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MID-TERM ASSESSMENT OF THE PSP-ONE PROJECT

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ANE	Asia and the Near East
ASHONPLAFA	Honduran Family Planning Association
BOP	Base of the pyramid
CA	Cooperating agency
CME	Continuing medical education
CMS	Commercial Market Strategies Project
CTO	Cognizant Technical Officer
CYP	Couple years of protection
DMPA	Depo medroxyprogesterone acetate
FP	Family planning
GH	Bureau for Global Health
HIV	Human immunodeficiency virus
HMO	Health maintenance organization
HUL	Hindustan Unilever Ltd.
IR	Intermediate result
IQC	Indefinite quantity contract
ISMP	Indigenous systems of medicine practitioners
IUD	Intrauterine device
LAC	Latin America and the Caribbean
LAPM	Long-acting and permanent method
LDC	Less developed country
MD	Medical doctor
MOH	Ministry of Health
MWRA	Married women of reproductive age
NGO	Nongovernmental organization
NSV	No-scalpel vasectomy
OB/GYN	Obstetrician/gynecologist
OC	Oral contraceptive
PASMO	Pan American Social Marketing Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PRH	Population and reproductive health
PSP-One	Private Sector Partnerships-One Project
QA	Quality assurance
RH	Reproductive health
SDI	Service Delivery Improvement Division
TA	Technical assistance
UCSF	University of California at San Francisco
VCT	Voluntary counseling and testing
WHO	World Health Organization
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This assessment by the Global Health Technical Assistance (GH Tech) Project was commissioned by the United States Agency for International Development (USAID) Bureau for Global Health (GH)/Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) as an independent mid-term examination of its Private Sector Partnerships-One (PSP-One) project. The assessment team had three main tasks:

1. Review PSP-One's strengths, weaknesses, successes, and constraints, and present results achieved to date, lessons learned, and recommendations for achieving planned results when the project ends.
2. Assess PSP-One's structure and management and the benefits and disadvantages of the PSP-One mechanism: a task order under a multiple-award IQC.
3. Identify activities that warrant additional investment and private sector initiatives not covered by PSP-One that could improve use and quality of reproductive health (RH), family planning (FP), and other health products and services.

BACKGROUND

The Private Sector Program (PSP) is a five-year (2004-2009) worldwide indefinite quantity contract (IQC) designed for flexible support of USAID private sector activities; it allows Missions to issue locally managed task orders. PSP-One was the first of more than 14 task orders awarded up to the time of the assessment. The task order was intended to increase the provision and use of quality private FP/RH and other health information, products, and services. It has been the primary USAID mechanism for supporting core-funded FP/RH activities in the private sector.

Abt Associates Inc., the lead organization, has four core partners (Family Health International, IntraHealth International, Population Services International, and Tulane University) and four specialized partners (Dillon Allman and Partners, Forum One, O'Hanlon Health Consulting, and Banyan Global). Total possible funding is \$59,129,638, with a field support ceiling of \$34,190,105 and a core support ceiling of \$24,939,533.

METHODOLOGY

Most of the quantitative information used for the assessment came from existing data and reviews of reports and other documents describing PSP-One work. Qualitative information was generated through interviews and observation at the project offices in Bethesda, MD, and sites in India and Honduras.

CONCLUSIONS: PROJECT PERFORMANCE

The conclusions below, drawn from the assessment findings, are organized by project performance and project design.

Progress toward Intermediate Results (IRs)

PSP-One has made progress in contributing to outcomes in all five result areas. The only notable contribution to IR 4, scale-up of proven strategies, is the project's work with the National Health Trust HMO in Nigeria. Most contributions to IR 1, knowledge and use of FP/RH and other health products and services from private providers increased, appear to come from more conventional social marketing models, fueled by pass-through funds. IR 5, monitoring, reporting and operations research, is the area in which the most progress has been made, for which the project has given the most examples, and where there is quantifiable expression of extending outreach beyond the project itself. Many examples of progress towards IRs cited in the project's annual reports are process-oriented. It is, therefore, difficult to assess or evaluate the project's overall achievement in the sub-result areas. IR 3, related to policy, is the area in which the project's process results are most closely aligned with sub-results; consequently, there is substantial attributable progress in this area.

Major Project Accomplishments

- ***High Quality Research and Effective Application of Evidence-Based Methodologies.*** The quality of research has been uniformly high. PSP-One's application of evidence-based rationales is innovative; it creates compelling arguments for the potential of the private sector to contribute to FP/RH and other health objectives. Technical standards for inquiry are models worthy of replication and contribute substantially to the project's technical leadership role.
- ***Creative Use of Assessments to Expand Private Sector Programming Options.*** PSP-One used assessments of the private sector as new initiatives or programming choices were being considered, thus expanding the range of alternatives available to missions and host countries.
- ***Expanded Policy Dialogue and Awareness of Broader Array of Policy Issues.*** PSP-One's efforts to address the policy environment have produced significant progress in broadening policy dialogue to include important new parameters affecting the possibilities for private sector participation.
- ***Increased Number and Range of Private Sector Outlets for Services.*** Through its country programs, the project has increased the number and variety of private sector outlets or providers for FP, RH and other health services.
- ***New Private Sector Partnerships to Introduce Innovative Service Delivery Approaches.*** The project looked beyond classical partnering organizations for social marketing efforts to creatively approach and incorporate different types of private sector entities that could bring new dimensions of outreach for health products or services.
- ***Refined and Simplified Indicators for Reporting Private Sector Partnership Progress.*** To improve the amount of information available and the regular submission of data, PSP-One staff led a successful effort to develop a common set of indicators for work in the private sector that competing organizations could comfortably share. Indicators were refined and simplified to make measurement more efficient and to encourage regular reporting.
- ***Advanced Understanding of Quality Assurance/Improvement Methods for Services Offered through Private Sector Providers.*** By identifying and trying quality assurance tools or techniques, the project advanced knowledge about the potential of selected quality assurance methods. Project staff used quality improvement mechanisms that are directly connected to private providers' financial interests; tying service quality to continued income is a likely effective way to sustain improved quality of care in the private sector.
- ***Innovative Internet-Based Tools and E-Learning Techniques.*** To improve public access and increase exposure to private sector partnership topics, the project creatively used information technology media and tools.
- ***South-to-South Partnerships for Generic Drug Supply.*** PSP-One successfully linked generic drug manufacturers in the developing world with private-sector partnering opportunities elsewhere, expanding affordable private sector options for country programs and planners. Increasing alternatives for obtaining lower-priced commodities helps to address sustainability issues in private sector-based service delivery initiatives.
- ***Using Business Motivations to Attract the Interest of More Private Providers in Delivering Desired Services.*** PSP-One has added new techniques for attracting private health care providers by creating ways in which participation in a partnership can enhance business capacities or increase business/entrepreneurial skills.

- ***Successful Collaboration in the Wider IQC Community.*** Despite the potential for competitiveness, Abt and its PSP-One task order partners have succeeded in creating a collaborative environment among the broader community of IQC members.
- ***Flexible Staffing.*** Project management has effectively and flexibly assembled staff to respond to changing needs. Due to insufficient funding levels to support full-time experts in all areas, management creatively used periodic, part-time or short-term expertise to meet specific demands.
- ***Expanded Availability of Private Sector Partnering Tools and Information.*** The project has produced tools, policy guides, and other resources, to cover new technical areas or expand the experience base for potential use in private sector initiatives, increasing the resources available to those considering private sector health partnerships.
- ***Effective and Flexible Response to Mission Needs or Funding Interests.*** PSP-One has provided high quality, flexible response to mission interests and evolving programmatic needs. Evidence of this is seen in some missions' use of the project for funding "pass-throughs" to finance ongoing private-sector activities after the AIDS-Mark Project ended.

Areas Where Improvement Is Needed

While the PSP-One project has an impressive number of major accomplishments, the assessment team has identified some areas of project performance that should be improved.

- ***Improving quality of private sector RH/FP services.*** Although the project has previously used a "quality scan" tool in some countries, there is no fully strategic approach to select the most appropriate quality improvement interventions for given private sector environments. The potential impact of the self-assessment approach, although associated with quality improvement in Uganda, has not yet been studied in other areas.
- ***Strengthening private provision of long-acting and permanent methods (LAPM).*** There is not a concerted effort within the project to strengthen private sector provision of LAPM. The project's one LAPM intervention (no-scalpel vasectomy in Honduras) appears to lack market relevance.
- ***Mainstreaming the private sector into RH/FP programming.*** The project appears to have focused its mainstreaming efforts on disseminating information and raising awareness. While raising awareness is necessary, it is not sufficient to accomplish behavior change. The assessment team has found little evidence of noticeable change among USAID staff from the attitudes and perceptions regarding the private sector's role in health reported in a 2006 survey.
- ***Scaling up private provider networks.*** Significant scale-up of proven interventions, such as provider networks, does not appear to have occurred. Outside of India, the assessment team did not see significant field support funds available for scale-up. This has led the project to identify a promising but unproven alternative mechanism: implementing innovative approaches within organizations capable of scaling-up successful trials.
- ***Recognizing strategic needs.*** Focus on specific requests for assistance from missions has led to missed strategic needs or opportunities. While responsiveness is commendable, concentration on the more immediate details of project implementation can preclude or limit recognition of national level opportunities for private sector strategy development.
- ***Searching for innovative approaches.*** An explicit component for investigating innovative opportunities is not included in the current country assessment process. There also appears to be no process for systematic review of current business news and literature and no regular channel for communication with targeted leaders/innovators.

- *Strengthening the relationship between project activities and FP goals.* Linkages between the project’s private sector-enhancing interventions and FP outcomes are not always strong.

CONCLUSIONS: PROJECT DESIGN

Major Strengths

- Comprehensive design promotes subject matter flexibility and allows activity on virtually any private sector topic.
- The many institutions encompassed by the IQC mechanism increases USAID access to a variety of the technical and programmatic strengths.
- The field support options of the task order give Missions a much-needed funding alternative.
- The pass-through option is valued and used by missions to support their portfolios.

Issues

- The scope of the project design is so expansive that it may limit the project’s ability to concentrate sufficient resources in areas where it can have the most substantial impact.
- Having a single comprehensive project tends to create a perception of “ownership” by the IQC holders that may unintentionally limit how other USAID global projects can foster private sector partnerships.
- The IQC mechanism forces continued competition between IQC holders for each task order, complicating coordination and making collaborative implementation more difficult.
- Some result areas and their supporting IRs do not appear to have very close causal linkages.
- There is an inherent tension between the quest for innovation or technical leadership and the demonstration of programmatic impact. It may be unrealistic to expect the trial of innovative private sector approaches to produce significant changes in FP consumption or health behaviors.
- The limitation on use of core funds to the demonstration of technical leadership or innovative approaches furthers the tension between the quest for innovation and the expectations implied in the project’s Intermediate Results.
- There are no commonly recognized indicators of success for private sector partnerships beyond (inadequate) sales figures.
- Assigning substantial funds to non-FP areas such as HIV/AIDS may dilute program effort or distract technical focus. This is particularly true for field support and mission funding where HIV/AIDS funds constitute nearly half of all field financing received by PSP-One.

The USAID Project Environment

- There has been no real change in the way the private sector is viewed within USAID since a 2006 study. The public sector orientation for addressing RH goals still predominates, and misperceptions or lack of understanding about how to work with the private sector remain.
- Many field health staff have little experience or familiarity with viable private sector partnership models.
- In most country development planning and health sector strategy exercises, roles for the private sector are noticeably absent or relegated to little more than an afterthought.
- Private sector partnerships are not a consistent priority for health sector interventions and do not benefit from regular top-level support. No clear management expectations are expressed regarding the regularity or extent to which private sector options should be part of normal Agency health or population programming.

- There is no visible system for recognizing staff whose efforts increase meaningful private sector involvement in achieving health sector or Agency objectives.

LESSONS LEARNED

Even though PSP-One is still underway, some lessons already have been learned:

- Infusing commercial innovation into USAID private sector programs requires flexibility, creativity, and time to align commercial interests with FP or RH objectives. It often takes considerable time to identify partners, inform them about public health goals, determine the specific contributions possible, and establish sound relationships.
- Commercial alliances, particularly vibrant social marketing efforts, can lead to more equitable access to FP, increased private sector share of the method mix, and greater FP prevalence.
- A multipronged intervention that addresses demand, supply, and policy together is the fastest way to achieve substantial progress in the provision of FP/RH services by the private sector.
- Donors can improve FP market segmentation through the way they channel funding to different service delivery sectors, which can stimulate change in the marketplace.
- Generic manufacturers are changing the worldwide contraceptive market; large, established manufacturers with research and development functions now compete more aggressively for partnerships to meet the needs of lower income clients.
- Some project experience suggests that the manufacturer's model can be successfully adapted through southern-based partnerships in sub-Saharan Africa, where it could offer new options for contraceptive security.
- FP scale-up is faster and more sustainable when integrated into existing structures than when introduced through an independent pilot initiative.
- National health insurance schemes appear to offer a powerful infrastructure to increase sustainable access to service: payment, monitoring, and accreditation mechanisms are already in place and the scale is already national. However, for such schemes to have an appreciable impact, benefit packages must specifically provide for FP services, contraceptives, etc.
- Considerable effort is sometimes required to ensure that the linkages between desired FP/RH results and private sector interventions remain strong. Once an opportunity is formed and a partnership is defined, it is possible for the FP/RH focus to diminish in the midst of addressing the actions needed for the private sector partners or prevailing business practices to become viable contributors to the desired health sector objectives.
- Weak or absent structures to effectively link private providers seem to be greater barriers to improving private quality of care than provider motivation, though QA mechanisms that offer supervision or checks and balances within a defined group of partners show promise.
- Promising innovations for private sector delivery of services or products can come from nontraditional commercial partners.
- Some interventions may not in the short term significantly increase user numbers or couple years of protection (CYP) but can help improve the policy and public relations environment, increase contraceptive options, improve provider acceptance, and identify and motivate champions.
- Information dissemination and awareness-raising are not enough to mainstream the private sector in RH/FP programming within USAID and other donor organizations; that will require changes in how donor organizations operate.
- Regular nationally representative household data are vital for engaging in dialogue with the private sector, assessing its role in health care use, and determining its impact on FP

sustainability. USAID and other donors should support national demographic and health surveys even where direct assistance for health or FP has ceased.

RECOMMENDATIONS

Recommendations for the Near Term

The team's recommendations for the near term are offered for the remaining 15 months of the PSP-One Project and perhaps beyond.

- ***Focus remaining efforts to maximize impact.*** Staff should focus remaining project efforts and available funding on advancing the implementation of selected interventions with high potential for sustainable impact to demonstrate more fully and convincingly what can be accomplished through innovative private sector programming.
- ***Mainstream the private sector into FP/RH programming.*** An explicitly stated strategy for mainstreaming/behavior change is needed. Such a strategy should facilitate movement from awareness of private sector potential in FP/RH to trial and then adoption of the desired programming behaviors. USAID staff and other project stakeholders should be included in the development of the strategy.
- ***Strengthen private provision of LAPM.*** A more concerted, focused effort is needed to increase private sector provision of LAPM. An assessment of how LAPM fit into the private sector provision of FP/RH services is needed to inform a plan for how, or whether, the project proceeds to strengthen private sector provision of LAPM.
- ***Improve quality of private sector FP/RH services.*** The project's work in quality improvement would benefit from further development and use of an assessment tool for quality of private sector FP/RH services, similar to the project's assessment tool for accreditation readiness. The project should concentrate its remaining efforts in the area of quality improvement on proving potentially high-impact interventions.
- ***Scale-up private provider networks.*** Future country assessments should include host country and/or mission willingness and ability to fund future scale-up of successful networks and other proven innovations, as well as the availability of existing networks that can and will scale-up innovative approaches once proven successful.
- ***Broaden opportunities to identify strategic needs.*** As a regular part of its early work in every country, the project should undertake a broad assessment of the potential and need for private sector participation in FP/RH product/service delivery and of any special conditions that may affect the country environment for private sector participation in planning and programming. Core support should be available to add these assessments to mission requests for specific technical assistance funded by field support.
- ***Expand the search for innovative approaches.*** In its remaining time, the project could make an important contribution with a more explicit and systematic approach to identifying promising innovations with relevance for FP/RH service or product delivery.

Recommendations for Future Private Sector Initiatives

The assessment team offers the following recommendations for the design and implementation of private sector initiatives beyond the life of the PSP-One Project.

- ***Develop a comprehensive agency strategy for working with the private sector in health.*** USAID needs a strategy for working with the private sector to support its health efforts. The absence of such a strategy makes it difficult to focus available resources on the most meaningful approaches for private sector involvement. The strategy should identify objectives to be achieved through

private sector partnerships and how commonly such partnerships should be part of mission bilateral health programs.

- **Create the facility for private sector partnering in all global health projects.** To maximize the potential for private sector contributions, each global project should include a mandate to work with or develop private sector partnerships as needed to help achieve its objectives. Partnering with the private sector should be as regular an approach as working with the public sector.
- **Clarify expectations for private sector involvement in FP/RH programming.** It would be useful for the designers of future initiatives to have first developed a clear statement of donor expectations for private sector involvement in FP/RH programming. These expectations should be consistent with an overall Agency strategy.
- **Focus core efforts to develop or test innovative private sector approaches on fewer and the most promising areas.** A broad, comprehensive project design allows implementation in virtually any possible private sector activity area but makes it difficult for significant progress to be achieved in any one area. For core funding, operational areas should be narrowed to selected private sector themes that offer the most promise.
- **Place greater emphasis on FP/RH focus.** To maximize the potential for FP/RH impact in a future project, it may be useful to provide some additional focus to the FP/RH and country conditions within which private sector interventions would be implemented.
- **Invest in the development of new measurements and indicators.** Despite progress in developing implementation indicators, defining and measuring health sector success from private sector partnerships remains incomplete. The current use of product sales, number of services provided, and/or funds leveraged is inadequate for capturing impact. Private sector contributions to health objectives need to be measured and defined in public health terms that are relevant to and recognized by public sector health planners.
- **Identify new or expand existing private sector networks.** Networks of providers or business outlets offer considerable potential for increasing access to services and provide some of the best opportunities for application of quality assurance mechanisms.
- **Adopt PSP interventions that seem worthy of additional investment,** including South-to-South partnerships for supply of generic products; quality improvement interventions aligned with private provider financial interests; base-of-the-pyramid marketing schemes, especially those that incorporate regular personal interface with consumers; and testing innovative approaches that can be scaled up.
- **Use core funds to provide technical assistance to missions in the development of private sector strategies or initiatives.** Given limited familiarity with private sector models among USAID staff, future global initiatives for the private sector should include technical assistance and support. This could include assessments of specific interest areas but should focus on the development of private sector strategies for health.
- **Facilitate information sharing and technical support for emerging public-private champions in ministries of health.** It may be necessary to facilitate a regular cross-country exchange of experiences and illustrative models that are being tried. Offices may need technical assistance to help formulate their role, develop partnership strategies, identify partnership opportunities, and support the brokering of the specific partnerships.
- **Expand dialogue with a broader corporate community to surface new private sector partnering opportunities and identify innovative marketing approaches.** Future private sector initiatives should include a component designed to explore the latest approaches for reaching consumers in developing countries or emerging markets.
- **Re-examine project expectations and performance indicators.** Available funding and expected results should be re-evaluated to diminish inconsistencies between what the project can do with

its core funds and the expected FP/RH results. Reasonable expectations for development, implementation, and impact within the five-year life cycle of a USAID project should be defined.

- ***Place managerial emphasis on USAID's role in mainstreaming the private sector.*** USAID senior management should encourage an environment supportive of mainstreaming the private sector into FP/RH programming. Overt interest can help create an environment in which inclusion of the private sector is perceived to be the norm. The “key technical areas” of the Bureau for Global Health do not include private sector partnerships. Perhaps the Bureau should consider creating a list of “key technical tools” in which private sector approaches feature prominently. A champion of each tool might be named, with responsibility for advocating its use across technical areas and projects.

I. INTRODUCTION

PURPOSE AND OBJECTIVES OF THE ASSESSMENT

The United States Agency for International Development's (USAID) Bureau for Global Health (GH)/Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) commissioned this independent mid-term examination of its Private Sector Partnerships-One (PSP-One) Project by the Global Health Technical Assistance (GH Tech) Project. The intent was to determine progress toward planned results; identify lessons learned to date; comment on project activities that warrant continued or additional future investment; and, for the future, propose private sector initiatives or approaches not currently part of the PSP-One Project.

Another objective was to generate general recommendations for enhancing the role of the private sector in contributing to reproductive health (RH) and family planning (FP) goals (including access to and increased use of services, enhanced service quality) and more active private delivery of other products and services that could further health sector development. The intent was to inform future USAID planning and identify opportunities to encourage public-private partnerships for achievement of health sector goals. Specifically, the assessment team had three main tasks:

1. Review PSP-One's strengths, weaknesses, successes and constraints, identifying contributing factors. The team will present results achieved to date, document lessons learned, and make recommendations towards achieving planned results in the remaining period of project implementation.
2. Assess PSP-One's structure and management and the benefits and disadvantages of the PSP-One mechanism, a task order under a multiple award IQC.
3. Identify activities that warrant additional investment and private sector initiatives and approaches not covered by PSP-One that could improve access to, use of, and quality of RH, FP, and other health products and services.

To accomplish these tasks, the team gave particular attention to the five intermediate results (IRs) expected:

1. Increase knowledge about and use of quality FP/RH and other health products and services from private providers.
2. Increase the supply of quality FP/RH and other health products and services through the private sector.
3. Improve conditions for private sector involvement in delivery of FP/RH and other health products and services.
4. Scale up proven strategies to accomplish the first three results.
5. Conduct monitoring, reporting, and operations research to support overall accomplishments of PSP.

The team also prospectively examined the evolving experience of private sector partnerships to improve or increase FP/RH services, and identified both promising approaches (tried or untried) and gaps or unexploited opportunities for meaningful private-sector involvement.

BACKGROUND

PSP-One, a five-year worldwide project, began on September 17, 2004, and is scheduled to end September 30, 2009. USAID awarded the project, through an indefinite quantity contract (IQC), to six organizations: Abt Associates Inc.; Academy for Educational Development; Chemonics; Constella Futures; John Snow, Inc.; and University Research Co., LLC. The IQC mechanism was selected to facilitate easy access by USAID Missions and Bureaus to high-quality TA. The project was also designed to flexibly support private sector activities of USAID Offices or Missions. USAID Missions were able to issue their own locally managed task orders under the IQC.

PSP-One was the first of over 14 orders awarded up to the date of the assessment. It was intended to increase provision and use of quality private FP/RH and other health information, products, and services. This task order has been USAID's primary means of supporting core-funded private FP/RH activities.

PSP-One was also designed to increase information about private sector programming by disseminating evidence about the strengths and the limitations of private sector approaches and strategies. It was expected to play a leading role in synthesizing annual results among all PSP task orders, publicizing best practices, and serving as the secretariat for the USAID private sector working group. It was to be a principal mechanism to receive field support funding from USAID Missions that do not issue their own task orders.

Abt Associates Inc. is the lead for the PSP-One task order. Its four core partners are Family Health International, IntraHealth International, Population Services International, and Tulane University, and the four specialized partners are Dillon Allman and Partners, Forum One, O'Hanlon Health Consulting and Banyan Global. Total possible funding for the project is \$59,129,638, with a field support ceiling of \$34,190,105 and a core support ceiling of \$24,939,533.

METHODOLOGY

The assessment team used both qualitative and quantitative methods. The quantitative information came from existing data and reviews of reports and other documents describing aspects of PSP-One work. Qualitative information was generated primarily through interviews, both in person and by phone, and observation both in the project offices in Bethesda and in India and Honduras. Patterns found in the quantitative information were probed during interviews. To help insure that comparable information was collected, the team drafted standard questions for all informants. Most of these were included in an e-mail survey questionnaire (see Annex B) sent to a number of USAID Mission staff in countries where the PSP-One Project had done work. However, only one replied. This may suggest a staffing capacity issue or a lower priority for private sector initiatives in mission programming (see Section V below).

The team then conducted phone interviews. Calls to a subsample of mission staff where the PSP-One Project had worked produced a much better response. The telephone was also used to canvass persons in non-USAID organizations that were identified as stakeholders for PSP-One work. Interestingly, some of those contacted expressed surprise they were considered stakeholders; however, they were all aware of the project and willingly answered questions about their involvement. The major questions were:

1. What has been PSP-One's progress to date in relation to planned results and performance indicators?
2. What have been the most important lessons learned to date?
3. How has PSP-One supported scale-up and mainstreaming of proven strategies and interventions?
4. What contributions has PSP-One made to global leadership, to advancing research and innovation, and to transferring new technologies to the field?
5. What were the most significant structural or management challenges (e.g., with regard to project design, staffing, partnering or funding) faced by the project?

6. What were the benefits and disadvantages of the IQC/Task Order mechanism, particularly with regard to achieving project results?
7. How has PSP-One demonstrated the value-added of a global rather than bilateral project? How has PSP-One complemented the work of bilateral projects?
8. How well have the results of all PSP task orders been synthesized through documentation and dissemination of evidence about both the strengths and the limitations of private sector approaches and strategies?
9. What are the issues, challenges, and lessons learned in monitoring, reporting, and operations research to support accomplishment of the PSP IQC goals and objectives?
10. What are the key PSP-One activities and approaches that warrant continued or additional investment or that are promising pilot initiatives that could be scaled up or applied elsewhere?
11. What are other promising, potentially sustainable private/commercial models and approaches not addressed by PSP-One that could provide a social benefit in future investments?
12. What are the outstanding issues and gaps related to private/commercial contributions to improving access to, use, and quality of FP/RH and other health areas still to be addressed?

Since PSP-One is still active, it is too soon to verify the impact of several country programs, such as India or Nigeria. There the team could only compare the design of the activity and its progress to date with the local private sector environment and estimate the impact potential.

II. FINDINGS

PROJECT DESIGN AND EXPECTATIONS

By design PSP-One is a complex and broad-ranging project that accommodates a variety of private sector programs, technical areas, and service-delivery mechanisms. As the GH flagship project for private sector initiatives, it is structured to do virtually anything needed to further private sector partnerships for health.

The expectations stated in project documents and reported in stakeholder interviews are equally complex, and sometimes conflicting—innovation, impact, pilot demonstrations, scaled-up projects, core funding, field support funding, replicability, private sector mainstreaming, private sector partnerships, and “proven” new service delivery methodologies and mechanisms—and all within five years.

The PSP-One lifespan limits the extent to which some expectations can be fulfilled. Private sector partnerships often cannot be conceived, negotiated, and fully implemented in the short term, as USAID’s long history with contraceptive social marketing projects confirms. Under the International Contraceptive Social Marketing Project (ICSMP), the Social Marketing for Change Project (SOMARC), and the Commercial Market Strategies Project (CMS), it was often only in the third year of effort in a country before effective partnerships were fully formed, product sales firmly established, and significant couple years of protection (CYP) ensured.

Fulfillment of some project expectations can also limit the extent to which the project can fulfill others. “PSP-One’s strategic objective is to increase the sustainable provision and use of quality private sector [FP/RH] and other health information, products and services. It serves as USAID’s primary vehicle to support core-funded [FP/RH] in the private sector.” (Self-assessment, page 1)

The IRs against which performance is measured (self-assessment, Figure 1) are

- increase in knowledge about and use of quality FP/RH and other health products and services from private providers;
- increase in supply of quality FP/RH and other health products and services through the private sector;
- improve conditions for private sector involvement in FP/RH and other health products and services;
- scale-up of proven strategies (three results above); and
- monitoring, reporting, and operations research to support overall accomplishment of PSP.

It would thus appear that the primary expectation for the project is delivery of increased use of contraceptives and other health products and services obtained from private sources.

Since PSP-One has no inherent or guaranteed field support platform, technical direction has been largely guided by the emphases GH has placed on core funds. Often, core funds have been generally available only for interventions demonstrating technical leadership—pilot testing of innovative approaches in service, information, or product delivery—in identified areas. Yet pilot projects cannot reasonably be expected to have significant near-term impact on contraceptive prevalence rates and other health products and services. There is an apparent disconnect between the expectations for the project, represented by its IRs, and the expectation of innovative pilots fostered by the allowable uses of GH core funds.

Fulfillment of some major expectations for the PSP-One Project—that it will initiate innovative private sector interventions with core funds, demonstrate their effectiveness, and then scale them up with field support to a level where FP/RH or other health impact can be measured—has sometimes been compromised by factors outside project control. Many USAID missions are understaffed and unable to accept the burden of managing new field-funded private sector projects. In some countries, PEPFAR programming seems to dominate not only the HPN agenda but also Mission limited personnel resources.

Mission HPN staff, often relatively new to the Agency and inexperienced in the area of FP/RH, seem in several countries to be fully occupied with learning Mission systems and procedures and fulfilling current programmatic responsibilities. Some newer staff do not seem to have come to their posts with an interest or belief that the private sector can be effective in healthcare delivery, and veteran staff, many used to working with the public sector, can be even more resistant to innovation.

PSP-One is expected to “mainstream” the private sector into mission and host-country health program planning and implementation. However, GH and regional bureaus seem reluctant to provide top-down advocacy to Missions for the role of the private sector and public-private partnerships.

PROGRAM EXPERIENCE

Organization

Within the PSP-One mandate “to expand private sector participation in meeting global family planning needs in a sustainable way” (self-assessment, page v), the work has been organized around themes for which core funding is available. These include four long-standing challenges:

- Strengthening private sector provision of long-acting and permanent methods of contraception
- Scaling up private provider networks
- Expanding financial mechanisms to cover FP/RH products and services
- Mainstreaming the private sector into FP/RH planning and programming.

They also include three promising new directions:

- Improving the quality of private sector FP/RH services
- Increasing sustainable and affordable product supplies through southern-based partnerships
- Facilitating commercial investment in FP/RH product and services delivery.

The PSP-One Project has adopted, and in some instances created, technical tools to address all these:

- Private sector and contraceptive security assessments
- Market segmentation analyses
- Behavior change communications
- Development of private sector partnerships;
- Accreditation readiness assessments
- Policy assessments and private sector advocacy
- Consumer research and project monitoring.

Project staffing and technical resources have been largely organized around the expertise required to use these tools while pursuing the selected technical directions. Design and implementation of interventions within each project-organizing area have been further organized by application of a number of project operational principles (self-assessment, pages 5-6):

- Stimulating the private sector profit motive through both organizational and system-level interventions
- Meeting the health needs of consumers with targeted interventions and information
- Upgrading private provider performance with a range of reinforcing and enabling strategies
- Mobilizing the public sector’s critical role in facilitating growth of the private sector’s role in healthcare/FP/RH product and services delivery
- Pursuing optimal market segmentation

- Ensuring that subsidized approaches facilitate rather than impede participation of the nonsubsidized private sector in healthcare/FP/RH product and services delivery.

Field Interest and Participation

The design of the PSP-One Project appears to be based on assumption of a two-step process for implementing interventions: (1) Core funds are used to develop and implement an innovative pilot intervention; then, (2) if the pilot intervention is successful, field support funds will be made available to expand or scale it up to generate more impact.

The interest and participation of Mission staff is essential to both steps. They are gatekeepers to country access even when core funds are available for pilot projects. They decide whether a core-funded PSP-One pilot will be implemented based on many considerations: Mission personnel available to manage it; number of “management units” already working in the country; other demands on Mission time and resources, such as disease-specific funding; funding needs of current projects; staff understanding of country health priorities; and commitment to the role that private sector can play in delivering FP/RH services. Many Missions prefer to take an active management approach to any effort in-country, whether it is supported by core or field funds.

Recognizing the expectation that expanding a successful pilot will be done with field support resources, Mission staff may decline a pilot intervention because of other priorities. Most USAID Missions are used to a bilateral approach to health where the public sector is USAID’s primary development partner and bilateral agreements often already exist. Where private sector program initiatives thus become an add-on to an existing package, a place for them has to be carved out. The private sector initiative has to compete for funds within country program assistance that is already designed to support public sector agreements.

Mission staff must have considerable commitment to the role of the private sector in health/FP/RH if private sector partnerships are to compete successfully with the other demands on Mission planning and programming resources. A 2006 PSP-One survey of USAID staff about their attitudes and perceptions of the private sector’s role in health indicates wide variance both within and between USAID missions and offices. The assessment team did not find significant changes in attitudes and perceptions since 2006.

PSP-One’s country assessment tool appears to be valuable in introducing new private sector approaches to Missions, but it does not by itself lead to buy-in (see Table 1). In some cases (such as the Ukraine), Missions have implemented some of the suggested interventions without using the PSP-One mechanism. These instances represent a success for private sector programming and exemplify PSP-One’s role in promoting greater private involvement in service delivery generally.

TABLE 1. PSP-ONE COUNTRY/REGION ASSESSMENTS AND THOSE ASSESSMENT LOCATIONS THAT ALSO HAVE PRIVATE SECTOR INTERVENTIONS	
Country/Region Assessment	Private Sector Intervention Initiated
Azerbaijan	Yes
Bangladesh	No
Bolivia	Yes
Central Asian Republics	No
Côte d’Ivoire	Yes
Europe and Eurasia	Yes
Guatemala	Yes
Honduras	Yes
India	Yes
Jordan	Separate Task Order
Nigeria	Yes
Peru	Yes
Philippines	Yes

TABLE 1. PSP-ONE COUNTRY/REGION ASSESSMENTS AND THOSE ASSESSMENT LOCATIONS THAT ALSO HAVE PRIVATE SECTOR INTERVENTIONS	
Country/Region Assessment	Private Sector Intervention Initiated
Russia	Yes
Senegal	Yes
Swaziland	No
Ukraine	Yes, through other mechanism
Zambia	No

Support of current projects—especially those related to HIV/AIDS and previously supported through AIDSMARK—is a major reason that Missions provided field support to the PSP-One Project (see Table 2). Among Missions providing field support directly related to FP, most provided funds for assistance to current social marketing projects. In only three instances (two in India and one in Nigeria) was field support provided to expand or implement innovative private service delivery approaches.

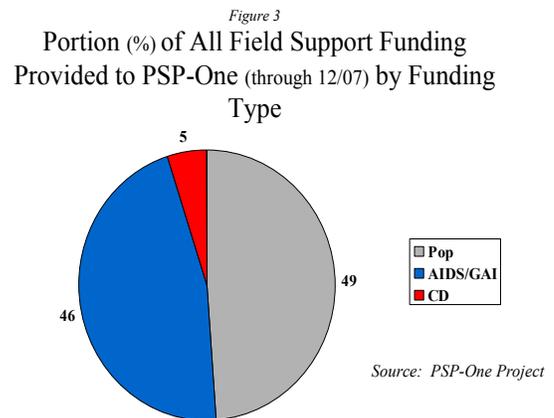
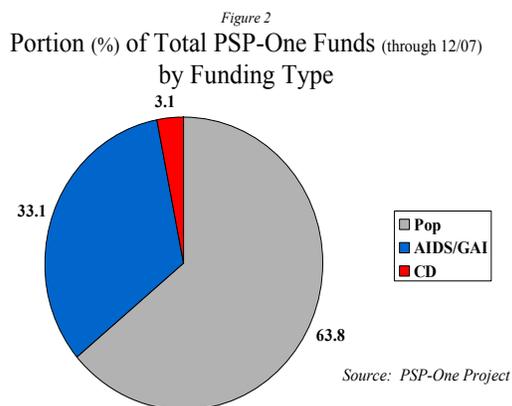
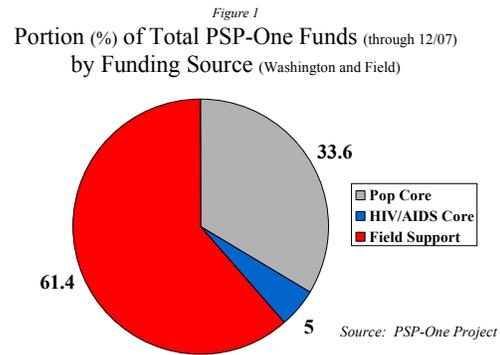
TABLE 2. USAID MISSIONS PROVIDING FIELD SUPPORT FUNDING TO THE PSP-ONE PROJECT	
USAID Mission	Purpose of Field Support Funds
India	Expansion of innovative DMPA intervention
	Expansion of existing condom promotion/behavior change project
	Implementation of Complete Home Diarrhea Management program
	Pass-through funding for existing HIV/AIDS project
Philippines	Assessments/evaluations of existing FP/RH country projects
Côte d'Ivoire	TA in HIV/AIDS policy development
Ethiopia	TA in HIV/AIDS private sector policy development
Nigeria	Implementation of innovative intervention to provide quality FP/RH services through HMO and NHIS networks
Mozambique	Pass-through funding for existing PSI HIV/AIDS safe water system project
Rwanda	Pass-through funding for existing HIV/AIDS project
Senegal	Assessment and TA to existing local social marketing organization
Azerbaijan	Assessment of private sector capacity to contribute to contraceptive security and implementation of market segmentation study
Russia	Assessment of availability and quality of modern contraceptives and participation in development of new plan for promotion of hormonal contraceptives
Ukraine	Assessment of private sector and assessment of HIV/AIDS risk among MSM
Guatemala	Pass-through to support existing HIV/AIDS project
Guatemala	Support for intervention improving private sector HIV counseling and testing
Bolivia	Assessment of CIES and development of financial sustainability strategy for CIES
Haiti	Pass-through funding for existing condom, hormonal contraceptive, and safe water systems social marketing
Honduras	Support for improved operation of existing social marketing projects
Mexico	Pass-through funding for existing HIV/AIDS condom social marketing and behavior change projects
Peru	Support for existing contraceptive social marketing project

Almost half (\$14 million) of all field support funds for the PSP-One Project has come from India. Almost 40 percent has been pass-through funds for continuing support to established in-country projects, providing most of the CYPs generated by PSP-One. About 46 percent went to HIV/AIDS interventions.

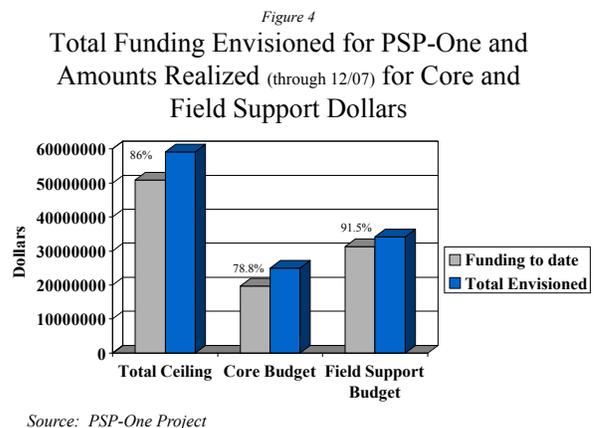
Allocation of Project Funds

The PSP-One Project has attracted a variety of funds from within USAID, a fact that demonstrates the utility of project capacities to different aspects of the Agency’s overall operations. Through December 2007, PSP-One received \$50,857,827, of which about 39 percent is core funding and the rest field support or Mission funds (Figure 1). The fact that the project has received three field support dollars for every two core dollars testifies to the willingness of some Missions to support PSP-One activities. Funding from the field has often been oriented toward support of existing mission programs with the use of project “pass-throughs”—a purpose for which the PSP-One project was designed.

Population resources (core population monies) compose the vast majority of core funding so far (87%) and represent about 34% of total project funds. The remainder of core funds (5% of all funding) comes from HIV/AIDS accounts. Population funds also make up about half (49%) of the field support funding (see Figure 2), bringing the portion of all funds from USAID population funding to about 64 percent. HIV/AIDS funds (CD/AIDS and GAI) compose 46 percent of field support (Figure 3) and a third (33.1 percent) of all project funding.



Pass-through funding (76.8% of it for HIV-AIDS) was a popular choice for Missions and some used PSP-One as a convenient financing mechanism to access task-order partners. About \$12 million (39% of field support funds and 24% of total project funding) were pass-throughs to finance previously initiated private sector programs. About half of all pass-through funds (\$5 million) came from India. This Mission also obligated an additional \$9.2 million for private sector programming to the project. Over the life of the project, pass-through funding has been progressively phased out.



The rate of Agency investment in PSP-One, especially considering the current stage in the life of the project, is substantial. For example, although 68 percent of the project’s total 5-year life has elapsed, funding made available represents 86 percent of the contract ceiling (see Figure 4). Core funding contributions now amount to about 79% of the total for the entire project period and field support levels are 92% of expected totals. Clearly, both Washington-based USAID Offices and USAID Missions abroad see utility in the project.

All four regions are represented in PSP-One. The Asia and Near East (ANE) region has contributed half of all field-generated funding (Figure 5), primarily due to India. Latin America and the Caribbean (LAC), at about 28% of all field support, is the next largest investor, followed by Africa and Europe and Eurasia (E&E).

Complementing Bilateral and Global Projects

Missions have regularly used PSP-One to expand the options they use to address country-specific needs. Mission representatives unanimously attested to the fact that the project’s activities complement Mission portfolios. In India, for example, PSP-One has represented a major part of the Mission’s program to improve FP/RH services; and Mission staff were integrally involved in planning project interventions. In other countries, Missions used PSP-One as a convenient and much valued mechanism to pass through funds to perpetuate initiatives that were already part of a Mission approach for involving the private sector.

All missions contacted felt the capacity of the PSP-One task order to accept field support funds was critical in fulfilling their programming needs and creating flexible and adaptable funding options.

PROGRESS TOWARD PLANNED RESULTS

Performance in Selected Technical Areas

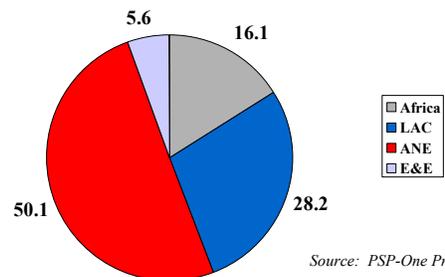
Quality of Private FP/RH Services

One assumption of the PSP-One Project is that the quality of private sector FP/RH services needs to be improved. While the assessment team is unaware of an explicit PSP-One strategy for identifying and addressing quality improvement issues in the private sector or assessing the impact of quality improvement on consumer use of private sector FP/RH services, the project seems to have adopted three mechanisms to improve quality: provider self-assessment (Uganda); accreditation standards within provider networks, HMOs, and national health insurance schemes (Nigeria); and continuing education requirements for recertification of private providers (Nigeria).

Which mechanism is used in a given country seems to be a response to collaborative opportunities that arise. The project has not yet developed a tool for assessing the quality of private sector services as it has for assessment of accreditation readiness. Such an assessment tool would facilitate the choice of the interventions and approaches that would be most efficient, have greatest impact, and best use existing management and supervisory infrastructures. Without such a tool, it is difficult to evaluate the appropriateness, efficiencies, and impact of a given quality improvement mechanism. However, PSP-One staff have done well in tying quality improvement mechanisms, such as accreditation standards, directly to private providers’ financial interests.

Although the self-assessment tool seems to have been associated with quality improvement in Uganda, given the training required alone, its replicability and feasibility elsewhere have yet to be demonstrated.

Figure 5
Portion (%) of Total PSP-One Field Support or Other Mission Funding (through 12/07) by Region



Source: PSP-One Project

PSP-One staff have recognized the role of policy/advocacy in quality improvement. In both Ethiopia and Nigeria, efforts are being made to influence public policy to include private sector HIV/AIDS and FP/RH services and protocols within national health insurance and HMO/network schemes.

PSP-One use of mystery clients to monitor the quality of provider practices is apparently effective. While the mystery client approach is not new within the private sector, the frequency with which it has been used by the project to monitor trained providers' actual rather than self-reported practice is innovative.

Expansion of Financial Mechanisms for FP/RH Services

Perhaps the most notable example of expanding financial mechanisms is PSP-One's work in Nigeria. There, the creation of a national health insurance system and the increasing role of private health maintenance organizations (HMOs) created opportunities for public financing of private health care. The project has worked creatively with 6 or 7 HMOs to enhance the ability of participating private health practitioners to improve FP/RH counseling and other skills. It included a local bank in the partnership to offer financing for private providers to improve facilities and more easily meet desired standards of care.

Mainstreaming the Private Sector into FP/RH Planning and Programming

The private sector is mainstreamed into FP/RH services delivery, in the opinion of the assessment team, when it is included in policy development, program planning, and service delivery strategies and is a regular part of the health sector and development processes of USAID, USAID Missions, other international donors, and ministries of host countries.

The PSP-One Project has chosen to focus the efforts it categorizes as mainstreaming largely on information dissemination and raising awareness. "The Private Sector Partnerships-One Project Self Assessment, February 2008, Section 8, Mainstreaming and Collaboration states (page 55):

"One of the principal challenges that PSP-One faced at the beginning of the project and continues to address is the misinformation and misconceptions regarding the role of the private sector in health. Members of the international health community often have only limited knowledge of the role of the private sector in the delivery of health care... They lack information ... Three years later, the PSP-One project has made great strides in directing the international health community and USAID's attention toward the private health sector. The project has successfully employed multiple strategies to raise awareness on the private health sector, including: 1) convening expert panels ... and other professional meetings, 2) repackaging existing evidence and research generated by the Commercial Market Strategies and PSP-One projects' policy briefs and research notes, which summarize issues and present factual information, 3) organizing high-level policy events and, 4) forming strategic alliances with other donors to add new voices to the dialogue on the private health sector."

The PSP-One website is cited (page 56) as one of the project's "key mainstreaming events to date,"

"... [It is] the source on the private health sector. The project continues to collect information, documents, reports from other cooperating agencies (CAs) and donors working in private health sector and has posted them on the website."

These reports, papers, policy briefs, and policy primers, as well as information dissemination tools such as real and virtual conferences prepared by PSP-One Project staff that are well crafted and solidly information-based. The materials reinforce the platform of credibility from which the project appears to the assessment team to operate.

With the mainstreaming focus on disseminating information and raising awareness, the primary progress measurement is quantifying the number of individuals and organizations that access or receive information. For example, there were about 3,800 downloads of policy primers from the web site, and over 900 people registered for the virtual conference.

Over the last two years, the project reports, there has been an increase in interest in the private health sector by new international players, such as the International Finance Corporation, Gates Foundation, WHO, Rockefeller Foundation, the Center for Global Development, the Brookings Institute, and UCSF's

new private sector health center. All sent representatives to PSP-One mainstreaming activities in Years 1 and 2, and consulted with PSP-One before launching their own private sector health strategies.

Mainstreaming the private sector is a challenge, the assessment team believes, that should be addressed through a sound behavior change process. While raising awareness is a necessary step in the process, it is not sufficient to accomplish behavior change by itself. The team could see no apparent change in the status of and prevailing attitudes toward the private sector within USAID compared to those expressed in the 2006 survey of the Agency. Moreover, leaders of GH, regional bureaus, and Missions seem only peripherally aware of the project. Even though the Administrator has designated private sector partnerships as a priority, the PSP IQC seems disconnected from any larger emphasis on stimulating private sector involvement in development.

PSP-One's self-assessment discusses (page 64) its resources for providing global leadership in terms of a staff that has the "right mix of connectors, mavens, and salespeople." The emphasis seems to have been on recruiting mavens through presentation of good technical papers and case studies, but a shortage of connectors and salespeople may be preventing the project from bringing even the mavens along the behavior change continuum from awareness and knowledge to active acceptance of private participation in health services planning and programming.

It should be recognized, however, that the project faces serious constraints in advocating for private sector approaches in that USAID management specifically directs centrally managed projects not to market themselves too strongly to Missions. As a result, the project is limited in its ability to advocate for the value of Missions investing in private sector FP/RH programs; the marketing and advocacy role lies primarily with project CTOs and country backstopping teams in Washington.

Scale-up of Private Provider Networks

In several countries the project has expanded or enhanced networks of private service providers. In India, for example, PSP-One is innovatively involving professional associations to identify and recruit chemists and indigenous practitioners of traditional medicine to provide FP counseling and contraceptives. In Honduras, the project has introduced new skills to physicians who were already part of a nongovernment organization (NGO) network that contracts with private providers. Participating HMOs in Nigeria are working with PSP-One to upgrade private provider skills to make them more vibrant sources of a full range of services. However, the project's provider network-related efforts to date are largely testing ways to improve networks. Most are implemented in only a few areas and not ready for scale-up.

Strengthening Private Provision of Long-acting and Permanent Methods

Thus far, contributions to expanding use of LAPMs through the private sector have been minimal. While project staff report that they investigated opportunities in as many as 10 countries to implement LAPM service interventions, only one program is so far active. According to staff interviews, most LAPM intervention opportunities were eliminated from consideration because there was no infrastructure that could ensure the quality of private LAPM services.

The one instance where there was an appropriate institutional context for private LAPM services is a no-scalpel vasectomy (NSV) initiative in Honduras. About 15 physicians have been trained in the technique and now provide the procedure, some less than once month and one several times a week, largely through their contract relationship with ASHONPLAFA, a national NGO, rather than their private practices. However, the strategic relevance of selecting even this one LAPM effort in Honduras (given the broad goals of the PSP-One Project) is puzzling:

1. There needs to be a critical mass of demand for any service to be sustainable enough to attract private providers. The latest Demographic and Health Survey (DHS) for Honduras found that male sterilization represents only 0.3 percent of current contraceptive users and only 0.5 percent of the contraceptive mix for modern methods. NSV seems, therefore, to lack relevance to the Honduran private marketplace, given the low demand for vasectomy. In fact, it was difficult for the project to find enough NSV clients to provide training opportunities for participating physicians.

2. For demonstrating private sector ability to affect contraceptive prevalence or CYPs through LAPMs, an intervention strengthening private delivery of IUDs or tubal ligation would seem to be more promising, given recent survey data on contraceptive consumption patterns.

The project does not seem to have a strategy for private provision of LAPM that would make it possible to identify feasible intervention opportunities. Ascertaining market potential and prospects for commercial sustainability for a given intervention may be just as important as service quality.

Facilitating Commercial Investment in FP/RH Product and Services Delivery

Increases in commercial investment in FP/RH usually occur as part of a country-specific effort that contains elements that contribute not only to PSP-One technical priorities but also to the business goals of the private investor. Facilitation of commercial investments is usually manifested through project efforts to get a commercial entity to agree to participate in a health/FP/RH program in a particular country when the private entity begins to invest in providing FP/RH service or products in new or additional ways.

In India, for example, through its alliance with PSP-One a major household products manufacturer, Hindustan Lever, has begun to invest in providing FP/RH products through its substantial village-level distribution network. In Nigeria PSP-One's partnerships with HMOs, a commercial health insurance company, a bank, a social marketing organization, and a generic pharmaceutical manufacturer have led to private sector investment of staff, time, and financial resources in enhancing provision of FP/RH services.

How commercial investments are applied within country programs can be just as important as the amount invested, particularly when the commercial investment represents a pioneering private sector approach (as may be the case with Hindustan Lever) that if successful may provide sufficient positive commercial experience to attract investment in FP/RH service delivery by other corporations.

Increasing Sustainable Product Supplies

Perhaps the most exciting potential for the private sector to be a sustainable source of FP products and other supplies is PSP-One's work to interest generic drug manufacturers in South-to-South partnerships. Such linkages offer lower-cost alternatives for supplying products for private sector service delivery. The principal project example is the relationship now being established between FamyCare, an Indian manufacturer, and the Society for Family Health, a local Nigerian social marketing NGO. Sales of the mid-priced generic oral contraceptive have not yet begun.

Performance Monitoring and Progress Toward Intermediate Results (IRs)

PSP-One's efforts to refine reporting indicators across all IQC holders have had a positive impact on standardizing measurement and increasing the frequency of reporting. However, the breadth of technical areas included within the project has made meaningful measurement of advances difficult. Even some IRs (e.g., IR 2, knowledge and use of products or services from the private sector) may be slow to change over time. Several of the indicators used are more suited to measuring aspects of process than impact. While the indicators do relate to the IRs, the relationship of some indicators to a specific IR seems indirect—for example, the relationship of one indicator (percent of target population residing within a specified distance of a private RH/FP SDP offering a specific product or service) to IR 2. The selection of defined IR results, however, has facilitated monitoring.

In some countries, like Nigeria, the nature of the intervention and its focus on improving private sector/business practices seems only indirectly related to the Mission's definition of the desired FP/RH impact. Even if successful according to its own near-term FP/RH objective, the project's work will only increase the frequency of private sector provider FP counseling, even though Mission staff in Nigeria told the team that the bottom-line FP/RH programmatic goal is an increase in CYPs. Thus, there is a gap between what the project can realistically expect to measure and any causal relationship to the Mission's CYP goal.

Funds Leveraging

PSP-One is tracking funding leveraged from the private sector. Even though the project uses a more conservative method than many other USAID projects for identifying qualifying contributions and

estimating the value of in-kind contributions, more than \$2.2 million have been leveraged as of FY 2007—about 4 percent of the total funding the project has received from all USAID sources.

The total amount of leveraged funding should not be a major measure of the success of the project: private sector partnerships should not be seen simply as an alternative or an addition to public funding. The greater economic value of partnering with the private sector to achieve health goals is the amount of public resources that will not have to be invested if private sector services do more to propel public health status and practices toward desired goals

CONTRIBUTIONS TO TECHNICAL LEADERSHIP

The assessment team sees five main mechanisms through which the PSP-One Project has contributed to technical leadership: country assessments, innovative private sector approaches, research, expansion of the policy agenda, and dissemination of the private sector experience.

The Role of Assessments

PSP-One has undertaken country-level and other assessments as new initiatives or programming choices were being considered. These assessments have become valuable mechanisms for exercising technical leadership, particularly with USAID missions. Private sector assessments have presented opportunities to apply the latest experience and lessons learned for sustainable private involvement in health care.

Through the assessment exercise the project has effectively expanded the range of alternatives available to missions or host country planners seeking to improve private efforts to achieve health objectives. The assessments have become opportunities to introduce new ideas into the planning process and generate more complete information for decision-making about the marketplace and private sector entities.

Assessments raised awareness within Missions and their public sector partners about available private sector intervention options. Country assessments also became a means to explore country-specific policy environments and identify policy issues that affect private sector involvement in service delivery.

The fact of an assessment, however, has not necessarily meant that Missions or host-country organizations acted on the information provided. In several cases in E&E, for example, PSP-One assessments do not seem to have led to any significant new private initiatives (see Table 1).

Innovative Private Sector Approaches

The project has produced advances in the application of private resources to achieving public health objectives through a number of initiatives. The Base of the Pyramid activity in India is a pioneering undertaking that combines marketing, distribution, and community outreach and operates in partnership with a non-health-related corporation. Although this approach is just now being tested, the potential seems promising.

The project has also been creative in segmenting markets to address contraceptive security issues. The market segmentation study in the Philippines is providing information for better addressing demand-side issues related to contraceptive use. More generally, the technical excellence of the project's work in all its endeavors has allowed PSP-One to play a leadership role in defining technical content and identifying technical issues that influence partnerships with the private sector.

Research as a Technical Leadership Tool

The uniformly high quality of the research undertaken by PSP-One is widely admired. This has created a platform of credibility that also enhances PSP-One's ability to lead technically on other fronts. One factor behind the exceptionally high quality of project research is the PSP-One global research and evaluation agenda drafted in conjunction with representatives from the IQC participants. In guiding research, this agenda has made analyses more relevant to the most pressing issues facing public-private partnerships.

The project has undertaken three global studies that encompass information from 10 developing countries; six evaluation studies were done in five countries; and three operations research or other studies were done in Asia.

PSP-One's application of evidence-based rationales is innovative: data from specifically designed analyses were used to formulate compelling arguments for the potential of the private sector to contribute to FP/RH and other health objectives. Technical standards for inquiry used in the project are models that are worthy of replication and contribute substantially to the project's technical leadership, as in the groundbreaking market segmentation study in the Philippines.

PSP-One staff led a successful effort to develop a common set of indicators for work with the private sector that competing organizations can comfortably share; these were refined and simplified to make measurement more efficient and encourage regular reporting. The information flow from the IQC community has since increased, as has the ability to monitor collective progress in public-private partnerships across all IQC implementers. The use of common indicators also makes possible the measurement of overall outcomes and combined impact.

Expanding the Policy Agenda

PSP-One TA efforts have focused on three areas for creating a more favorable policy environment: (1) restructuring incentives to encourage private sector participation; (2) facilitating dialogue on public-private partnerships; and (3) removing regulatory barriers to private sector involvement.

PSP-One's efforts have produced significant progress in broadening the policy dialogue on possibilities for private sector participation in achieving national FP/RH and other health objectives. The project has produced policy briefs and tools to help policy makers better understand incentives for and barriers to private sector participation; these were made available over the internet. The policy primer on FP legal and regulatory issues for the private sector has been downloaded 2,500 times, a primer on vouchers for health services 760 times; one for contracting, around 850 times; and one on insurance more than 2,300 times.

The experience accumulated from country assessments has demonstrated the importance that policy issues often have for private sector participation in service delivery. The information gained contributed to the dialogue initiated through PSP-One technical gatherings involving a Global Health Council expert panel and a meeting at the World Health Organization in Geneva. Both discussed policy issues and the enabling environment for private sector involvement in health.

Importantly, the project also succeeded in injecting new perspectives into the policy dialogue to represent a broader cross-section of the private sector. Not only did the project bring topics such as health insurance, health voucher schemes, and regulatory barriers into the private sector policy dialogue but also additional organizations, such as the Reproductive Health Supplies Coalition, the WHO, and the German Development Bank. This achievement is vital in helping disparate public and private sector parties share visions and goals as well as better understand their respective roles.

Capturing and Disseminating the Private Sector Experience

To capture and disseminate the collective experience of work with the private sector, the PSP-One Project has used a variety of methods, both traditional and creative, to encompass the range of private sector initiatives and reach out to a wide audience. The combined results are impressive.

Reports and other information products document experience and are effectively incorporated into on-going work, such as the use of policy briefs. In its efforts to increase exposure to and familiarity with private sector partnership topics, the project has also creatively used information technology media and tools to give the public easier access to information. Web-based and e-learning technologies have been successfully adapted to create on-line forums for information exchange, dialogue with expert panels, and on-line technical conferences, which have been accessed globally. Both within the U.S. and internationally, the discussion and information forums have made the experience gained through the project more visible and allow organizations and individuals outside the project to share private sector partnership experience or discuss common problems.

However, conferences (even web-based ones), panels, or workshops often discuss issues generically or offer specific country examples; they cater to all participants by offering “one size fits all” generalizations. Thus the information imparted may raise awareness but not necessarily lead to changes in how participants approach service delivery issues at home. Nevertheless, PSP-One has expanded the range of participation in information-sharing activities and served as a catalyst for the public/private dialogue.

Project staff attempted at least once to collect data on information recipients, their organizational or governmental affiliations, and how they use the information they received, but there are no current data on how information dissemination activities are affecting behavior. Thus it is not possible as yet to assess how dissemination efforts are affecting mainstreaming of the private sector in RH/FP programming or improving private sector practices and approaches in the health sector.

MANAGEMENT STRUCTURE AND IMPLEMENTATION

Changing Organization and Evolving Project Needs

At the beginning of the PSP-One project, uncertainties about field funding and specific Mission private sector interest, and the need to identify which technical directions should be undertaken, affected planning for how activities should be organized and resources managed. As the project unfolded and resource needs evolved, its management recognized that the original structure required revision to preserve responsiveness. Consequently, the management approach was changed to respond more flexibly to the funding available and the pattern of actual demand for technical support from the field.

Year-One project organization revolved around seven technical areas, each headed by a technical expert; this structure allowed the project to explore efficiently areas that might provide the most opportunity for effective programmatic involvement. The burgeoning number of country-specific assessments, studies, and intervention activities that PSP-One undertook over the following years, however, came to require a more country-specific organization to maintain responsiveness and management attention to the field. The structure now has about 23 country- or region-specific managers, each reporting to one of three regional directors. A pool of technical experts available for country-specific assignments reports to the country manager (see self-assessment, “Year One Organizational Chart,” p. 72, and “Year Four Organizational Chart,” page 73). This flexible management approach has worked well to further progress.

Coping with the Breadth of Topics and Range of Skills Required

Given the broad range of subject matter covered by the PSP-One task order, project management had to access diverse areas of specialized expertise while keeping personnel or staff costs within limits. Project management has creatively used both short-term and intermittently available experts to access all the specialized skill areas needed to respond to Mission requests and further work in designated technical initiative areas. USAID has thus benefited from access to a flexible pool of experts from a variety of PSP-One organizations; and saved significant costs in not having to keep staff employed full-time.

The Pass-through Funding Experience

Several Missions benefited from PSP-One’s ability to accept pass-through funds for Mission-identified activities—a financial convenience for the Missions. However, direct oversight of pass-throughs by Abt, the prime organization for the task order, has been limited. Moreover, over time, the growth in popularity of the pass-through option and the increasing funding volume began to impact the funding ceilings envisioned for PSP-One. A current managerial concern now is monitoring ceilings in the main funding categories against the implementation time remaining.

THE IQC/TASK ORDER MECHANISM

Management and Administrative Impact of a Multiple Award IQC

The IQC mechanism basically creates an opportunity for prequalified groups to compete for future USAID task orders. In the example of the PSP IQC, the mechanism produced a pool of experienced cooperating agencies and organizations with a variety of institutional strengths. Organizations within the PSP IQC community generally expressed satisfaction with the IQC mechanism and liked the opportunity to compete for task orders. Some remarked that there seemed to be few task orders emerging for bid over the past 12 to 18 months and that their interest in bidding has to be balanced with the costs of the bid.

Because they compete continually against each other for task orders, cross-organization collaboration is difficult to achieve because IQC organizations are less willing to share information or plan collectively.

USAID missions express general satisfaction with the IQC mechanism, and the staff of several Missions like the option of issuing task orders themselves; it gives them more control and a greater sense of ownership. Missions universally report that it is critically important that any centrally issued task order be able to accept field support funding. The benefit to Missions of this option in a central task order is so substantial that the assessment team recommends the ceiling for field support funding be raised.

One complication of an IQC mechanism with multiple task orders is that it is difficult for IQC holders and task order recipients to predict the total effort they will be required to deliver or support, so it is more difficult for them to quickly assemble staff and keep the best mix of technical expertise available.

Experience with Mission Participation

Participation of missions in the PSP-One task order seems to depend largely on how much private sector program expertise and familiarity with the private sector field office staff have. The project country assessments were valuable in surfacing new private sector options within Missions; without them Mission participation probably would have been considerably less.

Without regional Bureau or other headquarters guidance on USAID expectations for private sector programming in health, opportunities to explore or initiate new private sector partnerships have been limited. This seems to have been particularly true in the E&E region. The presence of the field support funding option within the task order definitely increased Mission participation.

Challenges in Synthesizing the Total IQC Experience

The number of independent IQC contract holders and the issuance of separate task orders not directly linked in implementation makes capturing and synthesizing the entire IQC experience and comparing the merits of various approaches far more difficult than if there had been just one implementing agency.

Moreover, having different organizational loci for implementation complicates measuring and assessing overall project impact and collective progress toward health goals. Measuring impact requires assembly of comparable data and use of common measurement techniques. PSP-One did manage to draft common indicators for implementing organizations to use, but the process of doing so proved difficult; and the simplified nature of the indicators limits the extent to which overall impact from disparate activities can be assessed. The reporting indicators also do little to identify and compare private sector interventions.

III. CONCLUSIONS

The conclusions drawn from the findings of its assessment of the PSP-One Project are discussed here in terms first of project performance and then of project design.

PROJECT PERFORMANCE

Progress toward Intermediate Results

As its three annual reports state, the PSP-One Project has made progress in all five of its designated result areas. The only notable contribution to IR 4, scale-up of proven strategies, however, is the project's work with the National Health Trust HMO in Nigeria. Most of the contributions to IR 1, increase in knowledge and use of FP/RH and other health products and services from private providers, seems to come from more conventional social marketing models, fueled by pass-through funds. IR 5, monitoring, reporting and operations research, is the area where PSP-One has made the most progress, where the project has given the most examples, and where there is quantifiable expression of extending outreach beyond the project itself.

Many of the examples cited in the annual reports of progress toward the five IRs are process-oriented, making it difficult to evaluate the project's achievement in subresult areas. IR 3, related to policy, is the area where the project's process results are most closely aligned with subresults; consequently, there is substantial attributable progress in this area. In a number of subresult areas, project efforts that the team can identify as showing demonstrable progress in contributing to desired outcomes are characterized by three factors: financing through both field and core support funds (affording a wider array of interventions); opportunity for synergy between project efforts in multiple result areas (addressing several private sector factors simultaneously); and multiyear implementation (allowing for the possibility of more change over longer periods). India is a program that exemplifies all three factors.

The project's efforts related to subresult 2.2, QA systems for private providers adopted, have focused on method development, testing, and adaptation. The team was able to find few examples of actual adoption.

MAJOR PROJECT ACCOMPLISHMENTS

High-Quality Research and Effective Application of Evidence-Based Methodologies

The quality of the research undertaken by the project is widely recognized for its technical excellence. PSP-One's application of evidence-based rationales is innovative; it creates compelling arguments for the potential of the private sector to contribute to FP/RH and other health objectives. Technical standards for inquiry used in the project are worthy of replication by others and contribute substantially to the project's technical leadership role. One often-cited example of the excellence of the analyses undertaken under PSP-One is the groundbreaking market segmentation study being conducted in the Philippines.

A project stakeholder interviewed by the assessment team suggested that the already considerable value of the project's research could be increased if not only the study results but also the details of innovative study methodologies and questionnaires were shared with other entities working in the private sector health/FP/RH arena.

Creative Use of Assessments to Expand Private Sector Programming Options

By using country-level and other assessments of the private sector when new initiatives or programming choices were being considered, PSP-One effectively expanded the range of alternatives available when Missions or host countries seek to improve private efforts to reach health objectives. The assessments became opportunities to introduce new ideas into the planning process and generate more complete information about the marketplace for use in decision-making. Assessments also raised awareness within Missions and their public partners about private intervention options.

Expanded Policy Dialogue and Awareness of Policy Issues

PSP-One's efforts to address the policy environment have significantly broadened the policy dialogue to cover new parameters impacting or limiting the possibilities for private participation in achieving national FP, RH, and other health objectives. The project produced several briefs and tools to help policy makers better understand incentives for and barriers to greater private sector participation. Country assessments also were effectively used to identify policy issues and suggest ways to address them.

The project also succeeded in bringing new perspectives into the policy dialogue to represent a broader cross-section of the private sector. This achievement is vital in helping disparate public and private parties to achieve shared visions for common goals and better understand their own roles.

Increased Number and Range of Private Sector Outlets for Services

Through its country programs the project has increased the number and variety of private sector outlets and providers for FP, RH, and other health services. The team noted how additional channels (for example, nonpharmacy retail sales outlets in Honduras; village household product sales agents in India; HMO-affiliated private providers in Nigeria) had been or are being activated to provide services.

Innovative Service Delivery Approaches Introduced

The project looked beyond classical partnering for social marketing efforts to creatively incorporate different types of private entities that could bring new dimensions of outreach for health products or services. In India, for example, building an alliance with Hindustan Lever, with its innovative marketing approaches for reaching the "bottom of the pyramid" consumers, offers an exciting alternative to traditional pharmaceutical distribution networks. PSP-One had to overcome several hurdles to convince a household products producer to add FP products to those it distributes through community sales agents.

In other countries, too, PSP-One has gone beyond existing models to identify private -sector parties that could help achieve desired health outcomes. In Honduras the project supported efforts to reach out to bar and club owners/operators and small-scale businesses who could facilitate service delivery to groups at high risk for HIV/AIDS. To help address the financial constraints of some potential participants in Nigeria, the project added a bank to the collaborating partnership of private sector organizations.

Refined and Simplified Common Indicators for Reporting Progress

PSP-One core staff led a successful effort to draw up common indicators for measuring the effectiveness of work in the private sector that competing organizations could comfortably share. Indicators were simplified to make measurement more efficient and encourage regular reporting. They increased the information flow from the IQC community and made it possible to monitor collective progress in public-private partnerships across all IQC implementers. The use of common indicators also makes it possible to measure overall outcomes and comprehensive impact.

Advanced Understanding of How to Ensure the Quality of Services of Private Sector Providers

Improving and assuring quality within services provided are a continuing issue in considering an expanded role for the private sector in service delivery. One constraint has been the absence of widely accepted methods for reliably assuring that service delivery standards are met. By testing different QA tools and techniques, PSP-One advanced understanding of the potential of certain QA methods. Its staff have done well in tying quality improvement mechanisms directly to private provider financial interests, such as standards of accreditation for participation in HMOs or NHIS schemes. Tying quality of service delivery to continuation of income is probably an effective way to sustain improved quality of care.

Innovative Internet-Based Tools to Broaden Access to Information

In its efforts to increase exposure to and familiarity with private sector partnership topics, the project creatively used information technology media and tools to allow easier public access to health information. Web-based and e-learning technologies were successfully adapted to create on-line forums for information exchange, dialogue with expert panels, and technical conferences, among other activities.

The use of information technology has increased the number of persons accessing data both within the U.S. and internationally. The discussion and presentation forums have broadened the visibility of experience gained through the project and are being used by organizations or individuals outside the project to share partnership experience and raise common problems.

South-to-South Partnerships for Generic Drug Supply

One exciting outcome of PSP-One's efforts to date is their success in linking generic drug manufacturers in the developing world (i.e., India) with private-sector partnering opportunities elsewhere in the world. This effectively expands the private sector options for affordable drug supplies available to country programs and planners and thus helps address drug sustainability issues in private sector-based service delivery initiatives.

Business Motivations to Attract More Private Providers

One of the necessary steps in creating private sector partnerships is convincing private entities to participate. PSP-One has added new techniques for attracting private health care providers by creating ways in which participation can enhance business capacities and business/entrepreneurial skills. These methods, for example, are part of the project's activities in Nigeria, where small-scale private health care providers need better skills or facilities to effectively offer services through an HMO.

Successful Collaboration between Competing Members of the IQC Community

By its very nature an IQC mechanism creates an environment in which organizations participating must compete against one another for each task order. Most of the organizations within the PSP IQC already had a long history of competing for USAID-funded projects. Despite the potential for competitiveness, Abt and its partners in the PSP-One task order have created an effective collaborative environment. Useful were periodic meetings and the creation of technical panels of representatives from the various IQC organizations. The collaborative spirit increased willingness to share information and collectively articulate common issues in promoting public-private partnerships for service delivery.

Flexibly Accessed Staff

The breadth of topic areas in the PSP-One design and the diverse universe of country-specific circumstances mean that a broad array of technical skills or expertise may be required for specific activities. The management of PSP-One has effectively and flexibly assembled the staff required to respond to changing needs. Funding was insufficient to support full-time technical experts in all operational or needed subject areas, so PSP-One management has creatively drawn on periodic, part-time, or short-term technical expertise to respond to specific demands.

Assembling part-time or intermittent sources of TA as required has worked well. However, although offering more flexibility at lower cost, this seems to have increased the need for coordination, oversight, and follow-up from full-time staff. Still, the project effectively meets the increased coordination need.

Partnering Tools and Information

The project has produced a number of private-sector partnering tools, policy guides, and other materials that cover new technical areas or expand the experience base for private sector initiatives. Dissemination of these products has increased the resources available to those considering private sector partnerships for health services.

Effective and Flexible Responses to Mission Interests

PSP-One has met Mission requests for TA with high-quality support and has been flexible in responding to Mission programmatic needs. Evidence of this is seen in the use of the project by some Missions for funding pass-throughs to PSP-One partner organizations to continue to finance private-sector-based activities after the AIDS-Mark Project ended. With about 24 percent (\$12 million) of total PSP-One funding coming from such pass-through contributions, this has offered a significant financing convenience to USAID field offices.

AREAS WHERE IMPROVEMENT IS NEEDED

While the PSP-One project has an impressive number of major accomplishments, the assessment team has identified some areas of project performance that should be improved.

Quality of Private RH/FP Services

Although the project has used a quality scan tool in some countries, it has no fully strategic approach for selecting the most appropriate quality improvement interventions for a given environment. The potential impact of self-assessment in improving private provider quality has not yet been studied or established beyond the Ugandan context. Given the training and other inputs required, its replicability and feasibility has yet to be demonstrated.

Private Provision of Long-acting and Permanent Methods

The PSP-One project has not yet made a concerted effort to strengthen private provision of LAPM. The single such project—the NSV program in Honduras—does not seem relevant to the market. Few country initiatives have been identified, and few staff resources committed to this issue. This may in part be due to insufficient funding. It also appears, however, that LAPM has not been a project priority. The assessment team, for example, found little evidence of strategies or assessment tools designed specifically to attract the private sector to deliver LAPM services or new ways to assess the potential for greater private LAPM service provision. It seems unlikely that the project will make any significant contribution in this key area.

Mainstreaming the Private Sector into RH/FP Programming

The assessment team found little significant evidence of noticeable change since the 2006 survey among USAID staff in attitudes and perceptions about the private sector's role in health. The level of project field support funds—primarily for continuation of social marketing programs—also suggests that Mission staff attitudes toward the private sector are relatively unchanged. However, Guatemala now has a private sector intervention within its RH/FP portfolio, an indication that the project has had at least some success in inducing Mission staff to try private sector interventions.

The PSP-One Project so far seems to have focused its efforts at mainstreaming the private sector into RH/FP programming on information dissemination and raising awareness. While this is a necessary step in the behavior change process, it is not enough by itself to accomplish behavior change. PSP-One staff recognize that mainstreaming is more than just raising awareness but have made a conscious decision to concentrate on preliminary steps in the behavior change process—the stage where most countries and Missions seem now to be.

Scaling up Private Provider Networks

There has not been significant scale-up of successful provider networks or other proven innovations to date. Other than in India, the assessment team did not identify field support funds for scaling-up successful private sector interventions to generate more impact. It is not clear whether Mission funds are not available or whether Missions are not willing to use their funds to scale up private sector interventions.

The relative absence of field support funding for scale-up has led the project to identify, as in Nigeria with the National Health Trust HMO and in India with Hindustan Lever, alternative mechanisms for scaling up through implementation of innovative approaches within organizations that are themselves inherently capable of scaling-up successful trials. While promising, this mechanism is not yet proven.

Recognizing Strategic Needs

Focus on specific requests for assistance from Missions led in at least one case, Honduras, to the project missing private sector strategic needs and opportunities. While responsiveness to Mission requests and short-term needs is commendable, concentration on the more immediate details of project implementation can preclude or limit recognition of national opportunities for developing a private sector strategy, such as is needed when a country is soon to be graduated from USAID RH/FP assistance.

Replicating Models

According to USAID/New Delhi HPN staff, PSP-One staff did not anticipate the likely need to tailor the Mexican youth-friendly pharmacy intervention they wished to replicate to the particular FP/RH needs and cultural conditions of India. Almost a year was required to negotiate between USAID/New Delhi staff and project staff revisions and adaptations necessary for doing so. GH staff, however, saw this process as largely due to intense involvement and oversight by the Mission as well as the time required for the research needed to inform the design.

Searching for Innovative Approaches

While the project does look for innovative opportunities to involve the private sector in RH/FP product and services delivery in the countries where it works, the current country assessment process does not include an explicit component for investigating such opportunities. There also appears to be no process within the project structure for systematic review of current business news and literature and no regular channel for communication with targeted private sector leaders and innovators.

Better Relating Project Activities to FP Goals

The linkages between the project's private-sector-enhancing interventions and FP outcomes are not always strong. In Nigeria, for example, the project has successfully reinforced the business practices of private providers in an HMO/NHIS system, and the quality of service delivered by private providers is addressed through creative use of the HMO supervisory infrastructure. Only RH/FP counseling, however, is made directly available to consumers through this scheme. (An assessment of the proposed project identified counseling as an area of greatest weakness among providers, so FP methods are covered in the PSP-One training course. Promotion and sales of FP methods to providers depends on the efforts of a local social marketing program.)

PROJECT DESIGN

Major Strengths

- The comprehensive design of the current project promotes subject matter flexibility and allows activity in virtually any private sector area.
- The IQC mechanism encompasses many institutions, increasing USAID access to the technical and programmatic strengths of a variety of organizations.
- Including field support options within a task order gives Missions a needed funding alternative.
- The pass-through option is valued and used by Missions to support their portfolios.

Significant Issues

- The topical scope of the project design is so large and expansive that it may limit the project's ability to concentrate sufficient resources in areas where it can have more substantial impact.
- Having a single comprehensive private sector project tends to create a private sector domain or territory that is perceived to be "owned" by a project and its IQC holders, perhaps unintentionally limiting what other USAID GH projects can do to foster private sector partnerships.
- The IQC mechanism forces continued competition between IQC holders for each task order, complicating coordination and collaborative implementation.
- Some result areas do not seem to be closely linked causally to their supporting IRs.
- There is an inherent tension between the quest for innovation or technical leadership and the demonstration of programmatic impact (such as FP use). Perhaps it is unrealistic to expect the trial of innovative approaches to produce major changes in FP consumption or health behaviors.
- Limiting the use of core funds to demonstration of technical leadership or innovative approaches furthers the tension between the quest for innovation and the expectations of the project's IRs.

- There are no commonly recognized indicators of success for private sector partnerships (beyond sales figures, which are neither adequate nor sufficient).
- The large amount of funds for non-FP areas (such as HIV/AIDS) has the potential to dilute program effort and distract technical focus. This is particularly true for field support and Mission funding, where HIV/AIDS funds constitute nearly half of all PSP-One field financing.

The USAID Project Environment

- The assessment team sees no real change in how the private sector is viewed within USAID since the PSP-One 2006 study. The public sector orientation to addressing RH goals still predominates, and misperceptions or lack of understanding about how to work with the private sector remain.
- Many field health staff have little experience or familiarity with viable private sector partnership models.
- In most country development planning and health sector strategy exercises, roles for the private sector are noticeably absent or are little more than an afterthought.
- Private sector partnerships are not a consistent priority for health sector interventions and do not benefit from consistent top-level support. Management has not expressed clear expectations about the regularity or extent to which private sector options should be part of normal USAID health or population programming.
- There is no visible system for recognizing staff whose efforts meaningfully increase private sector involvement in achieving health sector or agency objectives.

IV. LESSONS LEARNED

Even though PSP-One is still underway, some lessons already have been learned. In assembling this prioritized list, the assessment team solicited suggestions from PSP-One Project staff and used information gathered from a variety of sources:

1. Infusing commercial innovation into USAID private sector programs requires flexibility, creativity, and time to align commercial interests with FP or RH objectives. It often takes considerable time to identify partners, inform them about public health goals, determine the specific contributions possible, and establish sound relationships.
2. Commercial alliances, particularly vibrant social marketing efforts, can lead to more equitable access to FP (i.e., greater FP prevalence among the poorest quintiles), an increased private sector share of the method mix, and greater FP prevalence.
3. A multipronged intervention that addresses demand, supply, and policy simultaneously (e.g., social marketing and pharmaceutical partnerships) is the fastest way to make substantial progress in private provision of FP/RH services.
4. Donors have leverage to improve FP market segmentation through the ways they channel their funding to service delivery sectors, which can stimulate change in the entire marketplace.
5. Generic manufacturers are changing the worldwide contraceptive market and have prompted established manufacturers with substantial product research and development functions to compete more aggressively for partnerships to meet the needs of lower-income clients.
6. Some project experience suggests that the manufacturer's model can be successfully adapted to sub-Saharan Africa through southern-based partnerships. This model could offer new options for contraceptive security there.
7. FP scale-up is faster and more sustainable when integrated into existing structures (e.g., midwives associations or HMO networks) than when introduced through an independent pilot initiative.
8. National health insurance schemes appear to offer a powerful infrastructure to increase sustainable access to services: Payment, monitoring, and accreditation mechanisms are already in place and the scale is already national. However, to have an appreciable impact on FP, RH, or other preventive services, national health insurance benefit packages must specifically cover provision of FP services, contraceptives, etc.
9. Considerable effort is sometimes required to ensure strong linkages between desired FP/RH results and private sector interventions. Once an opportunity is formed and a partnership defined, the FP/RH focus may become diminished in addressing the actions needed for the private partners or prevailing business practices to become viable contributors to the desired health sector objectives.
10. Weak or nonexistent structures for linking private providers are greater barriers to quality of care improvement than provider motivation. QA mechanisms (such as accreditation systems) that offer supervision or a system of checks and balances within a defined group of participating partners offer promise for the future.
11. Promising innovations for private sector delivery of services or products can come from nontraditional partners within the commercial arena. Many social marketing programs have looked to pharmaceutical manufacturers and distributors for options for making FP and other products more widely available. In India, the exciting base-of-the-pyramid approach PSP-One is exploring is based on innovations in village-level marketing developed by a large household products manufacturer.
12. Although some FP/RH private sector interventions (the DIMPA project in India, for example) may not in the short term produce significant increases in user numbers or CYPs, they can make other important contributions, such as creating an improved policy and public relations environment;

increasing the range of contraceptive options available; improving provider acceptance and willingness to try a method; and identifying and activating method and behavior change champions.

13. Mainstreaming the private sector in RH/FP programming within USAID, USAID Missions, and other donor organizations is not fully realized through information dissemination and awareness-raising alone. It requires changes in how donor organizations behave and operate.
14. Regularly collected, nationally representative household data about contraceptive use, RH, and other health practices are vital tools for dialogue with the private sector; assessing its role in prevailing health care use patterns; and determining the impact of private investment on FP sustainability. Thus it is important for USAID and other donors to continue to support national demographic and health surveys, even in countries where direct assistance for health or FP has ceased (e.g., after graduation).

V. RECOMMENDATIONS FOR THE FUTURE

The assessment team offers the following recommendations based on its assessments of the PSP-One Project and of the potential for private sector involvement in the health/FP/RH sector.

RECOMMENDATIONS FOR THE NEAR TERM

The team's recommendations for the near term are offered for the remaining 15 months of the PSP-One Project and perhaps beyond.

- ***Focus remaining efforts to maximize impact.***

Given the time remaining in the PSP-One Project, staff should narrowly focus remaining project efforts and available funding on advancing interventions that have high potential for sustainable impact so as to demonstrate more convincingly how and what can be accomplished through innovative private sector programming.

The ultimate project impact may be enhanced by (1) assessing which types of private sector interventions are likely to work best in which FP/RH markets and countries; and (2) developing a strategy to take selected interventions into the places where they are likely to have the greatest chance for success.

PSP-One should consider categorizing countries by market similarities rather than geographic region and designing intervention strategies according to market type (size, FP/RH status, national health insurance system, economy, health and commercial infrastructures, etc.) A country market matrix based on such a categorization might prove useful in policy and information dissemination activities.

- ***Mainstream the private sector into FP/RH programming.***

PSP-One needs an explicit strategy for mainstreaming/behavior change. Such a strategy should facilitate movement of host-country program planners and implementers, USAID Mission staff, GH and regional bureau staff, and other donor staff from awareness of private sector potential in FP/RH programming to trial and then adoption of the desired programming behaviors. USAID staff and other project stakeholders should help formulate the strategy.

The project also should consider segmenting USAID Missions according to each Mission's perceived private sector and partnership readiness. Then the mainstreaming strategy could include approaches for reaching each category of Mission with information appropriate to its point along the private sector "readiness continuum." Technical support could be adapted accordingly.

To implement the strategy successfully, the project might consider assigning more staff who are "connectors" and "salespeople" on its mainstreaming activities.

The team noted that in India the USAID Mission has a very active private sector portfolio and a progressive approach toward working with the sector. We recommend that a case study be undertaken to document the process through which USAID/ India became fully vested in bringing the private sector into FP/RH and other health area planning and programming. A better understanding of that Mission experience could be instructive for other Missions, particularly in (1) learning how to encourage or duplicate that process elsewhere; and (2) developing reasonable expectations about the time, effort, and environmental conditions needed to achieve that change.

Lastly, the project should continue to try to find ways to track how its information dissemination products are used and applied, and by whom. The data available are largely limited to the frequency with which information products are accessed or the number of documents sent. Without additional information, it is impossible to ascertain the extent to which the information provided influences planning or programming—and ultimately mainstreaming.

▪ ***Strengthen private provision of long-acting and permanent methods.***

A more concerted and intensive effort is needed to make significant progress in building private sector provision of LAPM services, based on a project assessment of how LAPMs fit into private provision of FP/RH services. This analysis should examine at least the following issues:

- The market or other conditions under which provision of LAPM is profitable for private providers
- A socioeconomic profile of current and likely LAPM consumers
- Current levels of LAPM use by method, unmet need, and potential demand
- Differentiation by method and by provider type of the current and possible future segmentation of the LAPM market between the public and private sectors
- Comparative benefits, if any, of private provision of LAPM by method
- The possible role of HMOs, insurance schemes, vouchers, and other financial mechanisms in creating or increasing the private sector share of the LAPM market
- Self-sustainable monitoring or supervisory infrastructures that are available to strengthen and maintain the quality of privately provided LAPM services.

This assessment should inform a plan for how, or whether, the PSP-One Project can strengthen private provision of LAPMs. Any future country-specific interventions should be based on information from such analysis and examination of country-specific data on demand for and use of LAPMs.

▪ ***Improve the quality of private sector FP/RH services.***

The work of the project in quality improvement would benefit from further development and use of a tool to assess the quality of private sector FP/RH services similar to the project's tool for assessing accreditation readiness. PSP-One has produced a "quality scan" tool for use in selected countries; however, the assessment team recommends creating an additional quality assessment capacity.

A general assessment of quality in the private sector should inform the process of creating country-specific quality improvement strategies. The information from the assessment would also facilitate choosing country-specific interventions and approaches for private sector QA that will be most efficient and have greatest impact, using existing management and supervisory infrastructures wherever possible.

The project should concentrate its remaining efforts in the area of quality improvement on "proving" interventions likely to have the highest impact, such as whether or not inclusion and enforcement of quality-related service protocols in HMO/NHIS/other insurance systems is an effective way to influence and sustain the quality of private FP/RH care. The team recommends that any further use of the self-assessment approach for private/commercial sector quality improvement be carefully considered and that its cost/benefit (or cost/impact) ratio be substantiated before significant future investment.

▪ ***Scale up private provider networks.***

Future country assessments should include assessment of (1) the willingness and ability of host country and USAID Mission to fund future scale-up of proven innovative interventions; and (2) the availability of networks that—because of their own resources, coverage, and financial interests—can and will scale-up innovative approaches once proven successful (the approach now being used in Nigeria).

▪ ***Broaden opportunities to identify strategic needs.***

As a regular part of its early work in every country, the project should undertake a broad assessment of the potential and need for private sector participation in FP/RH product and services delivery and of any special conditions (such as imminent withdrawal of USAID support for FP/RH services) that may affect the environment for private sector participation in planning and programming.

Core support should be available to the project to add these assessments to Mission requests for specific TA that is field support-funded. Such general assessments of private sector potential and the status of Mission programs may help identify additional ways for the private sector to contribute to achievement of Mission development goals.

▪ ***Expand the search for innovative approaches.***

In its remaining life the project could make an important contribution by undertaking a more explicit and systematic approach to identifying promising private innovations that could have relevance for FP/RH service or product delivery. This effort to canvass the latest developments in the commercial world and private sector innovations might include such activities as

- introducing new voices from outside the development sector,
- creating a council of private practitioners,
- including an innovation module in country private sector assessments (demand, supply, policy, and possibilities for innovation), and
- developing a plan for monitoring or tracking new approaches in consumer marketing and relevant fast-moving consumer goods.

RECOMMENDATIONS FOR FUTURE PRIVATE SECTOR INITIATIVES

The assessment team offers the following recommendations for the design and implementation of private sector initiatives beyond the life of the PSP-One Project.

▪ ***Formulate a comprehensive agency strategy for working with the private sector in health.***

USAID needs a comprehensive strategy for how to work with and through the private sector in support of its efforts to improve health worldwide. The absence of such a strategy makes it difficult to focus resources on the most meaningful approaches to involving the private sector. The strategy should identify the general objectives the Agency wishes to achieve through private sector partnerships and how commonly they should be part of Mission programs for the health sector.

▪ ***Create facility for private sector partnering in all global health projects.***

To maximize the potential for private sector involvement in and contributions to FP/RH goals, each global project should include a mandate to work with or develop private sector partnerships to help achieve the project's objectives. Doing so would help to mainstream work in the private sector as a normal component of furthering health agendas. Partnering with the private sector should be as regular an implementation approach in GH projects as working with the public sector.

Inclusion of a private sector component in every USAID-funded health/FP/RH should not, however, be seen as eliminating the need for a centrally funded PSP project. Such a global project should still provide much-needed technical leadership by identifying and initiating innovative approaches, collecting and analyzing data related to private performance in the health/FP/RH sector, identifying and addressing policies that affect the ability of the private sector to function in FP/RH services delivery, disseminating lessons learned and state-of-the-art techniques, and monitoring evolving marketplace dynamics.

▪ ***Clarify expectations for private sector involvement in FP/RH programming.***

It would be useful if those designing future private sector initiatives first draft a clear statement of donor expectations for private involvement in FP/RH programming. These expectations should be consistent with the overall Agency strategy for involving the private sector in achievement of health goals. The range of possible expectations for private sector involvement in FP/RH programming might include at least some, if not all, of the following:

- Replacement of donor resources for FP/RH services delivery as countries are graduated from donor assistance

- Improved targeting of public sector and donor resources to provide FP products and services to the poorest quintiles of the population
- Replacement of public sector and donor resources in demand creation
- Expansion of service delivery points beyond the reach of the public sector
- Transfer of financially able consumers away from public services
- Reliable availability of needed products
- Provision of services not available through the public sector,

▪ ***Focus efforts to test innovative private sector approaches on a few of the most promising areas.***

The PSP experience suggests that while a broad, comprehensive project design allows for activity in virtually any possible private sector area, the broad range of topics makes it difficult for significant progress to be achieved in any one area. Flexibility of response is most important in creating an adaptable capacity to reply to varying Mission needs. However, for core funding, the team recommends narrowing the operational areas to a few private sector themes that offer the most promise. Selection of those areas should be consistent with the Agency strategy for the private sector in health, specifically FP/RH.

▪ ***Emphasize the FP/RH focus in private sector partnerships.***

To maximize the potential for FP/RH impact in a future private sector partnerships project, it may be useful to provide some additional focus to the FP/RH and country conditions within which private sector interventions would be implemented. For example, project focus might be given to some combination of the following:

- Countries about to be “graduated” from USAID FP/RH assistance
- Countries with the greatest potential for scalable interventions, whether due to potential field support funding or to the inherent strengths and outreach of commercial entities
- Countries where HMO, national health insurance, and other provider network schemes already exist.

A possible project focus on countries with low contraceptive or other health behavior prevalence, hard-to-reach populations, or expanded use of unpopular methods should be informed by a realistic assessment of how effectively private sector partnerships can deliver those results.

▪ ***Invest in development of new measurements and indicators for successful private sector contributions to health development goals.***

Despite progress in developing a common set of implementation indicators under the PSP-One Project, defining and measuring health sector success resulting from private sector partnerships is largely incomplete. The current use of product sales, number of services provided, or funds leveraged is inadequate to fully capture impact.

Private sector contributions to health objectives need to be measured and defined in public health terms that are relevant to and recognized by public sector health planners. A future private sector initiative could make a major contribution to the field by furthering the quest for indicators or techniques to measure how activities undertaken by the private sector contribute to health goals.

▪ ***Identify new or expand existing private sector networks for products and services.***

The experience gained in the PSP-One Project suggests that networks of providers or business outlets offer considerable potential for increasing access to FP, RH, and other health services. Such networks also provide some of the best opportunities for meaningful application of QA mechanisms to the private sector. The team recommends that identifying new or expanding existing private service-delivery networks be a priority intervention area for future private sector initiatives.

- ***Incorporate current PSP interventions that appear to have relevance for the future and will remain worthy of additional investment.***

Among the numerous accomplishments of the PSP-One Project are several private sector interventions and approaches that appear to the assessment team to be especially promising and to warrant continued investment in any new private sector partnerships project. Interventions that seem particularly relevant for the future include at least the following:

- South-to-South partnerships for supply of generic products
 - Quality improvement interventions that are directly connected to private provider financial interests, such as standards of accreditation necessary for participation in HMOs or NHIS schemes
 - Base-of-the-pyramid marketing schemes, especially those that incorporate regular personal interface with the consumer (personal selling, which is important for behavior change, is often missing in FP campaigns that rely primarily on mass media)
 - Testing innovative approaches within existing private sector infrastructures that are inherently able to scale-up successes, such as in the project partnerships with Hindustan Lever in India and the National Health Trust HMO in Nigeria.
- ***Use core funds to provide technical assistance to Missions on the development of private sector strategies or the design of new private sector initiatives.***

Because many USAID staff are not familiar with private sector models, future global initiatives for the private sector should include the facility of providing TA and support to field missions or USAID headquarter offices. Such support could include technical assessments of specific interest areas but should focus on assisting in development of private sector strategies for health. TA should primarily focus on involvement of the commercial or for-profit elements of the private sector but could also help Missions consider alternatives for nonprofit organizations to play a role in service delivery.

- ***Facilitate information-sharing between and provide technical support for emerging public-private champions in ministries of health.***

Increasing numbers of ministries in the developing world, particularly in Africa, have recently created positions for fostering public-private partnerships for health. If such liaison functions are to have the greatest impact, it may be necessary to facilitate regular cross-country exchange of experiences and illustrative models that are being tried. Similarly, such offices may need TA to help formulate their role within their own government; develop country strategies for private sector partnerships; identify specific opportunities for partnering; and, support or foster the brokering of specific partnerships. This assistance capacity, therefore, should be a part of future GH initiatives for the private sector.

- ***Foster expanded dialogue with a broader corporate community in order to (1) surface new private sector partnering opportunities and (2) identify innovative approaches for marketing to broader or underserved consumer segments.***

The marketplace is constantly evolving as differing market forces become more influential and economies grow. To continue to bring the latest developments from the business world to bear on the potential involvement of the private sector for solution of public health issues, innovations that emerge from any part of the market should be considered for possible application to health.

Future private sector initiatives should include a component designed to explore the latest approaches for reaching consumers in developing countries or emerging markets. This might involve forums to exchange information with representatives of nonpharmaceutical multinationals, major third-world industries whose products reach lower-income consumers, or cell phone networks active in developing country markets.

A private-sector-experience implementing entity should then be charged with identifying and adapting innovative approaches identified for possible application to meet FP/RH objectives within USAID-assisted countries.

- ***Re-examine project expectations and performance indicators.***

The types of funding available and the results expected from the PSP project should be re-evaluated to diminish inconsistencies between what the project can do with core funds—innovative pilot interventions demonstrating technical leadership—and the expected FP/RH results stated in the IRs. Field support funds, which make possible scaling-up of innovative interventions to larger-impact FP/RH interventions, appear to be largely outside PSP-One control. The FP/RH impact of scaled-up innovative interventions would largely occur or be measurable outside the five-year life of a project.

Private sector partnerships often take considerable time both to develop and to implement. Reasonable expectations for development, implementation, and impact of a partnership within the five-year USAID-funded project should be defined.

- ***Place managerial emphasis on USAID's role in mainstreaming the private sector.***

USAID upper-level management should support creation of an environment that is actively and explicitly supportive and encouraging of mainstreaming the private sector into FP/RH programming. While top-down advocacy is not currently in favor as a management tool, overt expressions of interest in the progress and success of private sector interventions expressed by upper level management can help create an environment in which including the private sector in FP/RH programming is perceived to be the norm.

GH's current list of key technical areas does not include private sector partnerships. Perhaps GH should consider creating a list of key technical tools in which private sector approaches feature prominently. A champion of each tool might be named, as has been done for key technical areas, and given responsibility for advocating its use across technical areas and USAID projects.

ANNEX A. SCOPE OF WORK: MID-TERM ASSESSMENT OF PSP-ONE

The purpose of this assessment is to provide the USAID Bureau for Global Health (GH)/Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) with an independent mid-term assessment of its Private Sector Partnerships-One (PSP-One) project. The assessment will draw from and build on a self-assessment of PSP-One and a USAID Field Mission survey conducted by PRH/SDI to determine the need and anticipated future demand for a private/commercial-sector focused project. The assessment also will identify opportunities for possible future investment.

PSP-One is a five-year worldwide project that began on September 17, 2004, and will end on September 30, 2009. As the project is approximately half way through implementation, PRH/SDI is commissioning this mid-term assessment to examine the project's progress toward achieving planned results and lessons learned to date. The assessment team will identify PSP-One activities that may warrant continued future investment, as well as other private sector initiatives and approaches not covered by PSP-One but which would likely contribute to improving access to, use of, and quality of RH, FP, and other health products and services.

The external assessment team will have three main tasks:

- Task 1: Review PSP-One's technical and programmatic strengths, weaknesses, successes and constraints, identifying contributing factors. Based on the assessment findings, the team will present results achieved to date, document lessons learned, and make recommendations toward achieving planned results in the remaining period of project implementation.
- Task 2: Assess PSP-One's structure and management as well as the benefits and disadvantages of the PSP-One mechanism, a Task Order under a multiple award IQC.
- Task 3: Identify those PSP-One activities that warrant additional investment in the future as well as other private sector initiatives and approaches not covered by PSP-One but which would likely contribute to improving access to, use, and quality of RH, FP, and other health products and services.

Illustrative questions to assist in the assessment are provided below. The team is expected to refine, prioritize, and finalize these questions in discussion with PRH/SDI at the start of the assessment.

TASK 1: Assess Progress to Date towards Achieving Planned Results (Estimated level of effort – 40%)

1. What has been PSP-One's progress to date in relation to planned results and performance indicators (provided in the Results Framework and the project's Performance Monitoring Plan)?
2. What have been PSP-One's most important lessons learned to date?
3. How has PSP-One supported the scale-up and mainstreaming of proven private sector strategies and interventions?
4. What contributions has PSP-One made to global leadership, to advancing research and innovation, and to transferring new technologies to the field?
5. Given that PSP-One is core population-funded, does the project have a sufficient FP/RH focus?
6. What are the assessment team's expectations regarding the project's future progress?

TASK 2: Evaluate PSP-One's Structure and Management (Estimated level of effort – 10%)

1. What were the most significant structural or management challenges (e.g., with regard to project design, staffing, partnering, or funding) faced by the project?
2. The PSP-One mechanism is a Task Order under a multiple award IQC. What were the benefits and disadvantages of using this mechanism, particularly with regard to achieving project results? Suggest,

if needed, alternate management/administrative models and mechanisms for consideration in the design of future initiatives.

3. How has PSP-One demonstrated the value added of a global project versus a bilateral project? How has PSP-One complemented the work of bilateral projects?
4. A critical function of PSP-One is to advance private sector programming knowledge by synthesizing results among all PSP task orders and by documenting and disseminating evidence about both the strengths and the limitations of private sector approaches and strategies. What are the issues, challenges and lessons learned in monitoring, reporting, and operations research to support the overall accomplishment of the PSP IQC's goals and objectives?

TASK 3: Identify PSP-One and Other Private Sector Initiatives and Approaches that Warrant Future Investment *(Estimated level of effort – 50%)*

1. What are the key PSP-One initiatives, activities, and approaches that warrant continued/additional investment in the future (for example, promising pilot initiatives that could be scaled-up or applied in different settings)? Illustrative criteria for selecting promising activities and approaches may include:
 - Expanding voluntary access to quality family planning services
 - Promoting healthy behaviors
 - Broadening contraceptive availability and choice
 - Strengthening policies and systems to address family planning and reproductive health needs
 - Promoting equity in access to appropriate methods among women and men
 - Devoting special attention to meeting the needs of the underserved and those most at risk of adverse reproductive outcomes, for example, the lowest socioeconomic groups, urban poor, conflict affected populations, populations in biodiversity threatened areas, youth, men and postpartum women.
2. What are other promising, potentially sustainable private/commercial sector models and approaches, not addressed by PSP-One, that provided a social benefit and that should be considered for future investment? (See illustrative selection criteria above).
3. What are the outstanding issues and important gaps related to private/commercial sector contributions to improving access to, use, and quality of RH, FP, and other health products and services that need still to be addressed?

SUGGESTED METHODOLOGY

The team shall use a variety of methods for collecting information and data. The following essential elements should be included in the methodology as well as any additional methods proposed by the team.

PRH/SDI Team Pre-Assessment Briefing: The team will hold a preliminary meeting with the PRH/SDI Private Sector Team (that manages the PSP-One project) to review the scope of the mid-term assessment, agree on the key research questions, and finalize the schedule. The outcome of this meeting will be a detailed Work Plan for the assessment, including milestones and deliverables with due dates clearly established. In addition to formal briefing and debriefing meetings, the team may contact the PRH/SDI private sector team as necessary to provide updates on their progress and obtain additional guidance on logistics, additional data and information sources, etc.

Document Review: PRH/SDI and/or PSP-One will provide the team with a package of briefing materials related to the PSP-One assessment. This documentation will include:

- PSP-One annual reports, work plans and management reviews that are developed and reviewed as part of the continuous monitoring of the project
- A self-assessment of PSP-One, which will be completed in November 2007

- A USAID Field Mission survey to determine the need and anticipated future demand for a private/commercial-sector focused project, which PRH/SDI plans to conduct in January 2008
- Technical, research, and private sector program documents

The team also is expected to collect additional documents and materials, which it will make available to PRH/SDI for future use, and to review PSP-One's website, which includes a database of private sector projects and activities.

Key Informant Interviews: The team will conduct qualitative, in-depth interviews with key stakeholders and partners. Whenever possible, the team should conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. Key informants should include, but not be limited to:

- Experts with a variety of perspectives on private/commercial sector initiatives, including those from private voluntary organizations (PVOs), donor organizations, and representatives from the private and/or commercial sector
- PSP-One project staff
- Staff of PSP IQC contract holders (Abt Associates Inc., Academy for Educational Development, Chemonics, Constella Futures, John Snow, Inc., University Research Co., LLC)
- Staff of the PSP-One consortium members (Abt Associates Inc., Family Health International, IntraHealth International, Population Services International, Tulane University, Dillon Allman and Partners, Forum One, O'Hanlon Health Consulting, and Banyan Global)
- USAID staff that currently manage activities with private/commercial sector development and/or who have experience with other private/commercial sector procurements
- USAID/Washington (PRH/SDI) PSP-One project management staff
- USAID Missions, including those in countries in which PSP-One works
- PSP-One in-country partners, including pharmaceutical manufacturers and commercial enterprises.

Field Visits: The team is expected to travel to a sample of three countries in which PSP-One implements substantial activities – India, Ethiopia, and Honduras. The team is expected to interview project staff, USAID Mission PHN staff, other implementing organizations, and PSP-One partners (including local NGOs, private and commercial enterprises, professional associations, etc.) in these three countries.

E-mail/Telephone Survey: The team should design and implement an e-mail and/or telephone survey to poll USAID operating units, including field missions, that have bought into/worked with PSP-One regarding their level of satisfaction and experiences with the project.

DELIVERABLES

The consultant will contribute substantially to all of the deliverables below, as assigned by the team leader.

Debriefing Meeting: The team will hold debriefing meetings with PRH/SDI and PSP-One to present the major findings and recommendations of the assessment. This will be done subsequent to the data collection phase, but prior to the presentation of the draft report. The debriefing meeting will involve an oral presentation and written summation of the findings. Succinct briefing materials appropriate for the audience will be prepared and distributed during the briefings. Meetings will be planned to include time for dialogue and feedback. The team may also consider an informal debriefing solely with the USAID private sector team prior to documenting major findings and recommendations, to ensure they are on track.

Approved Work Plan: Including milestones and deliverables with due dates clearly established. This plan might include, but not be limited to, the following items: key research questions, methods, and tools; timeline for key activities, including product due dates; schedule of interviews, both internal and external; schedule of formal debriefing presentations.

Draft Report: The team will provide the PRH/SDI and PSP-One with a draft report that includes all the components of the final assessment report. USAID and PSP-One will provide comments on the draft report to the team leader within 10 working days of receiving the report. The contractor is then required to submit final unedited content within 10 working days after USAID provides its feedback on the draft report.

Assessment Report: The final assessment report should include, at minimum, the following: executive summary; scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs). The report should be no longer than 50 pages, including annexes.

Documents: The team is expected to provide PRH/SDI with documents and materials reviewed for the assessment.

DURATION, TIMING, AND SCHEDULE

The following is a sample schedule to be refined during the Team Planning Meeting in collaboration with USAID client.

Task/Deliverable	Timing	LOE		
		Team Leader	Second Team Member	Total LOE
1. Pre-assignment organization	2 days	2 days	2 days	4 days
2. Review background documents	5 days	5 days	5 days	10 days
3. Pre-assessment briefing with PRH/SDI	2 days	2 days	2 days	4 days
4. Information and data collection. Includes interviews with key informants, field visits, and e-mail survey	40 days	40 days	40 days	80 days
5. Draft assessment report	5 days	5 days	5 days	10 days
6. Debriefs with PRH/SDI and PSP-One team	2 days	2 days	2 days	4 days
7. USAID and PSP-One provide comments on draft report	10 days	0 days	0 days	0 days
8. Prepare final assessment report	10 days	5 days	0 days	5 days
Total # days	76 days	61 days	56 days	117 days

ANNEX B. E-MAIL SURVEY QUESTIONS OF FIELD PERSPECTIVES

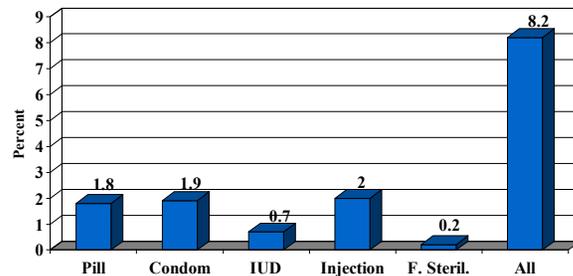
1. What did you want the PSP-One Project to accomplish in your country?
2. Were your expectations fulfilled? If not, why?
3. In your experience, what was the largest contribution made by PSP-One to your health sector goals?
4. What was the greatest challenge or constraint faced by the PSP-One activity in your country?
5. If there is to be greater private sector involvement in health services delivery in your country in the future, what will be the most important next steps?
6. If you were to re-access PSP-One Project assistance today, would you do anything differently than you previously did? If so, why?
7. Did you find that the PSP-One Project provided assistance in a timely way and appropriate to your country conditions?
8. How did the work of the PSP-One Project complement the efforts of bilateral projects in your country?
9. Did the IQC/task order mechanism work well for your needs? If not, why?
10. Any other comments or recommendations?

ANNEX C. COMPARISON OF FAMILY PLANNING USE IN THREE COUNTRIES WHERE THE PSP-ONE PROJECT IS ACTIVE

The assessment protocol included a more in-depth examination of PSP-One activities in three countries: Honduras, India, and Nigeria. One of the ways the assessment team looked at the FP/RH relevance and potential impact of PSP-supported activities in these countries was to examine the most recently available household survey data for contraceptive use, method mix, and existing role of the private sector in the provision of contraceptive services. The following graphs present the summary information assembled by the team for this exercise.

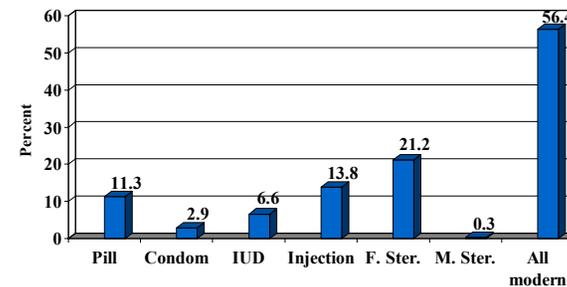
1. Current Contraceptive Use

**Current Contraceptive Use (MWRA)
in Nigeria by Modern Method**



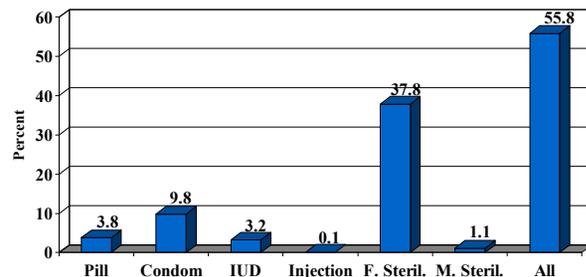
Source: 2003 Nigeria Demographic and Health Survey

**Current Contraceptive Use (MWRA) in
Honduras by Modern Method**



Source: 2005 Honduras Demographic and Health Survey

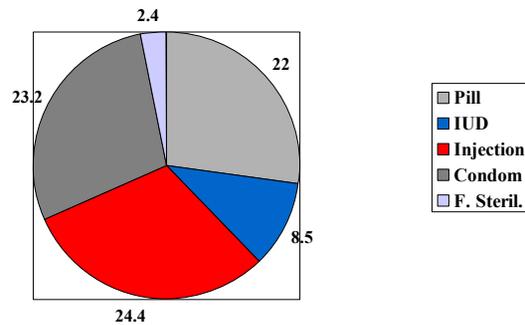
**Current Contraceptive Use (MWRA)
in India by Modern Method**



Source: National Family Health Survey-3, 2005-06

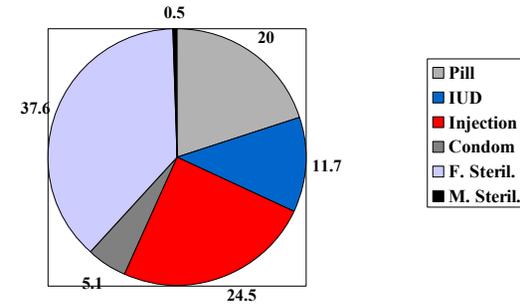
2. Contraceptive Mix

Contraceptive Mix (Percent) Among Current Modern Family Planning Users (MWRA) in Nigeria



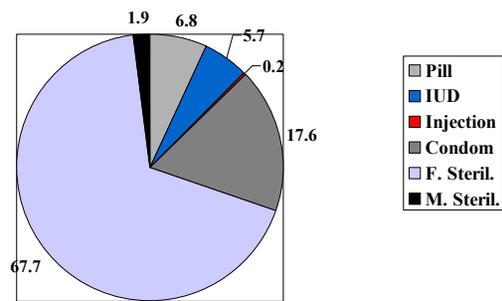
Source: 2003 Nigeria Demographic and Health Survey

Contraceptive Mix Among Current Modern Family Planning Users (MWRA) in Honduras



Source: 2005 Honduras Demographic and Health Survey

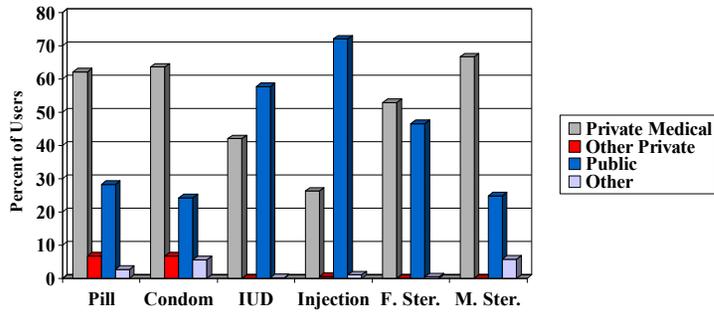
Contraceptive Mix Among Current Modern Family Planning Users (MWRA) in India



Source: National Family Health Survey-3, 2005-06

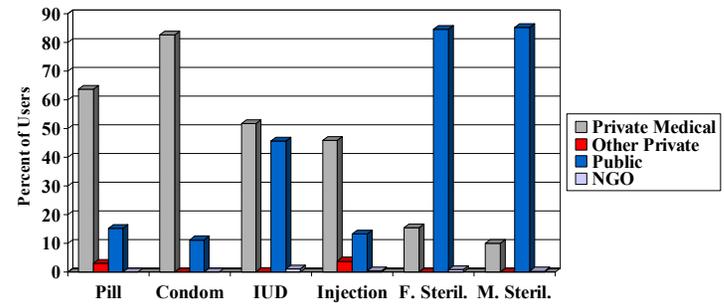
3. Source of Contraception by Specific Method

Source of Contraceptives Among Current Family Planning Users (MWRA) in Honduras by Modern Method



Source: 2005 Honduras Demographic and Health Survey

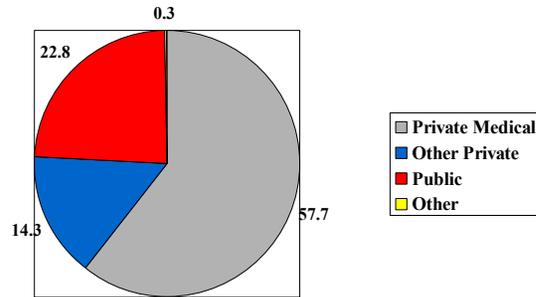
Source of Contraceptives Among Current Family Planning Users (MWRA) in India by Modern Method



Source: National Family Health Survey-3, 2005-06

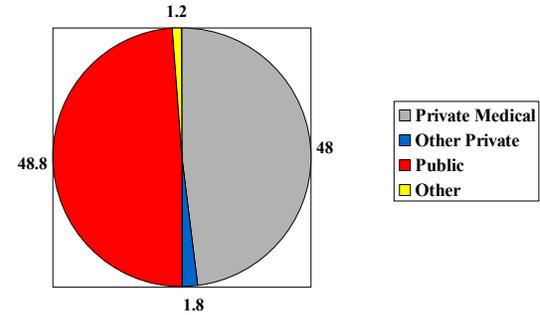
4. Source of Contraceptives for All Current Family Planning Users

Source of Contraception by Percent of All Current Family Planning Users (MWRA) in Nigeria



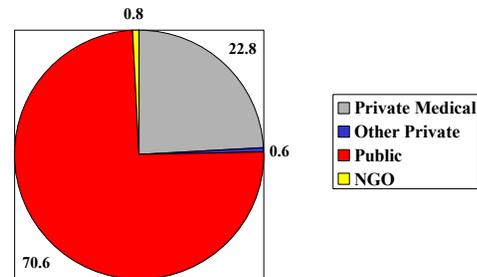
Source: 2003 Nigeria Demographic and Health Survey

Source of Contraception by Percent of All Current Family Planning Users (MWRA) in Honduras



Source: 2005 Honduras Demographic and Health Survey

Source of Contraception by Percent of All Current Family Planning Users (MWRA) in India



Source: National Family Health Survey-3, 2005-06

ANNEX D. LIST OF PERSONS CONTACTED

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