (ii) transferring this responsibility to local institutions? What conditions need to exist within a local institution in order to successfully transfer this responsibility? Where such conditions exist, what evidence is there that medical quality assurance systems have been established at the institutional level?
Service-based Training	How have the introduction of QA/QI systems contributed to the development of new training approaches and improved training capacity?	Mission and implementing agency questionnaires; key in-country informant interviews; country evaluation reports	What approaches have been used to train providers and other clinic-based staff in quality assurance and quality improvement? What new approaches have been used? Are different approaches more appropriate for different types of content or different physical settings? What evidence is there to demonstrate that EngenderHealth training approaches have contributed to improved quality?
IR3: Increased client satisfaction with services provided in EngenderHealth-supported programs.			
	How does EngenderHealth address client perspectives in its work?	Special studies; tools and approaches	What strategies does EngenderHealth pursue to understand client perspectives and improve client satisfaction? What kind of client-focused activities have been implemented (e.g., counseling, community COPE, special studies or informed choice/consent activities)? What are the findings from these activities and how have they been used to improve programs?
IR4: Contribution by EngenderHealth-supported programs to ensure an appropriate range of contraceptive methods and/or utilization of services within 5 years in selected countries.			
	In selected countries, how and to what extent have activities contributed to an appropriate range of contraceptive methods and utilization of services?	EngenderHealth service statistics; other program data; DHS; Sterilization Fact Book	In countries where EngenderHealth has had a significant and sustained presence, what is the range of methods that have been available over time (1993-present)? What evidence is there that the full range of contraceptive methods is used and what have been the trends over time? Where possible, disaggregate by method and by target population (e.g., postpartum, postabortion, interval). What is EngenderHealth's data collection strategy and what are its strengths and weaknesses? What are the PAC utilization trends? What is the data collection strategy for PAC and what are its strengths and weaknesses? To the extent possible, show separate utilization of postabortion emergency treatment, FP counseling, FP service/method given (yes or no) and other RH referral made. (e.g. Ghana, Nepal, India, Philippines)
IR5: Increased availability of technical and programmatic guidance for clinic-based services intended to improve program sustainability and client satisfaction.			
	How and to what extent have the EngenderHealth technical and programmatic guidance for clinic-based services contributed to improved program sustainability and client	EngenderHealth bibliography; Annual Reports; evaluation of tools and guidelines; key informant interviews	What technical and programmatic guidance have been newly developed or revised since October 1998? How does EngenderHealth decide which topics to develop guidance on? What process is used to develop, field-test and evaluate guidance? Is there evidence that (i) guidance has been implemented in country programs and (ii) once implemented that it contributes to improved programs? What topics have been the subject of clinical evaluation or research studies but have yet to be turned into

Focus		Overarching Question	Data Sources	Sub-Questions
		satisfaction?		guidance? How and to what extent has EngenderHealth guidance contributed to advancing the state of the art in improving clinic-based service delivery?
IR6: Increased leadership, contribution to and visibility within the international dialog on family planning and reproductive health.				
		How and to what extent have EngenderHealth activities contributed to the international leadership and dialogue on FP/RH?	Annual reports; bibliography; key informant interviews	Where and how have EngenderHealth activities influenced national policies related to FP/RH? Where and on what topics has EngenderHealth sponsored country, regional or international meetings or panels? What papers have been published in peer-reviewed journals or presented at professional conferences?
Other Questions				
	USAID Mission and Implementing Partner Views	How and to what extent have EngenderHealth activities contributed to achievement of USAID country-level results frameworks, and those of implementing partners?	Matrix of activities by Country; Mission and implementing partner questionnaire and follow-up interviews; EngenderHealth work plans and reports to USAID missions	Which of EngenderHealth's technical components are most often requested by Missions and why? What are the Mission and local implementing partners' views regarding the quality, value and cost of this centrally-managed mechanism and the technical assistance providered through it?
	Voluntarism and Informed Choice	How and to what extent has EngenderHealth advanced the state of the art regarding voluntarism and informed choice in USAID-supported programs?	Mission and implementing agency questionnaires; key in-country informant interviews	What has been done to improve voluntarism and informed choice in country FP programs? Are the Informed Choice tools developed by EngenderHealth easy to understand and use? Are they appropriate for a range of country contexts? Is there any evidence that country programs that have received Informed Choice technical assistance have improved conditions for voluntarism?
	Collaboration	How and to what extent have collaborative activities contributed to increased use of sustainable, quality FP/RH services through clinic-based programs?	EngenderHealth Annual Reports; management reviews	In what kinds of collaborative activities has EngenderHealth engaged? Are these activities appropriate for this cooperative agreement? What challenges and barriers to collaboration have been encountrered? Do other CAs seek out EngenderHealth for collaboration? Is EngenderHealth considered to be a good collaboration partner? Give examples of collaboration which resulted in better products or processes than could have been acheived by any one organization?
	Cost Share	How has the 25 percent cost share contributed to increased use of sustainable, quality FP/RH services through clinic-based programs?	EngenderHealth Annual Reports; management reviews	How has the match been used to support the strategic objective and intermediate results of this cooperative agreement?
	Internal Evaluations	What are the findings, conclusions and recommendations from EngenderHealth's internal evaluations of country programs?	EngenderHealth country program evaluations	What are the commonalities among evaluations in terms of findings and recommendations? What evidence is there that recommendations have been subsequently implemented? What have been the facilitating or constraining factors in conducting internal evaluations?

Focus	Overarching Question	Data Sources	Sub-Questions
Evaluation and Research	What are the key lessons learned from EngenderHealth's monitoring and evaluation and research activities?	EngenderHealth's strategic framework and M&E Plan; key informant interviews; special studies; annual reports	What are the key questions that EngenderHealth is trying to answer through M&E and research activities? Are these questions the most appropriate for this agreement? Will the M&E and research activities answer these questions? What evidence has been collected to support the lessons learned?
Scope of Agreement	How has the mandate of this agreement assisted in or detracted from achieving the strategic objective and intermediate results?	Management Reviews; interviews	Is this an appropriate mandate and set of interventions? Should something be added or subtracted? If possible, cite specific examples where this mandate has been an advantage or a disadvantage to achieving results. Are the advantages and/or disadvantages unique to EngenderHealth's agreement or are they applicable to other agreements as well? What type of activities under this agreement fall outside of FP/RH? Give specific examples. Based on costs, estimate what percentage of total activities fall outside of FP/RH.
Complementary with other CAs' Activities	Is the role of the EngenderHealth agreement complementary to that of other CAs?	Annual workplans, interviews	How well has EngenderHealth designed its global and country-level activities to complement the activities of other CAs? Cite specific examples of good complementarity and/or overlapping and redundant activities. [Similar activities in *different* countries would not be redundant. At the global level, different approaches to the same issue, such as PAC, are not necessarily redundant.]
Agreement Management by EngenderHealth	How have agreement management practices contributed to or detracted from the FPSD strategic objective of increased use of sustainable, quality FP/RH services through clinic-based programs?	Management Reviews; interviews	Has the management of EngenderHealth been responsive to USAID/W needs and requests? How effectively has the cooperative agreement been managed? Should any management practices be changed in any way? If so, how?
Agreement Management by USAID	How have agreement management practices contributed to or detracted from the FPSD strategic objective of increased use of sustainable, quality FP/RH services through clinic-based programs?	Management Reviews; interviews	How clearly has USAID/W and Missions communicated needs and expectations for EngenderHealth activities? When conflicts arise between USAID/W and Mission requests, how have they been resolved? In what time frame and level of satisfaction? How well has USAID/W supported EngenderHealth in achieving the strategic objectives and intermediate results? Should USAID/W or Mission management practices be changed in any way? If so, how? Has there been congruence between the IR's stipulated in the agreement and the levels and flows of USAID Mission funding?
Future Strategic Directions			
Funding Trends for Service Delivery Activities	1. What can be deduced from the recent declines in Field Support funding to EngenderHealth?	PPD Data Bank; Interviews	Do Missions still identify needs for assistance in clinical service training and support? Are Missions funding these activities through other Agency contracting mechanisms? What role do Mission Bilateral Agreements play? Are other donors financing these activities? Are other host country institutions providing these services?

Focus	Overarching Question	Data Sources	Sub-Questions
EngenderHealth Portfolio	2. Looking to the future, what components of the EngenderHealth portfolio should be maintained in their current form? What components should be retained, but modified? How should they be modified?	Interviews	
Broadening the Project	3. Is there a need for a Global Health Bureau-wide clinical service training and support project, broader than the existing project? What are the pros and cons of a broader, integrated family planning / reproductive health clinical services project?	Interviews	

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

UNITED STATES

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Bureau for Global Health
Duff Gillespie, Senior Deputy Assistant Administrator
Office of Population
Margaret Neuse, Director
Scott Radloff, Deputy Director
Services Delivery Improvement Division
Michelle Moloney-Kitts, Chief
Maureen Norton, Senior Technical Advisor
Kendra Phillips, New Entry Professional
Lily Kak, Senior Technical Advisor, Population Leadership Program, Bureau for Asia and the Near East, Office of Strategic Planning, Operations and Technical Support (ANE/SPOTS), USAID/Washington

USAID Missions Interviewed by Telephone

Bolivia
Dominican Republic
Guatemala
Honduras
Jordan
Nepal
Paraguay
Senegal
Tanzania

ENGENDERHEALTH

Amy Pollack, President
Lynn Bakamjian, Senior Vice President, Programs
Jeanne Haws, Vice President, Operations
Terrence Jezowski, Vice President, Development
Rachel Pine, Vice President, Public Affairs
Roy Jacobstein, Medical Director
Carmela Cordero, Deputy Medical Director
Sara Gardner, Director, Global Programs
Karen Beattie, Deputy Director, Global Programs
Connie O'Connor, Regional Director, the Americas
Lissette Bernal Verbel, Program Associate, Men as Partners and Latin America
John Pile, Senior Manager, Family Planning
Jan Kumar, Senior Manager, Informed Choice
Mary Nell Wegner, Senior Manager, Postabortion Care
Mark Barone, Senior Manager, Research and Development
Alana Gooley, Director, Finance
Carol Ryan, Director, Human Resources and Administration
Hannah Searing, Senior Program Associate, Evaluation and Research
Belinda Arthur, Executive Program Officer
Santiago Plata, Director of Field Operations

GHANA

USAID/Ghana
Jane Wickstrom, Senior Technical Advisor

EngenderHealth/Ghana
Nicholas Kanlisi, Country Manager
Isaiah Ndong, Regional Director, West Africa

Regional Directorate of Health Services, Ashanti Region
Ebenezer Appiah Denkriya

John Hopkins University/Center for Communication Programs
Emmanuel Fiagbey, Country Director

PRIME II/Ghana
William Sampson, Ghana Team Leader

The POLICY Project/Ghana
Benedicta Monica Ababio, Local Resident Advisor

JHPIEGO/Ghana
Abigail Kyei, Country Representative

KENYA

USAID/Kenya
Michael Strong, Senior Reproductive Health Advisor
Jerusha Karuthiru, Office of Population and Health

EngenderHealth/Kenya
David Adriance, Regional Director
Albert Henn, AMKENI Project Director
Joseph Rumingjo, Senior Medical Advisor
Theodora Bwire, Program Officer for Kenya
Joyce Isiaho, Senior Project Assistant
Karanga Mbugua, AMKENI Training and Supervision Specialist
Job Obwaka, AMKENI FP/RH/CS Services Advisor
Feddis Mumba, Area Manager, Coast Province
Patience Ziroh, Service Delivery Coordinator, Coast Province

Ministry of Health
Kenneth Chebet, Director, NASCOP/ONLTP
Jane Asila, Senior Nursing Officer
S.K. Sharif, Provincial Medical Officer, Coast Province

Family Planning Association of Kenya
Godwin Mzenge, Chief Executive
Linus Etyang, Program Manager
Josiah Onyango, Manager of Clinical Services

JHPIEGO/Kenya
Pamela Lynam, Regional Technical Director, East and Southern Africa

Marie Stopes/Kenya
Cyprian Awiti, Program Director

PHILIPPINES

USAID/Philippines
Jed Meline, Deputy Population, Health and Nutrition (PHN) Officer
Ephraim Desberaldes, PHN Program Officer
Wes Dulawan, PHN Program Officer
Cora Manaloto, Program Officer

EngenderHealth/Philippines
Evie Landry, Regional Director for Asia, EngenderHealth, Bangkok, Thailand
Annabel Sumayo, Director, Philippine Country Office
Leo Alcantara
Ellen Bautista
Francis Floresca
Cynthia Garcia
Lemuel Marasigan
Orlando de Ocampo
Ricedjane Santiago

Government of Philippines

Manila, Department of Health
Florence Apale, Medical Specialist, Center for Family and Environmental Health
Nerissa N. Dominquez, Division Chief, Women's Health and Older Persons' Division, Center for Family and Environmental Health
Laticia Ramos-Olivar
Milagros L. Fernandez, Undersecretary of Health

Davao City
Dolores Castillo, Regional Director, Department of Health (DOH)
Gerardo Cunanan, Chief of Hospital, DOH Region 11 Regional Health Center
Cecilio Gempesaw, Program Coordinator, Obstetrics/Gynecology and Family Planning Services, Community Health and Development Cooperative Hospital (CHDC)

Dagupan City, Region 1 Medical Center
Ellen A. Manzano, Head, Department of Obstetrics/Gynecology
Casimiro S. Bacugan, Medical Officer IV, Family Planning Unit Head

Panabo City, Clinica Rivera
Ramon Rivera and Dr. Zenaida Rivera, Proprietors/Managers
Marivic Carino, Nurse and Community Promoter
Analie Putian, Nurse and Community Promoter
Elvy Buena, Nurse and FP/RH Counselor

Pangasinan
Governor Victor E. Agbayani, Urduja House, Lingayen
Luzviminda Muego, Provincial Population Officer
Nemesia Mejia, Provincial Health Officer

Pangasinan Provincial Hospital
Mario de Guzman,Chief of Hospital
Josephine Francisco, Head, Obstetrics/Gynecology Department
Evelyn Angeles, Resident Physician
Salome Romero, Resident Physician

BANGLADESH

USAID/Bangladesh, PHN Office
Matthew Friedman, Program Coordinator
Jay Anderson, Team Leader
Moslehuddin Ahmed, Cognizant Technical Officer for NGO Service Delivery Program
Jeannie Friedman, Program Coordinator

EngenderHealth/Bangladesh
Abu Jamil Faisel, Country Representative
Sukanta Sarlar, Country Program Specialist
Mizanur Rahman, Senior Program Officer
S.M. Shahidullah, Senior Program Officer
Nazneen Sultana, Program Officer
Nowrozy Kamar Jahan, Program Officer

Gandaria Clinic, Concerned Women for Family Development
Farida Nasrin, In Charge
Clinic Staff, Counselor, Aides

Obstetrics and Gynecology Society of Bangladesh
A. B. Bhuiyan, President and Professor, Obstetrics/Gynecology
Anowara Begun, President-elect
Laila Arjumand Banu, Associate Professor, Obstetrics/Gynecology
Farhana Dewan, Senior Consultant, Dhaka Medical College
Firoza Begum, Treasurer
Rawshan Ara Khanam, Member
Ferdousi Begum, Joint Secretary, Associate Professor, Obstetrics/Gynecology

Ministry of Health and Family Welfare
Jafar Ahmad Hakim, Line Director, Essential Services Package–Reproductive Health

District Nilfamari
S.A. Fida Hasan, Regional Supervisor, FPCST and QAT
Tofiqur Rahman, Deputy Director, Family Planning
Mujibur Rahman, Upazilla Health and Family Planning Officer, and Staff
Family Welfare Assistants (15), and BRAC Field Worker
Male Nonscalpel Vasectomy Clients (20)

Yasmin, MCWC, Rangpur
A.K.M. Shahriyar, Director Rangpur Medical College

Urban Family Health Partnership Clinic (PAC Project Site)
Dipti Debi, Clinic Manager
Jinat Nasrin, M.O. PAC and Safe Delivery
Sabera Sultana, Project Manager

United Nations Population Fund (UNFPA)
Aslam Zulfiquer Baig, National Professional Project Person, Strengthening Clinical Contraception Service Delivery
Prasanna Gunasekera, Specialist, Reproductive Health Services, CST Team for South and West Asia

APPENDIX C

SITES VISITED

SITES VISITED

GHANA

Mamprobi Health Center, Accra
Planned Parenthood Association of Ghana (PPAG) Clinic, Accra
Komfo Anokye Teaching Hospital, Kumasi
Tafo Hospital Family Planning Clinic, Kumasi
Koforidua Regional Hospital, Koforidua
Maternal and Child Health/Family Planning Unit, Koforidua

KENYA

Naivasha District Hospital
Coast Provincial Hospital
Family Planning Association of Kenya (FPAK) Clinic, Mombasa
Bomu Mkomani Clinic, Mombasa
Malindi District Hospital
Kilifi District Health Management Office

PHILIPPINES

Region 1 Medical Center in Pangasinan
Pangasinan Provincial Hospital
Region 11 Medical Center in Davao City
Clinica Rivera in Panabo City, Davao City
Community Health and Development Cooperative Hospital, Davao City
Davao Medical Center

BANGLADESH

Concerned Women for Family Development Clinic, Dhaka
Obstetrics and Gynecology Society of Bangladesh
Nilfamari District, Upazilla Health and Family Planning Complex
Rangpur Medical College and Model Training Site
Maternal and Child Welfare Center, Rangpur
Population Services and Training Centre, Dhaka

APPENDIX D

SUMMARIES OF COUNTRY FINDINGS

SUMMARIES OF COUNTRY FINDINGS

GHANA

July 5–12, 2002

The trip included visits to the Mamprobi health clinic, the Planned Parenthood Association of Ghana Clinic and Korle Bu teaching hospital in Greater Accra, Kumasi teaching hospital, Tafo Hospital (Kumasi), Koforidua Regional Hospital, and Koforidua Maternal and Child Health/Family Planning unit.

The team interviewed the USAID cognizant technical officer, staff of The POLICY Project, PRIME II, JHU/PCS, JHPIEGO, the Ashanti regional health director, the EngenderHealth West Africa regional director, and the EngenderHealth Ghana country director.

There is a reasonably functional public health system in place in Ghana. The entire range of family planning services was available at all centers visited (except vasectomy services in Koforidua). Female sterilization, Norplant, intrauterine device (IUD), injectable and oral contraceptives, male and female condoms, and even emergency contraception were available.

The entire staffs of these facilities had been trained through EngenderHealth, with doctors and nurse-midwives trained in family planning counseling, minilaparotomy and Norplant, and infection prevention.

EngenderHealth has been the major agency improving quality and access to clinical family planning services in support of USAID/Ghana's Strategic Objective. It receives funds both through a direct cooperative agreement with USAID/Ghana and through the USAID/Washington cooperative agreement.

No other cooperating agency (CA) or donor is involved in clinical family planning services. Nearly all government of Ghana clinical sites with the necessary staff and facilities now have the capability to provide clinical services: 105 sites provide minilaparotomy and 210 sites provide Norplant.

Although contraceptive prevalence for all methods, including clinical methods, is still very low, there is evidence that contraceptive prevalence will show an increase in the next Demographic and Health Survey (DHS). There was a high demand for minilaparotomy and Norplant in the sites visited.

The team's perception was that quality of services was reasonable. One site visited showed obvious changes as a result of recent client-oriented, provider-efficient services (COPE) training, but at another site this impact was not apparent.

EngenderHealth is regarded highly by the Mission and the Ministry of Health. EngenderHealth has effectively transferred skills to enable ministry personnel to train and supervise service providers in minilaparotomy and Norplant. Because of the departure of physicians for higher paying employment, there is a continuing need to train additional trainers and service providers. Scaling up has not fully occurred in areas other than

clinical service provision. The MOH still relies heavily on assistance from EngenderHealth and other CAs, as well as the USAID provision of commodities.

There is effective collaboration between EngenderHealth and the other CAs working in reproductive health.

USAID/Ghana chose to use a direct cooperative agreement because it wanted greater control over the CA's activities during scaling up than field support allows. EngenderHealth agrees that the USAID/Ghana agreement is better for scaling up because it ensures long-term funding.

Field support represents about one third of the total funding for EngenderHealth in Ghana. USAID described field support as a vehicle for activities requiring technical assistance from EngenderHealth headquarters, while the USAID/Ghana agreement was used for scaling up, training, and local costs. However, the team was not able to make a clear distinction. Field support does finance technical assistance from New York and those evaluative studies not envisioned in the cooperative agreement, but it also finances some of the training and scaling-up costs.

Core funding has had a direct impact on the Ghana program in several areas. Important areas include a sentinel site survey and a Norplant study (financed with a combination of core and field support).

Because there seems to be a bias towards Norplant and away from IUDs among both providers and clients, there is a need for inservice IUD training for service providers, to bring about a more balanced emphasis among alternative methods.

Unsafe abortion appears to be an important public health issue that contributes to a high maternal mortality rate. There is a need for a structured postabortion care (PAC) program.

EngenderHealth has satisfactory monitoring and data collection in place, enabling it to assess progress, identify problems, and take corrective action. For example, monitoring identified a need to retrain staff at some sites in infection prevention.

Ghana's HIV/AIDS rates are still relatively low, but could increase if measures are not taken. There is a need to integrate HIV/AIDS counseling into family planning counseling.

EngenderHealth's current focus is on clinical family planning services and closely related reproductive health initiatives, such as counseling, training, and infection prevention. Over the remaining period of the cooperative agreement, EngenderHealth plans to expand into PAC, male involvement, and the integration of HIV/AIDS into family planning counseling.

KENYA
July 15–19, 2002

The team met with EngenderHealth and USAID staff, the director of the national AIDS/STD, tuberculosis and leprosy control program (representing the technical head of Promotive and Preventive Services of the Ministry of Health), and Family Planning Association of Kenya (FPAK) representatives. The team then visited Naivasha District Hospital, met with the Coast Province provincial medical officer, visited FPAK Mombasa, Mkonami Bomui Clinic, Coast Provincial Hospital, Malindi District Hospital, and the Kilifi District medical officer.

Health services in Kenya are greatly underfunded. The government started a cost-share mechanism to help pay for services 13 years ago, but this did not solve the problem. There is a shortage of physicians and other health personnel.

Access remains a problem. In clinics the team visited, all clinical and supply methods were available except for vasectomy; however, in some clinics, access to minilaparotomy was limited due to competing demands on medical doctors. Further, the cost of clinical services and long distances reduces accessibility.

Service statistics indicate that since the mid–1990s, clinical methods have been declining, and there is some doubt that the use of oral and injectable contraceptives is increasing. EngenderHealth, health providers, and other partners suggest several reasons for these declines: underreporting, an increase in services available from the private sector, and cost-sharing that makes family planning too expensive. The clinics observed did not have many family planning clients, indicating that, indeed, service utilization is not high. Many managers and providers do not seem concerned about the decline.

EngenderHealth has been working in Kenya since 1984. Important gains were achieved in female sterilization and Norplant training, infection prevention, counseling, quality improvement tools, and PAC. EngenderHealth is the only organization other than JHPIEGO that has provided assistance in clinical family planning services, infection prevention, and counseling. During the 1990s, first minilaparotomy and then Norplant services were introduced and expanded. More recently, EngenderHealth has expanded its core activities into broad reproductive health and is planning to expand into maternity care as well.

Several factors that prevented some of EngenderHealth's achievements from being sustained or fully institutionalized were observed.

- For many years, EngenderHealth reimbursed clinics for costs of expendable supplies for voluntary sterilization and Norplant. Since these payments abruptly ended, many clinics were unprepared and have been unable to finance these costs.

- EngenderHealth also put in place a regional supervisory system that was not formally recognized by the Ministry of Health. When the project ended, the system fell apart.

EngenderHealth developed and implemented several quality improvement tools in Kenya, such as COPE, facilitative supervision, whole-site training, and cost analysis. In

every site visited, managers provided many examples of how these tools improved the quality of services. Over the years, however, since there have been substantial staff changes at each site, many of the current staff had not participated in previous COPE exercises, and some who did participate could not cite many benefits. Further, except where AMKENI is operating, it does not appear that government clinics are continuing to use these tools.

Much more needs to be done in all the key areas of training: clinical skills, counseling, and quality improvement. Additional work should be conducted to find ways to sustain these gains. This requires firm government commitment. Future programs should include discussions with the service agencies on management and organizational reforms of clinical services to improve access. Advocacy for service delivery improvements at policy-making levels of government is needed. It is hoped that AMKENI will cover these areas.

PHILIPPINES
July 5–12, 2002

CONTEXT

While the Philippines continues to have one of the highest fertility rates in Southeast Asia, recent survey data suggest that fertility has been falling. As of 2001, an average woman in the Philippines could expect to have 3.4 children by the end of her reproductive life span, which is a decline from 4.1 children a decade earlier. However, since mortality has also been falling, the rate of population growth continues to be high. The 2000 population census reported a population growth rate of 2.38 percent between 1995 and 2000. If this rate of growth continues, the current Philippine population of 78.5 million will double by the year 2029 (USAID/Philippines 2002).

The use of contraception has increased somewhat over the past decade. The use of any method of contraception increased from 40.0 percent in 1993 to 46.5 percent in 1997, but does not appear to have risen significantly over the 1997–2001 period. Modern method use is still relatively low in the Philippines owing to the widespread use of natural family planning and traditional methods. However, female sterilization continues to be used by a substantial number of women. As of 1997, 10.3 percent of currently married women aged 15–49 reported using female sterilization to limit their fertility. This is a slight decline from 11.9 percent in 1993. This level is substantially higher than in neighboring Indonesia (3 percent in 1997), but somewhat lower than in Thailand (19.8 percent as of 1993) (EngenderHealth 2002:56–57). Male sterilization is currently very low in the Philippines (0.1 percent in 1997), and may have actually declined slightly since the 1970s. Other clinical methods are not used by many women. IUD prevalence is only registered as 3.7 percent (as of 1997), and Norplant use is even more limited.

In judging the recent performance of EngenderHealth in the Philippines, one must keep in mind that the period from 1991–2001 has not been easy for the Philippine family planning program. The Department of Health has undergone much restructuring in recent years, which has led to considerable instability in staffing and the demarcation of program management responsibility. More critically, the devolution of responsibility for many health services from the Department of Health to local government units (LGUs) in provinces and local municipalities has introduced new uncertainty with regard to how local budget allocations for family planning/RH commodities, equipment, and personnel are made. The effective coordination of national health policies and standardized best practices may also have been compromised compared with earlier decades.

However, owing to limited time in the field, it remains uncertain whether health sector reform as carried out in recent years has inhibited the effective delivery of family planning and reproductive health services through the public sector. The fact that some provincial hospitals are still agitating to be renationalized suggests that health sector devolution may not have been a roaring success. It is probably safe to say that decentralization has been more successful in some regions than in others. Clearly, opinions vary widely on the matter and decentralization remains an emotive issue for many Philippine health care professionals.

In part due to the efforts of EngenderHealth, the expansion of clinical contraceptive services through nongovernmental organizations (NGOs) and the private sector has been gathering pace in recent years, but the Philippines has also witnessed a substantial

increase in the provision of family planning care through NGOs and the private sector (e.g., commercial distribution of family planning commodities) over the past decade. Of particular note has been USAID's support for the FriendlyCare Foundation, a largely urban-based NGO that provides fee-for-service family planning and reproductive health services to a largely lower middle and middle income clientele.

Many NGOs providing FP/RH care in the Philippines are heavily subsidized by international donors and may not be financially viable without this continued support. Since long-term financial sustainability will likely remain an issue for some time, it is difficult to predict whether EngenderHealth's technical support to the private sector will have lasting benefit. However, in this brief evaluation, it does appear that EngenderHealth has had an important role in strengthening the provision of clinical contraceptive services through the private sector.

ENGENDERHEALTH PROGRAMMING

EngenderHealth has been actively involved in the Philippine family planning program since the early 1970s. Its early efforts to promote capacity building in the provision of sterilization services in several large hospitals (including the Philippine General Hospital and the Jose Fabella Memorial Hospital) contributed significantly to the development of clinical contraceptive services in the Philippines.

EngenderHealth's more recent programming has concentrated on providing technical assistance for the installation and upgrading of quality sterilization services in LGU hospitals participating in the LGU performance program (LPP) of USAID's Integrated Family Planning and Maternal Health Program (IFPMHP). Between 1995 and 2000, EngenderHealth provided assistance to 72 LGUs and 156 LGU hospitals. This package of assistance included training service providers in minilaparotomy under local anesthesia (MLA), family planning counseling, upgrading sterilization service sites, procuring essential supplies (for a period of 12 months in government hospitals), implementing a clinical quality assurance system, and working through community channels to improve the referral of sterilization clients. These efforts were geared toward ensuring that there be a minimum of two sterilization-capable hospitals for each provincial LGU and one sterilization-capable hospital or referral system for each urban LGU in the national capital region.

Since 1995, two sterilization teams (consisting of a surgeon and a nurse or midwife assistant) from each of the 156 LGU hospitals were sent to EngenderHealth-assisted training centers to become skilled providers of MLA and to become better schooled in family planning counseling and client-centered informed choice. These trainees then provided instruction to additional local staff in the 72 LGUs participating in the LPP initiative.

Quality improvement tools developed by EngenderHealth were also introduced in many LGU hospitals. These tools dealt with infection prevention and control as well as clinical quality improvement using COPE managerial tools.

While it is beyond the scope of this evaluation to judge the overall impact of USAID's LPP initiative, it does appear that EngenderHealth has met with some success in increasing the use of sterilization in LPP areas. In 1995, there were only 4,343 sterilization acceptors in LPP sites. By 1999, the sterilization caseload had increased to

16,826. While these performance levels are still modest, they do suggest that women will use sterilization if accessibility and quality are improved.

In addition to its support of the public sector through LPP, EngenderHealth worked with the private sector from 1997 to 1999 to improve the provision of sterilization services. Efforts focused on the enhancement of provider competencies, upgrading clinical facilities, strengthening counseling skills, and improving community outreach efforts. Particular emphasis was given to encouraging clients with the capability to pay to obtain clinical contraceptive services in private sector outlets. Eight NGOs and 28 private hospitals have been participating in this project. To date, it has not been possible to judge how effective this private sector work has been, partly because of the changing composition of midwife-operated clinics participating in JSI's TANGO-II Project and the adoption of new benchmarks midway through the project implementation period (couple years of protection [CYPs] being dropped for other performance measures preferred by the administration).

Since 2000, EngenderHealth has embarked on several new initiatives. At the request of the DOH (and the support of USAID), EngenderHealth has been working to strengthen the availability and quality of sterilization services in DOH hospitals and regional (LGU) health offices. The DOH has been interested in having EngenderHealth improve the monitoring and supervision of sterilization care and upgrade the quality of instruction in clinical contraceptive services throughout the 16 regions of the country. A priority objective was the institutionalization of high-quality sterilization training in DOH hospitals. With the assistance of EngenderHealth, 198 regional health office personnel based across all 16 regions have obtained training in sterilization. In addition, training in MLA has been enhanced for physicians undergoing residency training in obstetrics and gynecology at DOH hospitals. Two DOH hospitals (in Pangasinan and Davao) that have been participating in this program were visited.

EngenderHealth is also working with 24 LGUs that are participating in the USAID–funded Matching Grant Program. This project is being implemented by Management Sciences for Health (MSH) in LGUs with fewer than 100,000 people. Of particular note is the emphasis being given to the establishment of effective sterilization referral mechanisms, primarily between hospitals and local field health units.

USAID has also recently provided additional funding for EngenderHealth's work in the private sector. EngenderHealth has provided training in sterilization (MLA support) and family planning counseling to staff from the FriendlyCare Foundation. This training was conducted in FriendlyCare clinics situated in Metro Manila, Cebu City, and Davao (this site has since closed).

In addition, between 2000–01, EngenderHealth participated in the establishment of pilot reproductive health centers in eight private sector hospitals. EngenderHealth's role in these centers included not just support for sterilization and other clinical contraceptive methods, but assistance in maternal care, adolescent reproductive health, the prevention and management of abortion, reproductive tract infections, and the involvement of men. An ambitious community outreach program (including linkages with the commercial sector) also became a prominent project component. This project therefore appears to constitute a substantial broadening of the technical assistance role of EngenderHealth in the Philippines.

EngenderHealth has been successful in leveraging other donor funds to begin work in new program areas, such as PAC and men as partners. The postabortion care initiative (referred to in the Philippines as prevention and management of abortion and its complications [PMAC]) is addressing a critical need that is now being given high priority by the DOH. This is an essential program since the abortion rate is high (actual numbers are unknown since induced abortion is illegal in the Philippines) and PMAC interventions (e.g., manual vacuum aspiration [MVA]) are very cost-effective.

Our observations suggest that good counseling for postabortion follow up will need to be strengthened in the future. In addition, provider attitudes toward postabortion clients still tend to be judgmental. Providers will need to become more client sensitive as PMAC services are introduced widely.

Funding from the Packard Foundation in support of EngenderHealth's PMAC activities in the Philippines will soon be ending. Fortunately, USAID has recently agreed to provide supplemental resources to allow EngenderHealth to extend PMAC services to additional clinical reproductive health facilities throughout the country.

TEAM ACTIVITIES

Main Observations

Current USAID funding for EngenderHealth will continue through September 2002. A new population and health sector project is being designed by the USAID Mission in the Philippines, but the role EngenderHealth might play is presently unclear. It was also learned that current EngenderHealth field activities may have been compromised by the untimely availability of funding. There has apparently been some problem with the timely disbursement of funds in recent years, with EngenderHealth funding occasionally getting tied up at USAID. It is not clear to what extent this remains a problem and what possible remedies might be proposed.

In discussions with Mission staff, there was general agreement that EngenderHealth had made important contributions to the strengthening of clinical contraceptive services (especially sterilization) through its involvement in the LPP program and work with the private sector. However, it was also acknowledged that overall family planning program performance in the Philippines has been disappointing in recent years. This is especially true when considering trends in the use of modern methods and clinical contraception.

Sterilization Services

Based upon discussions with the DOH, there is considerable satisfaction with EngenderHealth's efforts to strengthen sterilization service in the public sector. The DOH currently does not have staff in place that can provide the training and technical support that EngenderHealth provides. The under secretary for health at the DOH stated that USAID support for EngenderHealth had been critically important and that continuing support would be essential for upgrading the availability and quality of clinical contraceptive services.

The DOH is presently developing a comprehensive strategy for promoting sterilization services through public sector hospitals and clinics. It was emphasized that additional inputs will be needed to implement this vision. The under secretary noted that future

assistance should go beyond the current emphasis given to provider training and clinical quality assurance. Greater efforts will also be needed in communications, community outreach, and the procurement of sterilization equipment and essential drugs/medications. On visits to the DOH and provincial hospitals in Pangasinan and Davao, it was reported that the timely supply of sterilization commodities was a problem that had become more severe in recent years under the newly devolved health care system.

EngenderHealth's support for sterilization in the private sector is now phasing out. Apparently this effort has met with mixed success. One private clinic visited, the Rivera Clinic in Panabo City, Davao, has significantly increased sterilization use at its facility in recent years. Gains were most pronounced for postpartum MLA. The training and technical support provided by EngenderHealth was credited as being an important catalyst for this success. However, a second private facility that received support from EngenderHealth, the Community Health and Development Cooperative (CHDC) Hospital in Davao, has met with more limited success. This disappointing performance was attributed to low levels of demand for sterilization (particularly male sterilization), local area price competition for sterilization clients among NGOs and private providers, and the lack of client and provider payments for sterilization that existed during the 1970s and 1980s. It is uncertain whether EngenderHealth's limited support for the FriendlyCare Foundation has proven beneficial since the FriendlyCare clinic in Davao had recently closed down.

Training

EngenderHealth was widely praised for its practicum training in male and female sterilization, the upgrading of clinical management procedures (e.g., infection control and prevention), and a strong commitment to institutionalize informed consent and voluntarism among clients. Particular praise was given to EngenderHealth's attempts to make instructional materials relevant (and culturally appropriate) for a Philippine audience. Several informants noted that other CAs tend to rely more on generic materials that are designed for international rather than country-specific trainees.

EngenderHealth has had some institutional impact in terms of promoting the integration of PMAC and sterilization content into basic education curricula of obstetrics/gynecology, nursing, and midwifery programs. It has also been successful in working with the DOH in developing new policy initiatives and implementing administrative orders that support sterilization and PMAC services in public sector facilities.

In the Philippines, EngenderHealth has given considerable priority to COPE training. While these efforts were favorably reviewed by all informants, it is worth pointing out that there has not been any thorough evaluation of the effectiveness of COPE training. Are the COPE exercises designed to improve interaction with clients and improve the management of clinical facilities having any lasting impact? What is the cost benefit of COPE training compared with more traditional, inservice provider training focusing on medical/surgical practice? Based on information obtained during field visits, it seems apparent that COPE has been a valuable tool for enhancing the quality of clinical services. However, until a systematic evaluation is undertaken in the Philippines, uncertainty will remain as to how high COPE activities should rank as priorities for the future.

Regional and Central EngenderHealth Office Relations

Communications between EngenderHealth/Manila, the regional field office in Bangkok, and EngenderHealth headquarters in New York appear to be excellent now. Coordination of field activities and budgetary allocations between these three administrative levels appears to be smooth, with no evidence of excessive oversight or micromanagement of Philippine country program activities by personnel in regional or headquarter offices.

A near term problem for EngenderHealth is the preservation of existing staffing patterns and professional capacity, given current uncertainties over future funding. Having to dissolve and then reconstitute professional and administrative staff in time with the vagaries of contracting poses serious difficulties in maintaining a high level of continuity in program support.

Management Information System

Despite the persistence of slow Internet connections in Manila, EngenderHealth staff appears to have no trouble accessing the integrated management information system (IMIS) maintained at EngenderHealth headquarters in New York. Project activity reports and budget information are updated on this system and technical reports emanating from the Philippines occasionally are posted. Manila staff also did not appear to have any problems downloading documentation from New York (unlike what was observed in Bangladesh).

Sustainability

It is apparent that family planning and reproductive health services will continue to be provided through public and private sector outlets. In theory, the private sector will serve lower middle, middle, and upper income clients based principally in urban settings, while the public sector will focus more on low-income clients and rural residents. In practice, the real future may not be so tidy.

Over the past decade, changes in government coupled with reorganizations at the Department of Health have tended to undermine the confidence that public sector services will adequately address reproductive health needs in the future. It is encouraging to note that the current leadership at the DOH seems more determined to promote family planning than in the recent past. The government now has a strategic plan for the provision of sterilization services, which is certainly a step in the right direction. However, the extent to which the DOH can effectively implement any new policy directive given its newly devolved structure remains to be seen.

As noted previously, the long-term viability of nonsubsidized private sector care (particularly in terms of cost recovery and pricing of services) is still uncertain in the Philippines. At present, funding sources and the extent to which private sector services are dependent upon external subsidization are not always clear. While it is important that private sector services be made affordable, long-term sustainability will not be served by promoting artificially low pricing for services in an already resource-starved system. This issue deserves further study.

BANGLADESH
July 13–20, 2002

CONTEXT

The Bangladesh government has supported a set of strong programs in health and population through two major mechanisms. The World Bank Consortium with eleven donors has concentrated on public sector programs, and USAID has concentrated on the nongovernmental side, including the private sector. Success in decreasing fertility rates from a total fertility rate (TFR) in 1975 of 7.7 to 3.3 in 1999/2000 resulted largely from a strategy of delivering contraceptive supplies to women in their village homes. This strategy is now being replaced by a service delivery system that will provide an "essential services package" through local community clinics. This new clinic-based approach is still not functioning in much of the country, even though fieldworkers have reportedly stopped making regular home visits in some rural areas. It is still too early to judge whether the rapid abandonment of domicile delivery (with little planning for the transition from reliance on fieldworkers to community clinics) will prove to have been wise.

A push to shift this service delivery strategy to clinic-based services began in the mid–1990s, along with the development of concepts of health sector reform and an essential service package which involved the integration of eight primary care services. Along with this integrated delivery package was the plan to integrate the two wings of the Ministry of Health and Family Welfare. Integration was achieved at the upazilla level and below, with resulting dysfunctions in data collection and supervision. This has resulted in a major morale problem. Movement to achieving delivery of this essential service package has slowed for several reasons, including a change in government leadership in October 2001.

The government of Bangladesh became aware that sterilization services did not feature prominently in the new essential service package and that permanent methods had dropped off radically from earlier rates. The TFR has been stagnant at 3.3 since 1994.

ENGENDERHEALTH PROGRAMMING

Since 1998, EngenderHealth has, with USAID funding, focused major efforts on a quality improvement project, which involved developing standards of care and measuring change in quality for the essential service package, as well as on strengthening sterilization services for nonscalpel vasectomy (NSV) and MLA in two pilot upazillas (and expanding to six more districts). Additional funding from other sources has been acquired to introduce PAC, improve infection prevention for emergency obstetric care (EOC), strengthen clinical contraception and RTI/STD case management, and build the capacity of HIV/AIDS focal points in 14 government ministries.

TEAM ACTIVITIES

USAID highly values the work of EngenderHealth, and describes it as one of the healthier organizations." The high degree of professionalism, the excellence in technical consultation, and the organizational culture make EngenderHealth a reliable agent for the promotion of good, clinical family planning services. It has been transparent in its operations and has kept USAID well informed. At times, EngenderHealth has been asked

to take on activities that were a challenge to its toolkit but it met such challenges as developing standards for the essential service package. The Mission prefers field support as a funding mechanism because it has more control.

Sterilization Services

EngenderHealth has taken an important role in assisting the government of Bangladesh in strengthening programming for male and female sterilization services. There is considerable potential for expanding voluntary sterilization services. EngenderHealth has made good efforts in provider training in technical service provision and counseling, as well as skill upgrading and the promotion of contraceptive method information and informed consent.

Regarding the potential for sterilization, strengthening is needed in management, logistics and supplies, and field communications/outreach to ensure that all elements are coordinated. Bangladesh has kept the English term "operation" in communications with patients so that men and women know that surgery is involved, even in NSV. The elected female union (parishad) leader is also involved in community outreach campaigns.

While the government of Bangladesh has sufficient funds for equipment and supplies, there are difficulties associated with the complex procurement system that the World Bank manages. These complications are well known to the Bangladesh government. Several donors (including USAID) are assisting in developing mechanisms to resolve these problems. One possibility is creating a buffer fund that would allow the timely purchase of supplies needed for sterilization surgeries.

EngenderHealth focused on identifying the key resources and inputs needed to make the sterilization program work. Upazilla planning meetings are considered to be one of the keys to success. Since the pilots began in two sites from October 2001 until June 2002, 5,102 NSVs and 2,731 tubectomies were completed. This was starting from a base of zero. These include a small number of cases performed at other facilities or by roving teams. EngenderHealth found it facilitative to support a number of roving teams to provide support, supervision, and back-up to pilot project sites.

In April 2002, EngenderHealth developed a brief paper, "Performance Projection and Estimation of Cost of Critical Items." This paper projects a total of 29,187 sterilizations between July 2002 to the end of June 2003. A ratio of 3:1 is expected for tubectomies and vasectomies. The estimated costs for critical supplies and medications are approximately $54,186 for this number of sterilizations.

There is substantial demand for male and female sterilization. The government of Bangladesh has asked EngenderHealth to expand to an additional six districts. That process is well underway, so that different regions throughout the country will be covered. How quickly can the pilots be expanded to additional regions throughout the country? What is reasonable to expect in the way of scaling up?

More needs to be done to incorporate voluntary sterilization skills in preservice education, but the professional institutions are difficult to change. Additional efforts are needed by the BMDS to incorporate the decontamination step into teaching programs. At present it is not a part of the basic curriculum.

Training

Medical doctors were observed using a heavily didactic teaching style that was less geared to practical, hands-on training. For example, the use of a rubber model to demonstrate the procedure for taking a vaginal smear did not assure that all trainees could see the steps in the procedure, and no opportunity was given for trainees to give a return demonstration. Physicians in training reported that they were learning new information about patient screening as well as newer surgical procedures (NSV and MLA). Paramedic training showed good use of written materials and opportunities for questions and answers (interactive learning).

There is a need for more two-way communication flow with clients. The press of patient loads squeezes clients into a short space of time, and providers are rushed to provide the care they think the client wants. It is also not a part of the public service culture for physicians to talk much with patients.

EngenderHealth office management and operations seem to be smooth and well managed. Few professional staff members (12) are supplemented by part-time help as needed to fulfill planned activities.

Regional and Central EngenderHealth Office Relations

The Bangladesh EngenderHealth office reports that the regional office provides good administrative and technical support. Annual reports are reviewed and feedback is provided. Overall, however, the Bangladesh office seems to have a fair amount of autonomy in day-to-day operations. The various consultants provided through the New York office are highly valued; they assist with program thinking and content development on a range of technical areas.

Management Information System

The Bangladesh government introduced a new recordkeeping system for patient services that covers the full set of the essential service package. While the client records of the package are in use in many government and NGO clinics, procedures are not yet in place to systematically gather that data. With respect to the pilot sites for the sterilization program, a separate data collection system has been established, with counts of services completed. At present, there is no data collection in place that would identify client characteristics along with service numbers. This should be added to the Bangladesh government system to identify the clients.

This EngenderHealth office has difficulty linking its unified management information system with the New York headquarters office. It is not easy to download documents, so staff relies on Bangkok for print copies. The system is not being used as a management tool because of connectivity problems. There is an information technology person based in Bangkok who only visits Bangladesh about once a quarter, but who has not fully resolved the problems. The staff also needs more hands-on experience.

Training materials reviewed in a number of technical areas were excellent in terms of content covered, detail, and teaching methods. The PAC efforts have been very important, with excellent technical materials that are sufficiently detailed to assist providers in knowledge development and awareness of the range of skills required. This

was funded by the Packard Foundation and is a very promising area for decreasing maternal mortality. The Bangladesh government is interested in promoting PAC, and has added the procurement of MVA supplies to the operational plan for maternal health. It may be possible to promote sterilization among the methods discussed with PAC clients.

Leadership development has been encouraged by EngenderHealth by seconding the Ministry of Health and Family Welfare Director of Maternal and Child Health Services for one year to assist with the development of the sterilization program. His knowledge of the government, combined with the opportunity to work at the implementation level, was fruitful in terms of understanding the limitations that the program faced as well as finding ways and means of stimulating the program. He was able to access Imprest funds at the upazilla level to assure that the operations would be able to be completed at the scheduled times. This avoided the breakdowns that are frequently the cause of missed opportunities to complete operations.

Sustainability

Sustainability needs to be considered on a number of levels. First, the EngenderHealth program is working closely with government and other donors (UNFPA, UNICEF) to integrate infection prevention activities, quality assurance activities, and improved clinical family planning services (especially surgical contraception) into both governmental and nongovernmental programs. By seconding government officers, such as the director of maternal and child health, to work with program development, the knowledge and understanding of key government officials is being increased, which will contribute to strengthening government services.

Second, EngenderHealth has made important contributions to the technical advancement of essential service packages (and clinical family planning) throughout the country. One government official said, "EngenderHealth is a must in clinical contraception." EngenderHealth works with the Bangladesh government in terms of standards, and written guidance materials have been of extremely high quality. These materials are developed in a variety of subjects; many have been translated into Bangla and are broadly distributed. The availability of detailed, pertinent, service information and patient care guidelines is an important adjunct to sustainability efforts that has been largely missing.

Third, principals of infection prevention and high standard decontamination are not yet incorporated into the basic curriculum of medical doctors. EngenderHealth is working to influence this powerful and deeply conservative professional group. To date, efforts with the Obstetrics and Gynecology Society of Bangladesh (OGSB) have been more productive. This professional group is promoting the use of good infection prevention practices in service sites where EOC is being upgraded. It is also promoting decontamination steps in its infection prevention procedures. Additional work is needed, however, to have OGSB members promote postpartum minilaparotomy at district hospitals. EngenderHealth is working with the OGSB to promote the development of continuing medical education programs for physicians in quality assurance and PAC, which would eventually be accredited programs.

APPENDIX E

MISSION INTERVIEWS AND RESPONSES

MISSION INTERVIEWS AND RESPONSES
Consolidated Mission Responses to EngenderHealth Evaluation (June 2002)

How have EngenderHealth activities contributed to achieving USAID country-level SOs and results in delivery of family planning and reproductive health services? Are there data available to support these results?

Bolivia

EngenderHealth provides technical assistance to NGOs in rural and urban areas to increase services, in IEC and training to professionals, and in commodities. EngenderHealth tracks the number of people trained, the number that were given equipment, the availability of commodities/methods in different places, and counseling for people who request services. The services are natural FP, LAM, pills, injections, DMPA, condoms, female condoms for sex workers, IUDs, and surgical methods. National norms and technical procedures for FP were developed, including surgical methods, rights and equity, and informed choice and informed consent as well as the development of technical procedures for control and infection prevention for reproductive health services. There are data available to support these results, including data about process (tools developed [norms and technical procedures] as well as registration of trained personnel) and impact (influence of these activities on the service demand and offer).

Guatemala

There are data to support SO progress and EngenderHealth has contributed to each of these goals. Prevalence is about 38 percent. EngenderHealth is part of the URC consortium working in Guatemala. The activities described apply to the entire consortium, not just EngenderHealth. However, the technical assistance provided by AVSC and EngenderHealth from 1992–99 as a bilateral program was greatly appreciated by the Mission. Most of the activities related to training, counseling, male involvement, and surgical contraception for male and female users.

Jordan

In Jordan, the SO is to increase access to and quality of primary health care. EngenderHealth is not working at the primary health care level. It is working in hospitals, at the curative tertiary care level, improving quality training on infection prevention in operating rooms for tubal laparoscopic operations, and using outpatient departments to improve tubal laparoscopy acceptance and referral. EngenderHealth supports IR 2. There are 400 PHCs. EngenderHealth has specific areas to strengthen long-term and permanent methods. Vasectomy is not acceptable in Jordan. Norplant acceptance is very low because of cultural and media factors. Injectable contraceptives were introduced but there are high discontinuance rates. The CPR of 58 percent includes traditional methods: 24 percent are IUD users, 9 percent are pill users, and 1.8 percent are condom users. Eighteen percent use traditional methods. EngenderHealth is trying to improve the quality of long-term methods, infection control, and training. There are many religious and other factors against tubal laparoscopy. EngenderHealth is introducing PP IUD in many hospitals in the country.

Nepal

EngenderHealth has been the main partner in supporting FP services and the CPR has increased from 28 to 35.4 percent; the fertility rate is down from 4.6 to 4.1 from 1996 to 2001. The gain in prevalence has largely been pills and injectable contraceptives. USAID's SO is to increase the use of quality FP services.

Paraguay

There is no direct work with EngenderHealth now, but many years with AVSC in the pioneering years assured that objectives were achieved. Quantitative results were not satisfactory. EngenderHealth achieved 42 COPEs, which was okay. EngenderHealth, within four or five years, improved the quality of services in the public sector by incorporating the COPE mechanism in five regions. This was its greatest accomplishment. We wanted to establish a standard public service delivery site that met certain standards. COPE started the process. It is one tool to use for improvement, but it is not everything—it gave us a big push. EngenderHealth also participated in quality seminars for service providers.

Bangladesh

EngenderHealth is presently involved in revitalizing sterilization services, training doctors, and doing a great job in advocacy. It is working very well with the government in two districts and the results are very encouraging; it reversed the trend from a position of zero. The Ministry of Health is requesting that EngenderHealth expand. EngenderHealth is almost the sole training source for government personnel. The unified management information system (UMIS) is a reporting system that is not flowing into any source. FP data from the government are not coming in these days. USAID has 42 NGOs that have an MIS. EngenderHealth is collecting data from its two pilot sites with a temporary data collection system.

Dominican Republic

EngenderHealth assistance, provided to the USAID Mission through field support (through GH) has been the main source of technical assistance to the public sector in terms of quality of clinical services. The main strategy used was inservice clinical training. Data are available in quarterly reports provided by EngenderHealth to the Mission.

Ghana

EngenderHealth's separate cooperative agreement with the Mission has worked very well. It is the prime CA for service delivery in family planning. Ghana has gone from very weak to very strong in service delivery in the past five years. EngenderHealth is the only CA working in service delivery. The indicators the Mission uses for service delivery are similar to those in the GH cooperative agreement. EngenderHealth keeps family planning visible; it visits the districts, checks service quality, and uses COPE.

Kenya

EngenderHealth has been a major contributor to USAID's reproductive health objectives. USAID used field support to obtain services from EngenderHealth until 2001, when we shifted to a bilateral project for which EngenderHealth is the lead partner. Under the CA, EngenderHealth worked on direct service delivery. Under the CA, the doctor–nurse team training was one of the greatest achievements, as well as the idea of the regional supervisor, which could have worked with better government commitment. The infection prevention module is a standard here—everybody knows it. However, since there is no national MIS program, there are no data on the status of long-term and permanent methods.

Tanzania

EngenderHealth activities contribute directly to the Mission's SO 1 by increasing the level of CYPs and CPR, which are among our high-level performance indicators. They closely collaborate with the Ministry of Health, the Tanzania Family Planning Association, the

Evangelical Lutheran Church, and the Seventh Day Adventist Church. We have a performance monitoring program and EngenderHealth has managed to provide data on their performance, as needed.

Honduras

We just had a national DHS. CPR increased from 50 percent in 1996 to 62 percent in 2001. History: Working with both governmental and nongovernmental programs, the family planning association accounts for about 30 percent of family planning in the country. There was a lot to be done on the public side, especially with respect to urban access. The CPR is 15 percent higher in urban areas. There was a big effort to work with government training and expansion of services, especially in the rural areas. EngenderHealth had a large role: surgical contraception for women (quality, access), IUD, pills, Depo-Provera, and condoms, including counseling. (The government increased CPR contribution from 35 to 45 percent.) Rural CPR increased from 35 to 45 percent and EngenderHealth was an important part of this change. Now that prevalence is up, it may be harder to increase the numbers. CYP used to come primarily from the hospitals but now it also is coming from rural health centers. Training nurses for IUD insertion (Population Council started and EngenderHealth took over) has some impact on increased availability. USAID is tracking all the methods. Every CA is in charge of collecting information and has to report results annually to USAID and the government. EngenderHealth is doing well. It is making sure that the supplies are not being slipped to the private sector and that the trainees in IUDs are delivering at the local level. JSI receives a small amount of money to do this but EngenderHealth is responsible for monitoring these things at the regional level. DELIVER works at the national level, while EngenderHealth works at the regional and local levels.

Senegal

Access, quality, and increased utilization (both frequency and regularity) of reproductive health services have improved. Demand has increased for services and clients have better knowledge of the types of services offered, along with improved relations between clients and providers. Financial improvements in health services have resulted from reinforcing the capacity of local communities to generate the resources needed to provide essential reproductive health services. EngenderHealth has done important work on all three of these results, according to evaluations. On increased access: based on management of training and quality of service using COPE, facilitative supervision, counseling, infection prevention, training and technical competencies, EngenderHealth has achieved the following results: 83 health sites provide coverage on reproductive health services, out of a total of 108 sites (11 of 12 referral centers, 13 of 15 health centers, 49 of 75 health posts, and all 8 hospitals). The quality assurance package, operated with COPE action plans, is much appreciated by personnel and the technology has been transferred to other cadres, who in turn introduced it in their facilities without direct assistance from EngenderHealth. Medical supervision, infection prevention, and contraceptive technology and counseling have been used in all 83 sites. COPE succeeded in resolving 50–90 percent of the issues it exposed. Forty-four people were trained in facilitative supervision and have trained others. Two hundred and twenty people have been trained in counseling, including trainers, counselors, and providers. Forty-six percent are working in the field. COPE and facilitative supervision continue to be used in the regions where EngenderHealth worked, and facilitators train others who continue to apply the tool. A. Le Dantec hospital has become a regional center for training in minilaparotomy, approved by EngenderHealth. Unfortunately, because the government controls service statistics, it is difficult to apply them to changes in utilization of services because of increased quality. On client knowledge and satisfaction: COPE's plan of action is to assure the orientation of staff to clients when they come into the health center. Here, they put in place a system of meeting counselors at the door and getting forms signed. Activities of counseling and IEC have become humanized, and relations between clients and providers improved. The interview with clients has been integral to COPE. Providers know that poor

relations with clients may cause them to have a poor evaluation. Their friendly attitude to clients has made clients more open to ask questions. But without a precise evaluation it is difficult to say how this has helped with increasing demand. Financial improvements: They have been very appreciated and have mobilized health services resulting in the following: in FY 1999/2000, there were 29,000,000 FCFA for four districts, and on these funds, 86 percent of activities were completed. In FY 2000/01, there were 168,750,000 FCFA for 9 districts. The difference provided allowed the health department to purchase an ambulance that was not eligible under USAID funds. At this level, they were able to realize 86 percent of activities. This matching strategy, requested by USAID and mobilized by EngenderHealth, has satisfied the needs of rural and urban populations in the project area. It was not easy to mobilize such scarce resources.

How well has EngenderHealth collaborated with other partners? Have there been areas of overlap?

Bolivia

Very good. For example, EngenderHealth worked to give CARE technical assistance so that they both could cover more areas. Also, EngenderHealth worked with PROCOSI with the development of the self-training model on FP and counseling, and with PROSALUD with quality improvement of reproductive health services, and with smaller programs with other CAs.

Guatemala

EngenderHealth coordination with other partners was excellent when it had a presence in Guatemala. As part of the current consortium, coordination is a plus.

Jordan

EngenderHealth goes to its counterparts and does not involve USAID enough in planning meetings. EngenderHealth collaborates with CMS and the FCI MOH initiative. It avoids duplication.

Nepal

EngenderHealth collaborates very well, including with JHPIEGO.

Paraguay

MOH was always happy. Also worked with IPPF affiliate. Other donors replicated programs. PAC has been replicated.

Bangladesh

No comment on this area.

Ghana

There are many CAs here. The separate cooperative agreement with EngenderHealth makes it easy to manage, most of the time you get what you want. EngenderHealth staff is so busy. The EngenderHealth mechanism makes management of subgrants very effective. Collaboration is good, but it could be better if it had more time. As for other donors, they are not working directly on FP service delivery. UNFPA is working mainly at the policy level on population issues, safe motherhood, and HIV. Other contributors use the sectorwide approach with government. DFID

is the key partner in providing assistance to the government, which is tied to a five-year program of work.

Tanzania

EngenderHealth collaborates very well with local partners and other CAs. It is a subcontractor of PRIME II and works closely with INTRAH, JHPIEGO, and JHU. We have prevented overlap by selecting INTRAH as a coordinating CA and involving all CAs in a roundtable agreement during preparation of the public sector work plan. UNFPA has been a close partner in providing clinical reproductive and child health services.

Kenya

This is a hands-on Mission, even with field support. We have quarterly meetings with CAs, annual work plans, and life-of-project strategic plans for each. Under the bilateral project, coordination is good among the partners. Other donors divide the costs of contraceptives (although no donor is in place for Norplant for next year). UNFPA has retreated to nine districts where it provides the whole range of reproductive health services. Since it no longer works on the national level, it has little contact.

Honduras

USAID has had 10 CAs working there, and all have to tailor their activities to the USAID/Honduras country strategy. We organized a CA collaborating mechanism. Work plans have to be linked to USAID's Strategic Objectives. They meet regularly, work out of the same office, and EngenderHealth is part of that group. Everyone knows her/his role. We meet with government counterparts to explain each of the CAs to them so that they know how to work with them and what to expect. USAID helps sort out the overlap to make it complementary. We will revise activities in the coming year because both EngenderHealth and JHPIEGO have the same infection control and quality assurance. EngenderHealth is moving through quality assurance, infection prevention, and providing technical assistance to improve the surgical contraception services. It is trying to expand into other areas where it overlaps with other donors. There is a big unmet need for FP. We do not want to duplicate.

Dominican Republic

Collaboration with PRIME II, working in other aspects of quality of care with basically the same sector, was commendable. The EngenderHealth local staff has been careful and proactive enough to coordinate work with other donors, such as UNFPA and GTZ.

Senegal

Collaboration and teamwork with the MOH was excellent. All activities were negotiated with the departments of planning and reproductive health. As one respondent noted, "We have made a team." Relations with other CAs are very cordial. EngenderHealth has worked with JHPIEGO in training and supervision for infection prevention, and with JHU on training for men as partners. It had an interesting experience in collaborating with MSH on approaching the community by facilitating community COPE. EngenderHealth also worked with Abt Associates in training and in the matching grant. It has worked in studying decentralization and the needs of PAC with the Population Council. Collaboration is underway with DISC with Community Cope, utilizing planning between the main representatives at the community level. Most importantly, perhaps, there has been some overlap with JHPIEGO, notably in the infection prevention and PAC areas, but it does not have the same targets or sites. EngenderHealth as an organization is recognized as having a very solid experience in reproductive health and is highly appreciated for the usefulness

of COPE and its efficient way of training. The Development Bank of Africa financed community initiatives in reducing maternal mortality in three districts with EngenderHealth.

What technical components have been most crucial in contributing to your country-level SOs and results? Could a different mix of interventions have been more supportive in your country? How satisfied have you been with technical assistance provided by EngenderHealth, overall in terms of quality, responsiveness, and value?

Bolivia

EngenderHealth helped a lot with female surgical contraception, client information, counseling and informed consent, medical quality assurance, and training. A very important milestone was the development of the national norm for family planning document in which is included male surgical contraception. The mentioned norms and procedures have a Ministerial Resolution that legally supports the documents to be implemented in public and private services nationwide. EngenderHealth is currently (since FY 01) with the whole gamut of contraceptive methods, in coordination with the Georgetown University IRH CA that works in Bolivia with NFP. In the future, we will need more in male involvement. We are very satisfied with the technical assistance. EngenderHealth is easy to work with and the quality of technical assistance is high. We value the work it is doing.

Guatemala

EngenderHealth is strongest in medical quality assurance, voluntarism and well-informed clients, service-based family planning, PAC, and vasectomy. In terms of the quality of interventions, it used several methodologies, tutorials, and open communication to make sure that it was delivering according to national and international standards. It worked very well here. EngenderHealth provided technical assistance to the MOH and the Social Security Institute to train medical and paramedical staff, updated norms, and in some cases, developed the norms (surgical contraception). Introduction of the quality of services has been a major area of emphasis. Training centers were developed and currently the country trains its own personnel. The FP program was instituted at the Social Security Institute. The counseling concept was introduced in Guatemala. Informed consent was always a major concern and EngenderHealth dealt with it successfully.

Jordan

Tubal ligation is the crucial element we ask EngenderHealth to work on. We need more work on empowerment and information to clients. There is a service provider bias towards IUD insertions. Their performance has jumped in the last two years. EngenderHealth has introduced a consultant, an MD, who is excellent, and another one who did RTI workshops. These replaced a less effective consultant from earlier years.

Nepal

Based on past experience, the best technical contributions are on medical quality assurance, voluntarism, and client-centered services. EngenderHealth has a small role in men as partners. PAC has been in joint partnership with JHPIEGO. EngenderHealth performs a limited technical advisory role in social marketing. EngenderHealth has played a key role in evaluation and research, especially in client-focused services. In general, we are very satisfied. The most important technical inputs are quality, training, and PAC.

Paraguay

EngenderHealth was involved with medical quality assurance, voluntarism, client-centered service systems, service-based training, vasectomy and male involvement, and postpartum and postabortion FP services. Vasectomy and PPFP/PAC were controversial. We were very satisfied with the technical assistance, although EngenderHealth did not have a local chief of party, which was a problem. We were always very happy with AVSC.

Bangladesh

In the past four to five years, EngenderHealth has concentrated on the quality improvement project, which was its largest achievement. It did very well in developing quality-related guidelines. USAID pushed hard to get EngenderHealth to quantify results achieved in this project. We expected a greater degree of analysis. Extra technical assistance was brought in that eventually resulted in streamlining quality measures and conducting periodic reviews of individual clinic sites that could be compared over time. This quality review covered all services in the essential services package, including maternal care and child health. PAC: An EngenderHealth representative came from Delhi to get the program started. EngenderHealth promotes counseling, quality assurance, and family planning information. HIV/AIDS: USAID feels that EngenderHealth was asked to do things beyond its scope of knowledge; this was a mismatch for the organization. We are happy about EngenderHealth's concentration on sterilization.

Dominican Republic

If in the future we should require a continuation of this technical assistance, it would be useful to tie it to the establishment and monitoring of a supervision system, and enhancement of the components of infection prevention and application of norms. Overall and in terms of quality, responsiveness, and value added, the Mission was satisfied. Other factors intervened, such as a high turnover rate in the trained medical staff at the GODR level, or political endorsement, to prevent optimal results. Otherwise, the quality of the assistance, the responsiveness of EngenderHealth staff, and the value added to the training processes was very good.

Ghana

We are very satisfied with technical assistance under the GH and the Mission's cooperative agreements. EngenderHealth has done very well on infection prevention and counseling, but there is still a lot to do. EngenderHealth is a subcontractor on PRIME and has done quite well in facilitative supervision, by having both EngenderHealth and PRIME cofund the facilitative supervision.

Senegal

Incontestably, the quality assurance of services has been a highlight of EngenderHealth, notably with COPE and the associated package of training materials. In the areas listed, EngenderHealth has participated in a pertinent way and has paid attention to the SO during this phase of transition: voluntarism and informed consent, quality assurance, whole-site training, infection prevention, training of trainers in long-term methods, and men as partners, in the eight hospitals and then going out to the regions. Postpartum FP and PAC have been realized by a study on the possibility of decentralization of PAC at an operational level and in the district health centers. EngenderHealth has expert staff, it has the same objectives as the Mission, not only in PAC and postpartum family planning but also decentralization and integration into maternal health. Moreover, the cumulative experience with facilitative supervision can help consolidate the program in maternal health. If EngenderHealth were more involved in maternal health, its work

on quality assurance could have a greater impact. EngenderHealth has worked with the MOH in developing an integrated curriculum in FP, covering general areas, sexuality, and STIs. This training would also be valuable for personnel working in HIV/AIDS and STI areas.

The Mission has been very satisfied with EngenderHealth technical assistance in the areas of quality assurance, infection prevention, and PAC. The Mission is also quite satisfied with the way EngenderHealth managed the matching grant funds. EngenderHealth has always been very open to Mission requests and has always participated in activities when asked. USAID appreciated EngenderHealth's flexibility in conducting and managing the funds collected locally without charging expenses during January 1 to March 31, 2001.

Kenya

Training of physicians and nurses, doctor–nurse supervisory teams, and infection prevention. COPE has worked well in some facilities.

Tanzania

EngenderHealth supports all nine areas. PAC is a new area and a new program as well. Basically, EngenderHealth did an excellent job involving all the key partners in Tanzania during the designing stage and the Ministry of Health is in full support of this activity. It is the first time that a USAID CA was able to sign a memorandum of understanding with the MOH on sensitive activities such as PAC. EngenderHealth has given extra effort to proposing to the Ministry of Health that it support the health providers in HIV/AIDS prevention. We are very pleased with the way EngenderHealth has handled concerns of the MOH. The Mission is very satisfied with quality of technical assistance, responsiveness, and that we get services of the value of our investment. Although EngenderHealth is not directly involved in social marketing, it has a cost-sharing and cost-analysis model, both of which are implemented by the Tanzania FP Association and that soon will be part of the MOH public sector service package.

Honduras

Quality assurance works well. EngenderHealth has more resources to do this than other CAs. It needs more support from the central office to increase the FP services in rural areas, counseling, training in IUD insertion, and maybe Norplant in the future.

Has management been responsive to Mission needs and requests? Should EngenderHealth management practices be changed in any way? How satisfied is the Mission with EngenderHealth country offices' staffing, management, and technical skills?

Bolivia

Yes. They have a local office that responds adequately and timely to any request. The Mission is very satisfied.

Guatemala

EngenderHealth does not have a local office. As part of the URC consortium, it has one expert on the team. The expert is doing excellent work. EngenderHealth never has had an office in Guatemala, but it was very responsive from the regional offices located in Colombia. The Mission was satisfied with the work performed by EngenderHealth in the past, and it is satisfied with the work it has done as part of the consortium.

Jordan

There have been improvements lately. It is not results oriented. In comparison with other CAs, the reporting skills are weak. Next year's work plan is more focused.

Nepal

The regional office in Bangkok is a real cost savings. EngenderHealth is highly supportive of its country team. The regional office is helpful in fielding consultants. Over the past two years, leadership in the country office has worked closely with the Mission. We are very satisfied with the responsiveness, administrative support, activity management, and interactions with the Mission.

Paraguay

Only had e-mail a couple of years. When there was direct communication, there were no problems.

Bangladesh

EngenderHealth is a very healthy organization that cares for its people, has capability, and many things to be incredibly proud of. It has excellent technical assistance consultants. The organization is willing to be very transparent. EngenderHealth keeps USAID well-informed.

Ghana

The Mission does not work with headquarters management much. Since the Mission has a direct grant with EngenderHealth, most of the time we deal directly with the country director or staff of the local office. The previous regional director spent a lot of time with the country director, conceptualizing, writing work plans, etc. That was a very good use of time/money. You cannot expect to get everything from a country director.

Senegal

Relations with the Mission have always been very good. EngenderHealth provided financial and activity reports. The Mission appreciates EngenderHealth's and other CAs' willingness to sign a contract of service without difficulty. We believe EngenderHealth has completed the mission that it was asked to do and was able to overcome difficulties between partners in mobilizing resources for local groups. The same applies to studies on the feasibility of decentralizing PAC to health districts. The Mission is satisfied with the benefits of EngenderHealth of Senegal in keeping a high priority on quality and maintaining organizational technical plans.

Tanzania

EngenderHealth has always responded to Mission requests and needs positively. It does not have an in-country office but we are working so that EngenderHealth can have an office in Tanzania. EngenderHealth is expanding services for Tanzania and it is increasingly evident that EngenderHealth cannot keep operating from the office in Nairobi.

Kenya

We found EngenderHealth to be quite responsive. We would like to see core funding used just for Kenya.

Honduras

EngenderHealth and BASICS have good projects with good people running them. It is important to have someone in-country to manage things. There is a manager in Colombia but it has hired local people to manage things in-country. It has worked very closely with governmental counterparts and USAID. The CA will be evaluated on how well it works together with other CAs, with USAID, and with the government. The regional director has been very responsive.

Dominican Republic

Yes, there is a small EngenderHealth local office with two permanent professionals who are very good technically and know the country and the people in the health area and are ready to collaborate with the Mission in many ways.

Has sufficient attention been given to ensuring sustainability and institutionalization of EngenderHealth technical assistance in your country?

Bolivia

EngenderHealth aims for sustainability at the central level, influencing the health policies and strengthening local capabilities at the Ministry of Health central, regional, and services levels, in order to apply the norms and technical procedures to standardize and improve the quality of service delivery. Emphasis is given to the supervision process, to empower central, regional, and local supervisory skills to ensure the implementation of the norms and technical procedures at service delivery. At the local level, it is already institutionalized. It is more difficult at the central level. EngenderHealth depends on foreign aid. There are national norms to show what is needed for each method—it is a plus for the work of EngenderHealth because it worked hard to promote health policy at the top.

Guatemala

Sustainability is still a concern. EngenderHealth was aware of it during the time it worked in Guatemala, and it is aware of the issue now as part of the consortium. Although some steps have already been taken, there is a long way to go until the FP program is sustainable in Guatemala.

Jordan

Sustainability is covered well. It established two training centers for tubal ligation. Capacity building for staff is complete and facilities are equipped. We should get documentation in hard copy of the content and database for trainees (e.g., training materials put on CDs so it is not lost for the future).

Nepal

Nepal relies on donors for 80 percent of the national budget. Financial sustainability is not possible in the near future.

Paraguay

Supervision was always a problem that prevented sustainability. EngenderHealth never knew how to supervise the public sector MOH providers; it goes to private practice after hours. Transferring of staff who were trained was frequently creating problems, since RH and FP is

really new to Paraguay. There is now an RH Council and AVSC did a key job on setting this up but there is still a lot to do. Knowledge provided by the training gets lost.

Ghana

The program here is run by Ghanaians in government, which aids sustainability. The main problem with institutional sustainability is losing staff. Financial sustainability: USAID is working on contraceptive security issues (DELIVER). At this point, USAID is financing 90 percent of the contraceptive commodities. We put $3 million per year into contraceptives.

Kenya

The problem (with regional supervisors) was government commitment. EngenderHealth was working with the right people, but should have been working through the provincial medical officers to make it part of the supervisor's official responsibilities. It worked well when it was working.

Tanzania

To ensure sustainability and institutionalization, the following actions have been taken: some service sites will be phased out in the next two years but their performance will be constantly monitored; a quality tool, such as COPE, is currently used at service sites, not only for FP but to improve the quality of other services; we are restructuring long-term and permanent contraceptive program management so that the FP Association of Tanzania has a larger role of providing needed technical assistance in the NGO sector and EngenderHealth focuses its efforts at public sector hospitals; all subagreements have a clear sustainability strategy for human resources and finances. In the public sector, more resources are expected to flow through the funding mechanism and cost sharing. The recent signing of a memorandum of understanding between EngenderHealth and the MOH on the long-term and permanent program, including PAC, is a clear indication that EngenderHealth will be part of the general MOH program.

Honduras

EngenderHealth work is very satisfactory. Most of the hospitals are doing surgical sterilization and the MOH is working to expand the services. When people are trained, that makes for sustainability. Hondurans who are EngenderHealth staff become leaders in the country—making sure the contraceptives are there, maintaining priority on services, and ensuring that people are trained and provide a comprehensive range of services. Most hospitals are now doing surgical contraception.

Dominican Republic

I have not been aware of this type of effort on the part of EngenderHealth, although the local office manages a number of activities through non–USAID financial sources.

Bangladesh

The MOH is requesting EngenderHealth to expand. It seconded a key government official to work with the sterilization program and he is now much better versed in the operational problems and what is needed to solve them.

Senegal

EngenderHealth has put in place a method of minilaparotomy at the hospital Aristide Le Dantec that has permitted the training of more medical staff from other Francophone countries. EngenderHealth has created a pool of trainers at the MOH for facilitating COPE, training of counseling, infection prevention, and facilitative supervision so that these have continued in the regions that EngenderHealth worked in although EngenderHealth has terminated its assistance.

What's needed in the future?

Bolivia

Only 48 percent of women in reproductive age use FP methods. Unmet need is still high. There is a need to provide training at the local level to provide IEC, counseling, and informed choice. There is a need to train doctors and health personnel in a complete range of methods. All these focused on rights, promoting among health personnel a change of attitude regarding clients' rights. Also, it is needed to improve the knowledge of the community regarding FP methods and rights and Seguro Basico de Salud (Basic Health Insurance, which covers 103 interventions mainly for women and children, free of cost for the clients). FP is included in the BSI and municipalities cover the cost of the service. So far, contraceptives commodities cost is not included because they are donated). To achieve this, it is also important to ensure the adequate and timely contraceptive commodity provision and to support local-level services (through municipalities and other levels as needed). For this, EngenderHealth is working in coordination with JSI/DELIVER, the CA in charge of contraceptive commodities logistics in Bolivia.

Guatemala

Improved method mix—taking measures to improve service delivery in IUDs. Method mix is currently skewed towards injectable and surgical contraception. There is provider bias against IUDs. EngenderHealth—as part of the consortium—is training local staff and staff at hospitals to enable auxiliary nurses to provide IUDs and improve the method mix. Many people ask for surgical contraception. Here the need is for informed consent and information to choose the most appropriate method for their needs.

Jordan

Reduce discontinuation rate for all methods, deal with TL issues. Training is needed in infection prevention, TL, counseling, Norplant (there are not enough cases for people to keep up their skills).

Nepal

Has EngenderHealth done enough to ensure that quality assurance is sustained? USAID needs to do more in this area—no one has done enough.

Paraguay

The critical needs are logistics and human resources. Public health does not have a good career structure. The public sector does not have finances to have the basic supplies and commodities they need or human resources to operate the equipment they have.

Ghana

In the future, there is a need for more linking of true reproductive health services, not just family planning—for example, PAC—although electively induced abortion is illegal except for rape and physical and mental health of the mother, almost 20 percent of pregnancies (some statistics show 27 percent) end in abortion. The other area is male involvement, not just in family planning but for HIV, MCH, etc. IUDs have gone way down. We would like EngenderHealth to revitalize IUDs.

Kenya

The biggest future needs are to reintroduce IUDs, take a closer look at permanent methods, and address the issue of sustainability.

Tanzania

Overall, we critically need both PAC and FP clinical and counseling training as we start expanding the program. The challenge will be for us and EngenderHealth to assure that we join the knowledge and skill provided during training with ensuring the quality of services at service sites. We would like to expand the scope of operation in Tanzania in order to increase the number of public sector hospitals using the resources available through the MOH funding mechanism but EngenderHealth remains with the role of providing technical assistance in order to ensure the provision of quality services.

Dominican Republic

One of the critical problems encountered through research and experience in RH is the high rate of maternal mortality in a country with 98 percent institutional deliveries. This indicator has a number of determinants, among which the quality of clinical care is a major one, as well as short intergenesic spacing, adolescent pregnancies, etc. Therefore, in the near future, efforts should concentrate on trying to improve the quality of clinical reproductive and maternal health care. Other donors (e.g., UNFPA, GTZ) are providing discrete funding for clinical service delivery. Regions are assigned to them by the local MOH, as USAID will have in the future; therefore, our assistance continues to be crucial. On what concerns the private sector, EngenderHealth works with two NGO clinical service providers that have no other support.

Bangladesh

In the future, USAID believes that the situation with clinical contraception is so bad that we will have to collaborate with other donors to meet the need. USAID and EngenderHealth may not have enough money. The action is in the government sector. The scheduling of services, supplies, and planning can be a very facilitating process with the biggest payoffs. There is a high unmet demand for sterilization that needs to be implemented in a friendly environment with good technical skills, quality, access, and management.

Senegal

USAID's strategy for 1998–2006 charges agencies such as MSH with implementing programs for family planning and reproductive health. USAID is involved in PAC for five regions ($150,000). USAID/Washington has provided EngenderHealth with funds to conduct PAC activities in as many of the 15 health districts as possible, where all our CAs intervene, including MSH for RH. What we want to ensure (and we do not think that this is going to be a problem) is that EngenderHealth's work in PAC complement, and not duplicate, MSH's work in RH.

Comments on field support versus bilateral projects

Nepal

With a bilateral project, we can give better technical direction than field support and can be sure that we know what is going on. Also, more money stays in-country. With the bilateral project, we will pay about $600,000 per year for clinical FP services in each of next four years. Under the CA, we paid $1–1.5 million annually for about the same level of clinical services.

Bolivia

No problems so far (re: funding levels) with field support.

Guatemala

The consortium works well for the Mission—there are not as many CAs, which was an administrative burden for USAID. FP supervision, monitoring, information, child survival, and micronutrients have very incredible results. Their goals were met and surpassed. A consortium agreement was signed in December 1999. It was decided that bilateral instead of field support activities would be used and that there would be better coordination with the MOH and the integration of services. Having a consortium saves money. The MOH has to contribute $6.5 million from regular resources. A tool to negotiate: have one administration working with all the MOH—use an integrated approach. More resources would stay in-country.

Paraguay

Paraguay has a limited budget so it does not like to transfer funds to Washington. It would rather go directly to an NGO. The MOH would not let anyone manage an office (for $1 million, half would have to go to local office support/overheads) and it cannot supervise the project. We were always happy with AVSC.

Bangladesh

Field support is easiest and USAID has sufficient control. The problem is that the lead time to get funds through is 6–9 months. We did not get the 2002 money until June.

Ghana

We decided to use a separate cooperative agreement for scaling up services because it gives USAID more control. There is about $1 million per year in the Mission cooperative agreement and $450,000 (for two years) in field support. Field support has the flexibility to be used for activities not included in the Mission's agreement that require technical assistance from EngenderHealth headquarters, such as evaluation, visits for facilitative supervision, introduction of COPE, and expanding the counseling curriculum. I recommend the new leader-type cooperative agreements, where Missions can award country-level cooperative agreements to an organization that wins the overall cooperative agreement, without additional competitive procurements.

Kenya

Population funding has gone way down. Because of these decreases, we decided to cut back on direct service delivery and provide only technical assistance and to focus on two large provinces

to decentralize and make the program manageable and to show results. Pathfinder's old global program was about to expire just as our grants were, and we had no idea what would replace it. So we decided to go our own way. We also felt we had more control over the design of the project with a bilateral.

Honduras

Provide bilateral funds through OYB transfers through Washington. This reduces the whole contracting role for the Mission in Honduras.

APPENDIX F

ANALYSIS OF ENGENDERHEALTH SERVICE STATISTICS

ANALYSIS OF ENGENDERHEALTH SERVICE STATISTICS

Since 1998, EngenderHealth has been successful in increasing the accessibility of clinical contraceptive services in many countries. As shown in table 1 (all tables follow the text, beginning on page F–5), the number of EngenderHealth-affiliated service sites has increased in most countries supported between FY 1998/99 and FY 2000/2001. However, the total number of facilities affiliated with EngenderHealth has actually fallen by 24 percent since USAID Missions have graduated (e.g., Mexico and Turkey), concluded bilateral programs (e.g., Indonesia) or phased down the level of EngenderHealth activity (e.g., the Philippines). This shift in the composition of countries in which EngenderHealth has been working is the main factor in determining aggregate results pertaining to service accessibility and method utilization under the cooperative agreement. Therefore, it is more informative to focus on country-level results rather than total regional or global figures in evaluating EngenderHealth's performance.

Over the period of the current cooperative agreement, the number of sites supported by EngenderHealth closely correlates with trends in USAID budgets by country. As shown in table 2, the USAID budget was stable or increased in nine countries. In seven of these countries, the number of sites also increased. USAID budgets fell in 15 countries. However, the number of sites supported by EngenderHealth only fell in 7 countries, while the number of sites was either stable or increased in 11 countries. The essential point of table 2 is that whenever USAID budgets have been stable or rising, EngenderHealth has usually been able to increase access to clinical family planning services.

Trends in the number of sites offering female sterilization, vasectomy, and postabortion care are shown for FY 1999/00 and 2000/01 in table 3. During this two-year period, the number of sites offering female sterilization declined by 18 percent. This drop was largely due to the conclusion of EngenderHealth technical support for sterilization in Indonesia and the phaseout of program support for the Local Government Unit Performance Project (LPP) in the Philippines. In most other countries, the number of sites providing female sterilization increased slightly, while more substantial gains occurred in Nepal, where the number of service facilities offering female sterilization increased by 54.7 percent in just two years (from 65 to 100 sites).

The number of EngenderHealth-affiliated facilities offering men's reproductive health services has increased by 37 percent since 1999 (see table 3). The number of sites providing male services in FY 2000/01 (1,044) was about the same as the number providing female sterilization (1,033). Sites providing male reproductive health services increased most rapidly in Nepal and India. This expansion may be partly reflected in the rise of male sterilization prevalence in Nepal between 1996 and 2001. The number of sites offering male sterilization services in other countries tends to be quite low (Bangladesh and Tanzania are the exceptions). These levels of service provision are not usually sufficient to influence national vasectomy prevalence.

THE UTILIZATION OF CLINICAL FAMILY PLANNING METHODS

As noted previously in the main body of the report, service statistics data are unavailable from more than 40 percent of supported sites with which EngenderHealth does not have a formal subagreement. Of the 32 countries assisted through the cooperative agreement, only 17 have even partial utilization data. The USAID budget for EngenderHealth activities declined or went to zero in 11 of these 17 countries since FY 1998/99. In addition, trend data based on multicountry aggregates are virtually meaningless since the total number and identity of countries changed significantly over the period. These caveats need to be kept in mind when interpreting the utilization data reported below.

The total number of long-term and permanent method clients served by EngenderHealth-assisted facilities in countries is shown in table 4. The total number of clients by clinical method is provided in tables 5, 7, 8, and 10. As can be seen in table 4, the total number of clients using female sterilization, male sterilization, IUDs, and Norplant fell from 111,911 in FY 1998/99 to 71,706 in FY 2000/01. Increases in the number of clients are reported in 7 countries, while declines are reported in 10 countries. Declines in performance are due in large measure to the conclusion or recasting of technical assistance in such countries as Guatemala, Indonesia, the Philippines, and Uganda. Kenya has seen a decline in the number of clients served from 10,983 in FY 1998/99 to 4,366 in FY 2000/01, a reduction that largely stems from USAID's decision to have EngenderHealth work in fewer sites situated in rural areas (although there may have also been some recent deterioration in the timely reporting of service statistics). On a more encouraging note, there have been improvements in the number of clients served in such countries as the Dominican Republic, Ghana, Jordan, and Malawi.

The number of female sterilization clients served by EngenderHealth-assisted facilities has fallen from 73,518 in FY 1998/99 to 38,152 in FY 2000/01 (see table 5). The ending of several country programs is again the principal reason why performance levels have declined. Three-year data are only available for 10 countries; the reported number of female sterilizations declined in 6 countries and increased in 4 countries.

It is worth pointing out that one of the largest declines has occurred in Pakistan, a country in which EngenderHealth recently ceased work and that has not received USAID support through EngenderHealth. In Nepal, the decline in clients served is disappointing, given the 54.7 percent increase in the number of facilities providing female sterilization care between FY 1999/2000 and 2000/01. It is worth noting that service statistics collected by the State Innovations in Family Planning Services Project Agency (SIFPSA) show that there has been a modest increase in the number of female sterilizations performed in Uttar Pradesh under the Innovations in Family Planning Services (IFPS) Project (from 194,776 in FY 1999/2000 to 197,332 in FY 2000/01. However, this information is not reported directly to EngenderHealth through a subagreement, and is therefore not shown in table 5.

Much of the decline in female sterilization has occurred among postpartum women. Since 1998, the number of postpartum minilaparotomy clients fell from 32,866 to 7,644 (see table 6). Interval minilaparotomy, laparoscopy, and Caesarean-section minilaparotomy did not experience the same sharp decline. It is important to note that these trends are again influenced by the changing composition of countries in which EngenderHealth has

been working (e.g., much of this decline occurred in Guatemala). To the extent that these data reflect actual practice, the results suggest that future programming will need to give greater attention to strengthening the provision of clinical contraception for mothers during the 6–month postpartum period.

Table 7 shows that the number of vasectomy clients served by EngenderHealth facilities has increased slightly, from 4,564 to 6,059 between FY 1998/99 and 2000/01. These figures do not include a substantial number of vasectomies performed in India at 319 EngenderHealth-affiliated sites situated in the state of Uttar Pradesh. Nepal has the greatest increase in the number of vasectomy clients served (from 3,484 to 4,047). In most other countries, the number of vasectomy clients reported by EngenderHealth is very low.

The number of IUD clients served in EngenderHealth-supported facilities is shown in table 8. The total number of IUD clients has fallen nearly 50 percent over the three-year period from FY 1998/99 to FY 2000/01 (from 15,589 in FY 1998/99 to 7,881 in FY 2000/01). As in the case of other methods, this trend partly reflects the changing composition of countries where EngenderHealth has been engaged. Of the five countries for which three-year data are available, four declined (Kenya, Nepal, Nigeria, and Tanzania) and one increased (the Dominican Republic). Reductions in the number of IUD clients in Kenya reflect the decline (and redistribution) of sites supported by EngenderHealth since FY 1998/99. However, there does appear to have been some decline in IUD performance at EngenderHealth supported facilities in Nepal, Nigeria, and Tanzania. These declines appear to have typically occurred between interval rather than postpartum IUD clients (see table 9). In FY 2000/01, only 20 percent of all IUD clients obtained an IUD as part of their postpartum care.

These results tend to mirror the downturn in IUD prevalence that has occurred in many parts of the developing world. However, there is clearly untapped potential for improving IUD prevalence. Middle Eastern countries, such as Jordan and Turkey, as well as Bolivia, Colombia, and Honduras in Latin America, have had successful IUD programs in recent years. EngenderHealth would benefit from examining these country programs in order to strengthen IUD services in other settings.

Norplant use has remained low in most countries that report service statistics to EngenderHealth. The overall decline in Norplant use can be partly attributed to the conclusion of field activities in Pakistan and Uganda and to significant declines in Norplant insertions in Nepal and Kenya. EngenderHealth maintains that public sector funding cuts combined with the hesitancy of private sector doctors to report client data can account for part of Nepal's decline. Kenya has had a 51.2 percent decline in the number of Norplant clients since FY 1998/99. EngenderHealth attributes this reduction to the lack of trained staff and commodity shortages, particularly in more remote areas. It is also probably because the national program financed through the cooperative agreement phased out during this time, so reports were made on fewer sites in 2001.

It is encouraging to note that EngenderHealth appears to be achieving some success in promoting the use of Norplant in Ghana, Tanzania, and Malawi, as well as in Colombia and the Dominican Republic. Table 10 shows that the number of Norplant clients in

Ghana rose from 1,850 in FY 1998/99 to 5,819 in FY 2000/01. Clinic facilities affiliated with EngenderHealth in Tanzania also report substantial Norplant use.

CLIENTS SERVED PER SITE

Trends in the average number of clients served per EngenderHealth-supported site are reported for all clinical methods in table 11 and for female and male sterilization in table 12. Since information on the number of sites offering IUDs and Norplant is not available, no estimates are provided of average client loads at service facilities for these methods.

Results suggest that the average number of clients per site has been falling over the past three years of the cooperative agreement. In FY 1998/99, an average of 138 long-term and permanent method clients were served per site. This figure declined to 59.8 clients per site by FY 2000/01 (see table 11). There also were declines in the average number of sterilization clients served per site between FY 1999/2000 and FY 2000/01 (see table 12). While these trends may imply that there have been declines in CA performance, they also certainly reflect change in the number of countries reporting results since FY 1998/99 (e.g., countries with relatively high client loads such as Indonesia, Uganda, and Guatemala stopped reporting results in FY 2000/01) and change in the distribution of sites within countries (e.g., Kenya and the Philippines).

What is apparent from tables 11 and 12 is that the average number of clients served per site is quite low on an annualized basis. For example, there were 71 female sterilization clients served per site in FY 2000/01. This works out to only 5.9 female sterilization clients per site per month. In the same fiscal year, there were only 1.2 vasectomies performed per site per month. These performance levels vary considerably across countries. For example, in FY 2000/01, the Dominican Republic and the Philippines reported high female sterilization client loads per site (312.7 and 385.1 clients, respectively) while Nepal, Kenya, and Nigeria appear to have lower performing facilities.

Table 1
Total Number of Reported EngenderHealth–Supported Sites
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Bangladesh	74	299	303
Cambodia*	0	108	200
Central Asia	0	3	3
India	169	449	449
Indonesia	14	81	84
Jordan	26	45	43
Mongolia*	1	1	0
Nepal	168	190	198
Pakistan*	26	22	7
Philippines	194	197	32
Turkey	239	605	54
Africa			
Ghana	97	144	157
Guinea	4	9	26
Kenya	100	94	86
Malawi	0	31	33
Nigeria	36	61	48
Senegal	46	80	92
South Africa	0	34	0
Tanzania	110	116	116
Uganda	25	25	11
Latin America			
Bolivia	7	31	150
Colombia*	5	22	26
Dominican Republic	10	15	15
Guatemala	20	24	0
Honduras	0	14	12
Mexico	1,626	0	0
Paraguay	11	14	58
Europe			
Moldova*	0	3	0
Russia	0	14	20
Total Sites	**3,008**	**2,731**	**2,223**
Total Countries	**22**	**28**	**24**

*Supported with non–USAID funds, and therefore not attributable to the cooperative agreement with the Bureau of Global Health.

Table 2
USAID Investments in EngenderHealth and
Trends in Increased Access to Family Planning
FYs 1999 to 2001

COUNTRY	Percent Change in USAID Budget	Percent Change in Number of Engender-Health–Supported Sites	USAID Budget Increase and Engender-Health–Supported Sites Increase	USAID Budget Increase and Engender-Health–Supported Sites Decrease	USAID Budget Decrease and Engender-Health–Supported Sites Increase	USAID Budget Decrease and Engender-Health–Supported Sites Decrease
Asia and Near East						
Bangladesh	0	31	x			
Cambodia*	92	85				
Central Asia	-100	0			x	
India	-26	166			x	
Indonesia	-100	500			x	
Jordan	45	65	x			
Mongolia*	NA	NA				
Nepal	-19	18			x	
Pakistan*	-100	-73				x
Philippines	-69	-84				x
Turkey	-5	-77				x
Africa						
Ghana	222	62	x			
Guinea	-100	550			x	
Kenya	-35	-14				x
Malawi	-54	6			x	
Nigeria	1,064	33	x			
Senegal	-90	100			x	
South Africa	209	0	x			
Tanzania	-19	5				
Uganda	-85	-56			x	
Latin America						
Bolivia	-8	204			x	
Colombia*	NA	NA				
Dominican Republic	200	50	x			
Guatemala	222	-100				x
Honduras	21	-14		x		
Mexico	-100	-100				x
Paraguay	19	427	x			
Europe						
Moldova*	NA	NA				
Russia	-100	43			x	

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau of Global Health.

Table 3
Total Number of Reported EngenderHealth–Supported Sites by Program Area
FYs 1999 to 2001

COUNTRY	Female Sterilization		Male Sterilization		Postabortion Care	
	FY 1999/2000	FY 2000/01	FY 1999/2000	FY 2000/01	FY 1999/2000	FY 2000/01
Asia and Near East						
Bangladesh	9	27	299	300	0	5
Cambodia*	3	5	3	10	0	0
Central Asia	0	3	0	0	0	0
India	411	420	319	425	0	0
Indonesia	61	14	0	0	20	48
Jordan	43	22	0	0	0	0
Mongolia*	0	0	0	0	0	0
Nepal	65	100	0	98	0	3
Pakistan*	17	0	7	7	0	0
Philippines	184	30	0	0	4	8
Turkey	8	13	23	15	34	30
Africa						
Ghana	91	102	5	6	0	0
Guinea	4	5	2	2	0	0
Kenya	94	60	0	18	18	10
Malawi	31	31	0	31	0	0
Nigeria	21	30	0	12	0	0
Senegal	8	0	2	0	0	18
South Africa	4	0	8	0	0	0
Tanzania	116	116	116	166	18	18
Uganda	25	0	7	2	4	11
Latin America						
Bolivia	8	7	0	0	0	0
Colombia*	3	5	3	10	0	0
Dominican Republic	14	15	0	0	6	7
Guatemala	14	NA	2	NA	0	NA
Honduras	14	12	0	0	0	0
Mexico	0	0	0	0	0	0
Paraguay	0	0	0	0	0	0
Europe						
Moldova*	3	0	0	0	0	0
Russia	0	0	0	0	0	0
Total Sites	**1,266**	**1,033**	**796**	**1,044**	**122**	**201**
Total Countries	**24**	**19**	**13**	**14**	**8**	**12**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau of Global Health.

0 = service was provided but there were no clients

Table 4
Total Number of Clients Reported Through Subagreements at EngenderHealth–Supported Sites
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Cambodia*	0	115	1,010
Indonesia	0	6,643	0
Jordan	98	582	1,422
Nepal	13,435	11,909	10,342
Pakistan*	19,919	4,597	1,815
Philippines	27,330	32,624	11,554
Africa			
Ghana	4,409	6764	8,267
Guinea	167	NA	NA
Kenya	10,983	10,919	4,366
Malawi	NA	1,181	3,316
Nigeria	1,370	236	1,419
Tanzania	21,019	20,981	18,163
Uganda	4,381	2,171	NA
Latin America			
Bolivia	1,893	311	996
Colombia*	251	0	948
Dominican Republic	4,667	4,126	8,088
Guatemala	1,989	8,018	0
Honduras	0	0	0
Mexico	0	0	0
Paraguay	0	78	0
Europe			
Moldova*	0	879	0
Total Clients	**111,911**	**112,134**	**71,706**
Total Countries	**14**	**17**	**13**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau of Global Health

NOTES

FY 2000/01: No Turkey data are included since figures are nationwide. Nationwide data reported were interval ML (10,315), vasectomy (477), interval IUD (148,298), injectable (24,330), MVA for PAC (15,770).

FY 1999/2000: FY 1999/2000 data were adjusted down by 20 percent to make them comparable with the 12–month periods presented in the other two annual reports.

FY 1998/99: No Turkey data are included since figures are nationwide. Nationwide data reported were laparoscopies (4,578, which include all female sterilizations including postpartum and interval procedures and sterilizations with Caesarean sections), vasectomy (345), interval IUD (119,383), implants (298), and injectable contraceptives (26,755).

Table 5
Total Number of Female Sterilization Clients Reported Through Subagreements at EngenderHealth–Supported Sites
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Cambodia*	0	108	295
Indonesia	0	6,489	0
Jordan	66	543	1,050
Nepal	3,086	2,986	2,329
Pakistan*	15,364	2,611	0
Philippines	27,200	28,763	11,554
Africa			
Ghana	2,550	2,782	2,434
Guinea	167	0	0
Kenya	4,764	4,294	1,493
Malawi	0	1,092	2,797
Nigeria	20	116	324
Tanzania	12,933	11,961	10,189
Uganda	3,136	1,037	0
Latin America			
Bolivia	200	311	996
Colombia*	0	0	0
Dominican Republic	4,667	4,126	8,088
Guatemala	881	5,387	0
Paraguay	0	0	0
Europe			
Moldova*	0	88	0
Total Clients	**73,518**	**72,277**	**38,152**
Total Countries	**13**	**16**	**11**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau of Global Health.

Table 6
Type of Female Sterilization Reported Through Subagreements at EngenderHealth–Supported Sites
(FYs 1998 to 2001)

COUNTRY	Postpartum Minilaparotomy			Interval Minilaparotomy			Laparoscopy			Caesarean-Section Minilaparotomy		
	FY 1998/99	FY 1999/2000	FY 2000/01	FY 1998/99	FY 1999/2000	FY 2000/01	FY 1998/99	FY 1999/2000	FY 2000/01	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East												
Cambodia	0	21	0	0	10	0	0	0	295	0	78	0
Indonesia	0	746	0	0	1,354	0	0	4,389	0	0	0	0
Jordan	0	0	0	9	0	246	47	217	308	10	326	496
Nepal	107	0	48	2,802	2,962	2,240	110	24	15	67	0	26
Pakistan*	15,364	2,611	0	0	0	0	0	0	0	0	0	0
Philippines	10,883	19,204	3,379	5,312	5,177	2,890	0	0	0	11,005	4,382	5,285
Africa												
Ghana	874	0	0	563	1,505	1,323	0	0	0	1,113	1,277	1,111
Guinea	87	0	0	80	0	0	0	0	0	0	0	0
Kenya	1,337	1,417	232	2,629	1,933	1,167	0	0	0	798	945	94
Malawi	0	417	934	0	407	1,042	0	0	0	0	268	821
Nigeria	20	16	0	0	80	324	0	0	0	0	20	0
Tanzania	2,091	2,802	1,559	9,987	8,566	7,791	1	0	0	854	593	839
Uganda	836	0	0	2,091	1,037	0	0	0	0	209	0	0
Latin America												
Bolivia	100	201	902	100	110	94	0	0	0	0	0	0
Colombia*	0	0	0	0	0	0	0	0	0	0	0	0
Dominican Republic	414	657	590	2,311	2,550	3,555	0	0	0	426	502	546
Guatemala	753	5,387	0	128	0	0	0	0	0	0	0	0
Paraguay	0	0	0	0	0	0	0	0	0	0	0	0
Europe												
Moldova*	0	0	0	0	88	0	0	0	0	0	0	0
Totals	**32,866**	**33,478**	**7,644**	**26,012**	**25,778**	**20,672**	**158**	**4,630**	**618**	**14,482**	**8,391**	**9,218**
Total Countries	**12**	**11**	**7**	**11**	**13**	**10**	**3**	**3**	**3**	**8**	**9**	**8**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau for Global Health.

Table 7
Total Number of Male Sterilization Clients Reported Through Subagreements at EngenderHealth–Supported Sites
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Cambodia*	0	7	81
Indonesia	NA	154	NA
Jordan	0	0	0
Nepal	3,484	3,175	4,047
Pakistan*	409	1,550	1,815
Philippines	130	160	0
Africa			
Ghana	9	14	14
Guinea	0	0	0
Kenya	117	86	10
Malawi	0	0	10
Nigeria	7	0	0
Tanzania	176	38	39
Uganda	96	37	0
Latin America			
Bolivia	0	0	0
Colombia*	0	0	43
Dominican Republic	5	0	0
Guatemala	131	0	0
Paraguay	0	0	0
Europe			
Moldova*	0	0	0
Total Clients	**4,564**	**5,221**	**6,059**
Total Countries	**10**	**9**	**8**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau for Global Health.

Table 8
Total Number of IUD Clients Reported through Subagreements at EngenderHealth–Supported Sites
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Cambodia*	0	0	634
Indonesia	-	0	-
Jordan	0	0	346
Nepal	4,472	3,335	2,600
Pakistan*	3,313	416	0
Philippines	0	3,701	0
Africa			
Ghana	0	0	0
Guinea	0	0	0
Kenya	277	56	18
Malawi	0	0	0
Nigeria	1,343	24	985
Tanzania	1,933	1,039	1,001
Uganda	0	0	0
Latin America			
Bolivia**	1,512	0	0
Colombia*	251	0	0
Dominican Republic	1,511	417	2,297
Guatemala	997	2,630	0
Paraguay	0	78	0
Europe			
Moldova*	0	791	0
Total Clients	**15,589**	**12,487**	**7,881**
Total Countries	**9**	**10**	**7**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau for Global Health.

**For FY 1998/99, Bolivia reported all methods that were offered at EngenderHealth-supported sites, including postpartum IUD and implant data. They did not do this in later years, therefore showing an artificial decline in these months.

Table 9
Type of IUD Procedure Reported Through Subagreements at EngenderHealth–Supported Sites
FY 1998 to 2001

COUNTRY	Postpartum IUD			Interval IUD		
	FY 1998/99	FY 1999/2000	FY 2000/01	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East						
Cambodia*	0	0	0	0	0	634
Indonesia	0	0	0	0	0	0
Jordan	0	0	0	0	0	346
Nepal	949	0	10	3,523	3,335	2,590
Pakistan *	0	0	0	3,313	416	0
Philippines	0	0	0	0	3,700	0
Africa						
Ghana	0	0	0	0	0	0
Guinea	0	0	0	0	0	0
Kenya	277	56	18	0	0	0
Malawi	0	0	0	0	0	0
Nigeria	0	24	85	1,343	0	900
Tanzania	16	15	9	1,917	1,024	992
Uganda	0	0	0	0	0	0
Latin America						
Bolivia	1,512	0	0	0	0	0
Colombia*	251	0	0	0	0	0
Dominican Republic	247	244	545	1,264	173	1,752
Guatemala	486	2,630	0	491	0	0
Paraguay	0	50	0	0	28	0
Europe						
Moldova*	0	0	0	0	791	0
Totals	**3,738**	**3,019**	**667**	**11,851**	**9,468**	**7214**
Total Countries	**7**	**6**	**5**	**6**	**7**	**6**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau for Global Health.

Table 10
Total Number of Norplant Clients Reported Through Subagreements at EngenderHealth–Supported Sites
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Cambodia*	0	0	0
Indonesia	0	0	0
Jordan	32	39	26
Nepal	2,393	2,413	1,366
Pakistan*	833	20	0
Philippines	0	0	0
Africa			
Ghana	1,850	3,969	5,819
Guinea	0	0	0
Kenya	5,825	6,482	2,845
Malawi	0	89	509
Nigeria	0	96	110
Tanzania	5,977	7,943	6,943
Uganda	1,149	1,098	0
Latin America			
Bolivia**	181	0	0
Colombia*	0	0	905
Dominican Republic	0	0	1,100
Guatemala	0	0	0
Paraguay	0	0	0
Europe			
Moldova*	0	0	0
Total Clients	**18,240**	**22,149**	**19,614**
Total Countries	**8**	**9**	**9**

*Supported with non–USAID funds and therefore not attributable to the cooperative agreement with the Bureau for Global Health.

** For FY 1998/99, Bolivia reported all methods that were being offered at EngenderHealth-supported sites, including postpartum IUD and implant data. They did not do this in later years, therefore showing an artificial decline in those methods.

Table 11
Average Number of Clients Served per EngenderHealth–Supported Site Reported Through Subagreements
FYs 1998 to 2001

COUNTRY	FY 1998/99	FY 1999/2000	FY 2000/01
Asia and Near East			
Cambodia*	0	1.1	5.1
Indonesia	0	82.0	0
Jordan	3.8	12.9	33.1
Nepal	80.0	62.7	52.2
Philippines	140.9	165.6	361.1
Africa			
Ghana	45.5	47	52.7
Guinea	41.8	0	0
Kenya	109.8	116.2	50.8
Malawi	0	38.1	100.5
Nigeria	38.1	3.9	29.6
Tanzania	191.1	180.9	156.6
Uganda	175.2	86.8	0
Latin America			
Bolivia	270.4	10	6.6
Dominican Republic	466.7	275.1	539.2
Guatemala	99.5	334.1	0
Paraguay	0	5.6	0
Clients per Site	**138**	**95.8**	**59.8**

Table 12
Average Number of Sterilization Clients Served by EngenderHealth–Supported Voluntary Sterilization Site Reported Through Subagreements
FYs 1999 to 2001

COUNTRY	Female Sterilization		Male Sterilization	
	FY 1999/2000	FY 2000/01	FY 1999/2000	FY 2000/01
Asia and Near East				
Cambodia*	36.0	59.0	2.3	8.1
Indonesia	106.4	0	0	0
Jordan	12.6	47.7	0	0
Nepal	45.9	23.3	0	41.3
Philippines	156.3	385.1	0	0
Africa				
Ghana	30.6	23.9	2.8	2.3
Guinea	0	0	0	0
Kenya	45.7	24.9	0	0
Malawi	35.2	90.2	0	0.3
Nigeria	5.5	10.8	0	0
Tanzania	103.1	87.8	0.3	0.3
Uganda	41.5	0	5.3	0
Latin America				
Bolivia	38.9	142.3	0	0
Dominican Republic	264.9	312.7	0	0
Guatemala	384.8	0	0	0
Clients per Site	**89.9**	**71.0**	**26.6**	**14.1**

Table 13
EngenderHealth–Supported Sites Providing Services to Men

SERVICES	FY 1999/2000	FY 2000/01	Percentage Difference
Vasectomy (but not other RH)	369*	167	-55
Vasectomy plus other men's RH services	46	187	+307
Men's RH services (but not vasectomy)	400	760	+99
Total number of sites providing services to men	**815***	**1,114**	**+37**

*These data do not directly correspond with data in EngenderHealth's FY 1999/2000 annual report. Discrepancies were found and corrections made in the FY 2000/01 report.

APPENDIX G

REVIEW OF QUALITY IMPROVEMENT TOOLS AND APPROACHES

REVIEW OF QUALITY IMPROVEMENT TOOLS AND APPROACHES

COPE (client-oriented, provider-efficient services) is the main tool EngenderHealth uses to promote quality in hospital and clinical sites. Developed and refined over time, its features include a systematic approach to involve managers and provider staff in a team endeavor. Specific COPE tools allow for problem identification in services (self-assessment), client interview guides, clinic walk-through checklists (client-flow analysis), and action planning to resolve problems.

Concepts covered in COPE include information and informed choice; access to and safety of services; privacy and confidentiality, dignity, comfort and expression; and continuity of care. There is a specific focus on staff needs for facilitative supervision and management; information, training, and development; and supplies, equipment, and infrastructure. COPE involves an introductory exercise of 2 days in which the full team participates with an experienced facilitator. A site facilitator is trained in the process and undertakes subsequent COPE exercises after about 3 months and every 6 months following. In other words, it is anticipated that COPE will become a regular program activity within the site/facility and all staff will continue to use the methods to keep quality at the best possible level.

The **quality measuring tool (QMT)** is a checklist for measuring change in quality at the service delivery sites. It produces a numerical score for various quality elements and allows for tracking changes over time.

Whole-site training (WST)[1] is an approach for meeting the learning needs of all staff at a health care service-delivery site. It focuses on teamwork, improvement of services, and facilitative supervision, and is consistent with the principles of organizational development, which stress improvement of organizational effectiveness. One way this is achieved is through the involvement of workers in the design of new and more effective training strategies. It attempts to link individual staff needs to organizational goals, leading to an increased organizational capacity for effectiveness. EngenderHealth determined the need to develop whole-site training as a result of cumulative experiences with training, which showed that conventional training approaches were limited for the following reasons:

- training systems are divorced from supervisory systems;
- follow up is lacking,
- knowledge and skills acquired during training are not applied to the trainee's work,
- training focuses too much on individuals and not enough on the systems in which they work,
- capacity building at local sites is limited,

[1] *Source*: EngenderHealth web site at http://www.engenderhealth.org/ia/sfq/qwst.html

- trainees are selected inappropriately,
- the content and timing of training are inappropriate and do not reflect the realities of the service site, and
- offsite, centralized training is unable to meet expanded needs for training and causes disruption of services.

Facilitative supervision is an approach to supervision that emphasizes mentoring, joint problem-solving, and two-way communication between the supervisor and those being supervised. Adoption of a facilitative approach leads to a shift from inspection and fault finding to assessment and collective problem-solving, and to continuous improvement in the quality of care.

The supervisor facilitates and manages the process of change by breaking the staff's dependence on supervisors to solve all problems, and by empowering and enabling staff to take action at various levels when appropriate. In order to do so, supervisors themselves must break out of traditional mindsets and have solid technical knowledge and skills in order to perform tasks. When needed, they must know how and where to gain access to additional support.

Through a series of workshops and activities, supervisors become involved in defining quality. They have an opportunity to improve interpersonal communication skills as well as coaching and group process skills. The workshops teach supervisors

- the principles underlying quality improvement,
- how to manage the quality improvement process,
- how to link training to supervision,
- concepts of adult learning,
- communication skills,
- how to set measurable objectives and examine opportunities for improvement with site staff,
- how to use records and data to help improve service quality, and
- quality improvement tools to implement ongoing quality improvement at the site level.

Medical monitoring is an element of facilitative supervision that identifies gaps between standards and actual practice. Clinical practice observations of service delivery procedures and staff/client interaction, client record reviews, and discussions with site staff and managers are all important to medical monitoring. EngenderHealth has assigned a medical associate to every country program to monitor clinical quality and choice in service delivery activities. They conduct regular site reviews with the local staff

responsible for quality at the local or institutional level. In turn, a senior medical associate is assigned to cover each of the four regions to improve the linkage between medical monitoring and program development and implementation.

APPENDIX H

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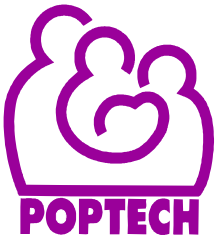

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