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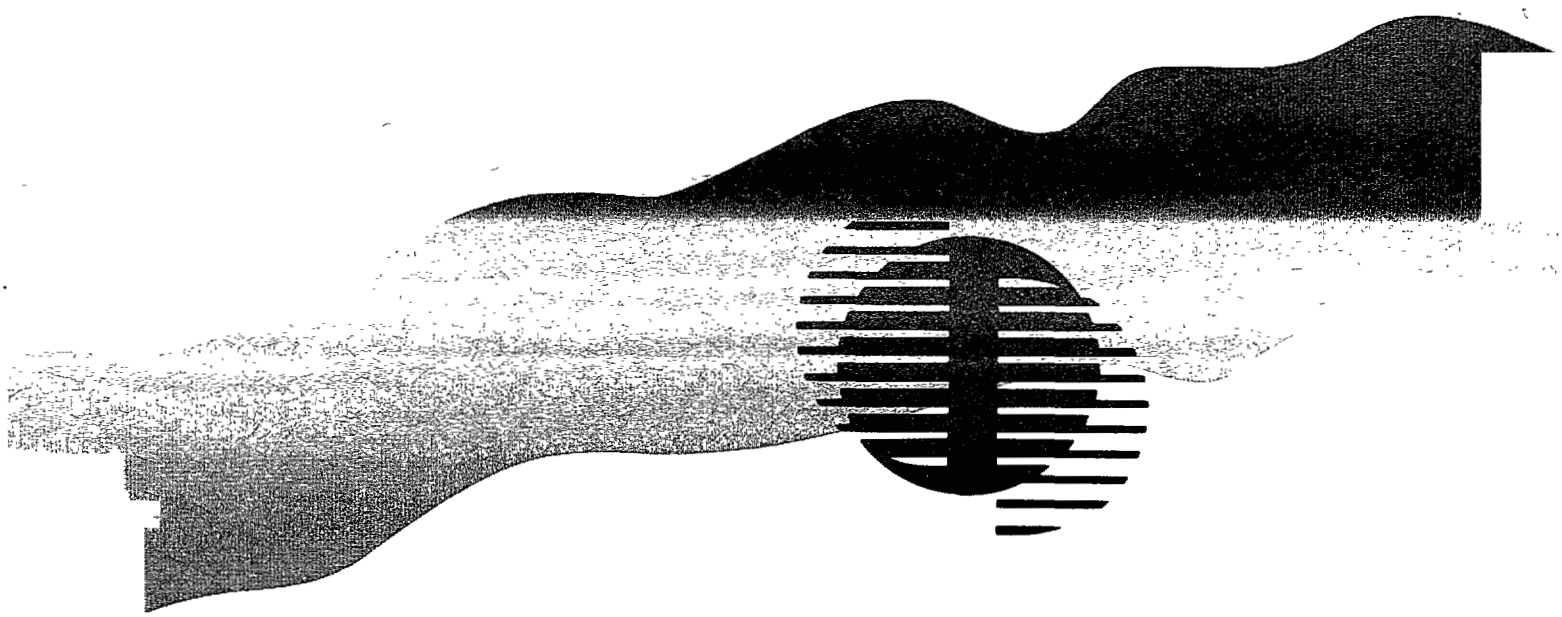
PROVEN APPROACHES, NEW STRATEGIES

INNOVATIONS, BEST PRACTICES AND LESSONS LEARNED FROM THE SEATS II PROJECT



SEATS

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Family Planning
Service Expansion
and
Technical Support

June 2000

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The goal of the Family Planning Service Expansion and Technical Support (SEATS II) Project is to expand the development of, access to and use of high-quality, sustainable family planning and reproductive health services in currently underserved populations. It built on the SEATS I Project (1990-1995) which preceded it

John Snow, Inc. (JSI), an international public health management consulting firm, headed a group of organizations implementing the SEATS II Project. These included the American College of Nurse-Midwives (ACNM), American Manufacturers' Export Group, AVSC International, Initiatives, Inc., Planned Parenthood Federation of America, the Program for Appropriate Technology in Health (PATH), World Education, and United States Agency for International Development (USAID) Missions and other partner organizations in each country where SEATS was active.

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Acronym List

AIDS	Acquired Immune Deficiency Syndrome
CA	Cooperating Agency
CBD	Community-based Distribution/Distributor
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CMA	Cambodian Midwives Association
CYP	Couple-years of Protection
EC	European Commission
FP	Family Planning
FPLM	Family Planning Logistics Management Project
FPPMES	Family Planning Program Monitoring and Evaluation System
HIV	Human Immunodeficiency Virus
ICO	Independent Clinics Organization (Zimbabwe)
ICPD	International Conference on Population and Development
IEC	Information, Education, and Communication
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Cooperation in Family Planning
JHU/CCP	Johns Hopkins University/Center for Communication Programs
LAM	Lactational Amenorrhea Method
M&E	Monitoring and Evaluation
MAPS	Midwifery Association Partnerships for Sustainability
MAQ	Maximizing Access and Quality
MOH	Ministry of Health
NGO	Nongovernmental Organization
OC	Oral Contraceptives
PATH	Program for Appropriate Technology in Health
PIR	Program Improvement Review
PLA	Participatory Learning and Action
PVO	Private Voluntary Organization
QIQ	Quick Investigation of Quality
QOC	Quality of Care
RACHA	Reproductive and Child Health Alliance of Cambodia
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
SANFAM	Santé de la Famille (Senegal)
SEATS	Service Expansion and Technical Support Project
SSK	Sosyal Sigortalar Kurumu; Turkish Social Security Institution
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization
WRC	World Relief Corporation
ZINA	Zimbabwe Nurses Association
ZNFPC	Zimbabwe National Family Planning Council

Preface

This paper provides an analysis of the SEATS experience. It describes innovations, best practices, and lessons learned in increasing access to and improving the quality of reproductive health services and in promoting their sustainability. It is the result of a project-wide analytic process that included input from all technical staff, in the field and at headquarters, as well as an assessment of SEATS data and reports. Various experiences summarized in this paper are described in more detail in other SEATS' reports and publications (see Appendix 1). Many of these documents are available on the SEATS website, **www.seats.jsi.com** or from the United States Agency for International Development's (USAID's) Development Experience Clearinghouse at **www.dec.org**.

Executive Summary

The purpose of SEATS II was to expand the development of, access to, and use of quality family planning and reproductive health (FP/RH) services in currently underserved populations and ensure that unmet demand for these services was addressed through the provision of appropriate financial, technical, and human resources.

The implementing agency for SEATS II was John Snow, Inc. in partnership with: the American College of Nurse-Midwives (ACNM), the American Manufacturers Export Group, AVSC International, Initiatives, Inc., Planned Parenthood Federation of America, the Program for Appropriate Technology in Health (PATH), and World Education, Inc.

The 1994 International Conference on Population and Development (ICPD) endorsed new ideas for addressing the reproductive health needs of people at different stages of their lives, emphasizing quality of care and the benefits to the individual of combining, or integrating, family planning with other elements of reproductive health care. The SEATS II project, which began in 1995, provided one of the first opportunities to test the practicalities of the ICPD ideas and to understand the challenges that they presented. The project responded by fostering the development of client-centered services that placed the customer at the center of all activities and, where appropriate, SEATS integrated broader reproductive health care—safe pregnancy services and the prevention of sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV)—into its core area of family planning.

The approach focused on interventions to expand access, improve quality of care, and enhance sustainability, and to leverage the synergies among these three core areas. SEATS implemented 30 subprojects and some 14 other activities in more than 20 countries. A characteristic of the project was that it faced a broad range of challenges and worked in a remarkable variety of situations, including countries new to USAID's population portfolio; countries with extreme poverty; countries with high HIV prevalence; countries coping with change, such as war, civil unrest, and health sector reform; countries with relatively longstanding FP/RH programs; and countries requiring large-scale national efforts in family planning and reproductive health care.

In all, SEATS trained 11,099 people in 632 training courses and established or improved 2,982 service delivery points. Through December1999, 773,943 couple-years of protection (CYP) were provided, 424,828 new users had been served and 1,143,128 revisits had been attended. The contraceptive prevalence rate (CPR) increased 44 percent in the aggregate from beginning to end of each subproject.

SEATS succeeded in reaching underserved clients in all its service delivery subprojects, but especially through five Special Initiatives that succeeded in engaging underused resources in providing care to the underserved. Through these initiatives, SEATS empowered city leaders, midwives, private voluntary organizations (PVOs) and nongovernmental organizations (NGOs), and community-based paramedical personnel, peer educators, and policymakers, enhancing their capacity to extend services to adolescents and to the urban and rural poor.

Innovations, Best Practices, and Lessons Learned

SEATS developed and used many innovative tools, models, and methodologies that are expected to be a lasting legacy of the project, with continuing importance to future generations of service delivery projects. SEATS used documented approaches gained through the collective experience

of programs worldwide and confirmed their value as best practices for expanding access to sustainable, quality services. The SEATS experience has lent legitimacy to the ideas that were advanced five or more years ago—the time leading up to and immediately after the ICPD meeting. What SEATS has done is to bring to life the real world of managing support for service delivery in a post-ICPD world. Its lessons reaffirm what many in the reproductive health community have learned over the last five years—a reassuring endorsement of the strategies adopted.

Access—making services available to clients: SEATS' experience with increasing access underscores the lessons of implementing more comprehensive reproductive health programs—a key goal of the ICPD. The project learned that:

- Access encompasses more than physical availability of services, and barriers to access still exist.
- All basic components of service delivery should be in place to ensure access and use—and some components are so vital that without them, other improvements lose their effectiveness.

Quality of care (QOC)—meeting client needs: SEATS sought to build a client-orientation among service providers, to mainstream continuous quality improvement, and to identify a workable approach to measuring quality. The best practices and lessons learned were:

- Quality must be built in from the beginning.
- The capacity for continuous quality improvement must also be built.
- Quality of care has three core aspects: improving the capability, or "readiness," of facilities to provide quality services, improving provider knowledge and skills, and increasing client satisfaction.
- QOC needs to be continuously monitored and measured—at different levels of the system.
- Attention to quality pays; it results in improvements, it empowers clients and providers, and it ensures that clients will pay more for quality services.

Sustainability—continuing to serve clients: Some clear directions for enhancing sustainability are indicated by what SEATS has learned:

- Investment from the outset in institutional planning and management capacity is fundamental to sustainability.
- The inherent tensions among rapid service expansion, service to the poor, and long-term sustainability can be managed effectively.
- Many sustainability issues are effectively addressed through the continuous quality improvement process of team-based problem solving.
- Access to contraceptive commodities is critical for program continuation.
- Public-sector and adolescent programs require special approaches to sustainability.
- Successfully leveraging additional resources can also create new organizational challenges.

General Lessons: Some of the lessons learned through the SEATS project are crosscutting:

- Unmet need is most effectively addressed through simultaneous, synergistic improvements in access, quality, and sustainability.
- Reinforcing evidence-based programming encourages ownership of problems and solutions and appropriateness of interventions.
- Future programming, particularly in systems undergoing decentralization, needs to build in a permanent capacity to collect and use data.
- Integrating family planning and other reproductive health services responds better to what clients and countries are demanding.

- At the global level, demand is high for a responsive, broad-based capability that combines proven approaches with new strategies.
- Sufficient time should be allowed in country for programs to be effective

Conclusion

The SEATS project highlighted the inter-relatedness of the three core elements of access, quality and sustainability. Most important, the project demonstrated that with a carefully managed approach to all three, it is possible to balance the apparently competing demands of expanding access, reaching the poor and achieving long-term sustainability.

In SEATS experience, a client focus is key. This concept, commonplace in the development community, was new to many in-country partners. Once equipped with the appropriate understanding and skills, however, they became enthusiastic proponents. Services flourished, and long-term sustainability became a real possibility. There are now proven approaches and the tools required to make profound changes in service delivery systems and providers. These approaches and tools offer the opportunity to make 'client focus' not just a consultant mantra but a cornerstone of the day-to-day activities of reproductive health services everywhere.

1. Introduction: The Family Planning Service Expansion and Technical Support (SEATS II) Project

The SEATS II project began in February 1995 immediately after the end of the SEATS I project (1989-1995). The purpose of SEATS II was: to expand the development of, access to, and use of quality family planning and reproductive health services in currently underserved populations and ensure that unmet demand for these services was addressed through the provision of appropriate financial, technical, and human resources.

1.1. SEATS Partners

The implementing agency for SEATS II was John Snow, Inc. in partnership with:

- The American College of Nurse-Midwives
- American Manufacturers Export Group
- AVSC International
- Initiatives, Inc.
- Planned Parenthood Federation of America
- Program for Appropriate Technology in Health
- World Education, Inc.

SEATS partners in countries: In the field, SEATS worked with any and all groups that could contribute to the aim of developing and expanding quality reproductive health services, including national and local organizations in the public sector, private sector NGOs and PVOs, and private providers (midwives, private practitioners, and pharmacists). Successful partnerships between the public and private sectors were a feature of many SEATS' field programs. SEATS also collaborated in programming and implementation with other USAID Cooperating Agencies, multilaterals like UNFPA and the World Health Organization (WHO), and USAID Missions in each country where SEATS was active. ***A key message from the SEATS experience is that no single organization can adequately address the range of challenges inherent in a comprehensive response to reproductive health needs.***

1.2. The Challenges

The original design of the SEATS project was grounded in a familiar argument: first, that there is a significant **unmet need** for family planning and second, that despite progress in recent decades, current national family planning programs all but ignore some segments of the population. These **underserved** groups include men, the unmarried, and the poor—especially the rural poor who are isolated from effective care by distance, cost of transportation, and inadequate knowledge of the options available. A special effort is needed to reach these groups and especially the enormous numbers of adolescents who are entering their reproductive years ill-prepared to promote and protect their reproductive health.

Meanwhile, the **HIV/Acquired Immune Deficiency Syndrome (AIDS)** pandemic has forced us to think of the consequences of sexual activity other than pregnancy. Yet it has also given family planning programs added importance. They offer the opportunity to help prevent the spread of HIV/AIDS and other sexually transmitted infections through the use of condoms and by providing information on responsible sexual behavior. The disease disproportionately affects the young and the disenfranchised, two key groups for a project seeking to reach the underserved.

Increasing **urbanization** and **health-sector reform** are presenting challenges, but are also opportunities to create new partnerships in expanding services, especially through the private sector.

Finally, the 1994 **International Conference on Population and Development** endorsed new ideas of addressing the reproductive health needs of people at different stages of their lives. It emphasized quality of care and the benefits to the individual of combining, or integrating, family

planning with other elements of reproductive health care.[1] These ideas have had important implications for service delivery programs.

The mid-1990s were also a time of great change for USAID. The Agency established the Population, Health, and Nutrition Center for better integrating these three programs. The field support funding mechanism, introduced in the first year of the project, shifted decision making more squarely to country Missions, and led to different emphases in programming. This, and a climate of uncertainty around international population funding, created challenges, especially in the early years, for planning and implementing a centrally funded project that had been designed with different funding mechanisms in mind. SEATS was expected to scale up activities in several countries supported under SEATS I, but with some Missions closing and other programs transitioning to bilaterals, the needs changed. In fact, almost half of SEATS' funds were devoted to countries new to USAID population programming, providing many exciting opportunities. All of these changes affected SEATS' programming.

1.3. The Response

SEATS responded to these challenges by fostering the development of client-centered services that put the customer at the center of all activities. Also, in response to demands from the field, where appropriate SEATS integrated into its core area of family planning, broader reproductive health care, including safe pregnancy services, and the prevention of STIs, including HIV.

SEATS took a strategic approach, with programming in countries starting with local needs assessments undertaken with local partners and key informants, reviewing existing information and data, and sometimes collecting new data, as needed, in simple surveys. Guided by assessment findings, SEATS built on existing local or regional resources and offered countries support for what they needed, whenever possible mainstreaming existing best practices, innovations, and materials developed by SEATS as well as by other USAID Cooperating Agencies (CAs) (see box for examples). The need was often to establish programs that ensured that all the key service delivery components were in place, were promoted, and showed improvement. This would typically involve SEATS staff and counterparts in customizing tools and curricula, and data collection, financial, and reporting systems to best meet local needs as indicated in the examples.

Adapting the tools of other CAs: In Russia, SEATS expanded on existing Russian-language curricula and tools developed by AVSC International, JHPIEGO, The Johns Hopkins University/Center for Communication Programs (JHU/CCP), and MotherCare, and used the JHU/CCP information, education and communication (IEC) materials to provide uniform support to the different regions served by the various CAs throughout the country. In Kyrgyzstan, SEATS strengthened the reproductive health component of the health reform program being implemented by Abt Associates, again using JHPIEGO and AVSC curricula that had been previously developed with, and sanctioned by, the Kyrgyz Ministry of Health. In Zambia, SEATS used a Participatory Learning and Action (PLA) Tool and peer educator training package developed by CARE and the Lusaka District Health Management Team to extend youth-friendly services to seven additional clinics in Lusaka. In Albania, Cambodia, and Turkey, SEATS adapted tools and techniques developed by the Family Planning Logistics Management (FPLM project).

The flexibility built into the SEATS design made it well able to address evolving and emerging challenges and a variety of field situations. The ability described above to address all aspects of service delivery was combined, when needed, with new strategies. These strategies were

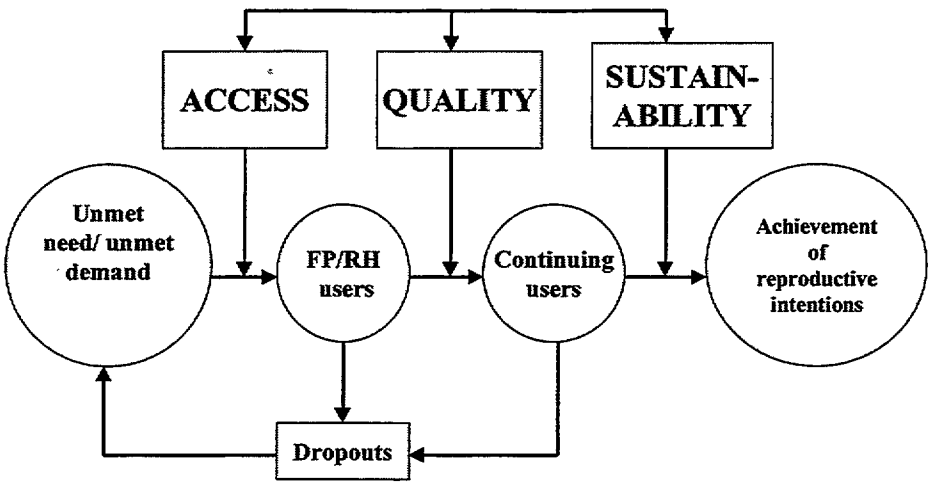
[1] *UNFPA. 1995, p. 4.*

developed primarily through five Special Initiatives (see below) that reached out to the underserved.

2. SEATS' Approach

SEATS' conceptual approach is illustrated in Figure 1. The unmet need and unmet demand for services, circled on the left, represents the potential users of FP/RH services. Activities to promote and expand access increased the numbers of users. For SEATS, maximizing access meant not just increasing the availability of quality services but making sure that people were aware of these services and had the information they needed to reach and use them. This meant working beyond static service delivery points to focus efforts on a continuum—beginning with individual clients and providers, extending to the service infrastructure and to the community that supports the services. SEATS' definition of access, therefore, encompassed psychosocial and cognitive barriers as well as physical, temporal, and administrative barriers.

Figure 1. SEATS II Conceptual Approach



Without adequate quality of care, however, many users drop out and again swell the numbers of people with unmet demand. So SEATS worked with its counterparts to improve the quality of care in reproductive health services and to make them more client-centered. SEATS' definition of quality was contextual, in line with its strategic, diagnostic approach to program development and its commitment to client orientation. Quality improvement was built into each subproject and focused on two interdependent components: 1) quality in perception—the recognition of clients' needs, expectations and level of satisfaction with the organization and delivery of services, and 2) quality in fact—performance according to up-to-date program guidelines, clinical protocols, and institutional and national policies that do not limit access or quality. Quality was viewed as dynamic, calling for continuous monitoring and improvement, and fragile—able to disappear overnight in the absence of monitoring.

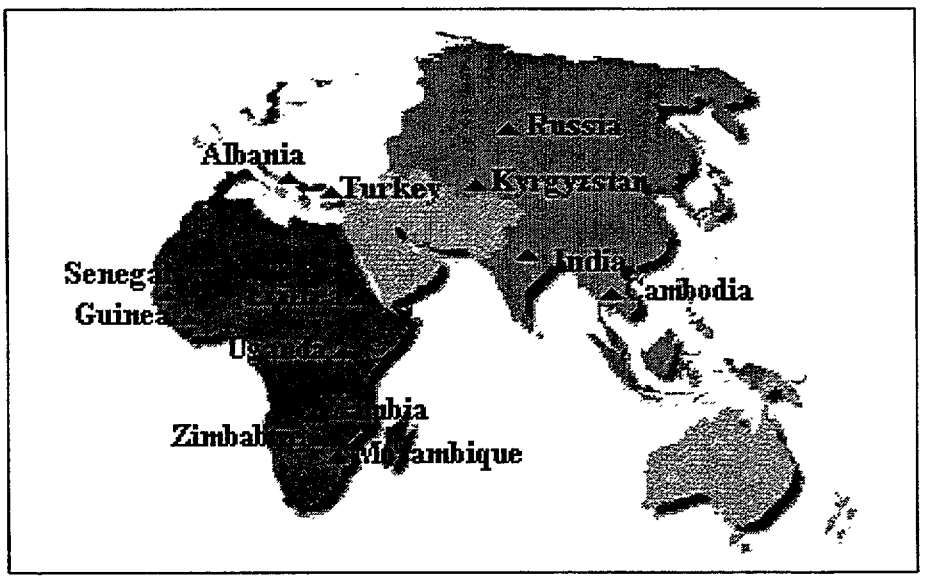
But if services are unsustained, even users who wish to continue will no longer have the option and their needs will go unmet. In SEATS, sustainability was viewed as the capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to an underserved population while decreasing dependence on external aid. Sustainability plans were developed for all service delivery projects.

Figure 1 presents a simpler picture than is really the case. In reality, access, quality and sustainability are closely interrelated, and changes in one can have marked effects—both positive and negative—on the other. Improvements in quality—changing clinic opening times to better suit the convenience of customers, for example—can lead to greater access. In contrast, efforts to enhance sustainability through charging fees can have a negative impact by generating economic barriers to access. Also, improvements in quality lead to increased demand, which in turn contributes to enhancing sustainability.

By deliberately addressing access, quality, and sustainability in a coordinated way, SEATS was able to promote access to sustainable, quality services and help clients realize their reproductive intentions. Details of SEATS' approach to expanding access, improving quality and enhancing sustainability can be found in the many SEATS' publications listed in Appendix 1.

3. Where SEATS Worked

SEATS implemented a total of 30 subprojects including 2 regional ones in Africa and 28 others in 13 countries in Africa, Central and South East Asia, Eastern Europe, and the Near East. An additional 14 initiatives were implemented in about nine other countries. Appendix 2 provides a summary of project activities by country.



The project faced a broad range of challenges and worked in a variety of situations.

Some illustrative examples follow.

SEATS developed programs in countries that were new to USAID's population portfolio. In fact, some 41 percent of SEATS' funds were devoted to helping USAID Missions in Albania, Cambodia, Eritrea, Kyrgyzstan, Mozambique, and Russia bring better health care to previously underserved people in these countries.

SEATS established or expanded services in countries with extreme poverty—per capita gross national product less than $400. SEATS confirmed that extreme poverty, although challenging, is not an insurmountable barrier to establishing high quality, sustainable services (see box)

Cambodia—overcoming the constraints of poverty: SEATS worked in Cambodia from March 1996 to January 2000 with three partner organizations—the Reproductive Health Association of Cambodia (RHAC), the Cambodian Midwives Association (CMA), and the Reproductive and Child Health Alliance (RACHA)—to improve maternal and child health by enhancing and expanding reproductive health service delivery. Efforts focused on better logistics management systems; protocols and guidelines for service delivery; quality improvement plans; information, education, and communication (IEC) activities; financial planning and leveraging; and training and continuing education programs. Despite a destructive recent history and severe poverty, intensive support from SEATS has enabled dedicated local partners to achieve outstanding results.

Key Activities

- Trained more than 1,500 service providers and clinic managers on topics such as counseling, family planning, safe motherhood, logistics, and management.
- Trained thirty midwives and six trainers in life-saving skills.
- Trained midwives to insert and remove Norplant® implants.
- Established a continuing education program within CMA.
- Established or expanded: three new clinics; existing community-based distribution programs; reproductive health services for youth; and antenatal and postnatal services.
- Established national logistics management information system.

> *"RHAC and CMA are the best local NGOs. They have good activities and have made good progress compared to other NGOs and associations."*
> —Dr. Eng Hout, Director General for Health, Ministry of Health

- Helped develop a national Safe Motherhood policy, strategy, and action plan.
- Enhanced partners' capacity to implement effective IEC efforts.
- Integrated logistics management into ongoing essential drug training programs.
- Integrated quality improvement methods into program management.
- Strengthened the organizational structure of RHAC and CMA.

Results

- Clients have access to 408 new and 468 improved service sites providing quality family planning services, including programs for youth.
- Midwives have the skills to decrease the incidence of infant and maternal death.
- Providers are better able to supervise, monitor, and implement changes to improve quality of care in reproductive and child health services.
- RHAC and CMA can sustain their operations through leveraging and cost recovery measures (see Figure 14).
- The Ministry of Health can procure and monitor contraceptive commodities and other pharmaceutical supplies through its new logistics management systems.
- A total of 88,023 CYP was achieved, and 69,677 new family planning users were served in the four years of SEATS activities in Cambodia.

SEATS made progress in countries with a reported HIV prevalence among pregnant women of up to 28 percent. In these places, family planning service providers had to deal with many issues related to the epidemic, including counseling on sexuality and risk, addressing infection prevention in their practice, and dealing with infected colleagues. Midwives in Eritrea, Uganda, Zambia, and Zimbabwe addressed issues of cross-infection between clients and providers, an area of great concern to them (see box). In Uganda and Zimbabwe, midwives also had to cope with ill staff and the need to weigh client fears, infection concerns, and the rights and needs of sick colleagues.

Using family planning as an entree for HIV/AIDS prevention was challenging for many service providers. For example, when SEATS field-tested the quick investigation of quality (QIQ)[2] assessment tools at 39 SEATS-supported clinical sites in Zimbabwe, the lowest scores related to the mention of HIV/AIDS in client-provider interactions. Also few non-condom users were told about their method's failure to protect against STIs/HIV, a disturbing finding in a country where HIV prevalence in the general adult population is close to 30 percent—one of the world's highest.

> *"In Uganda, it was so disheartening to sit in on monthly association meetings and have the names announced of more midwives who had died the previous month from AIDS."*
>
> SEATS Senior Technical Advisor, MAPS Initiative

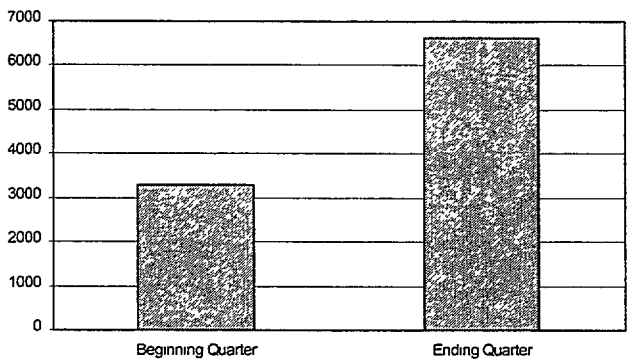
Three stories from countries with high HIV-prevalence:

Eritrea saw a significant drop in applicants for midwifery training because of fears of the risk of HIV infection. Experienced midwives, too, were afraid. SEATS provided training in infection control and data from a study in Uganda that showed relatively low risk in clinical situations versus personal situations. Eritrean midwives were reassured and training is expected to pick up.

In Zimbabwe, clients refused to be cared for by a midwife with AIDS. A CQI session discussed ways to reassure and inform clients about HIV transmission, ways to utilize the midwife's expertise with less direct exposure to clients, and how the clinic staff and community could offer support to her.

In a community survey in SEATS' catchment areas in Eritrea, 34 percent of respondents mentioned 'avoid injections' as a way to avoid AIDS, a finding which shows that clients may be denying themselves good health care because of the fear of cross-infection.

Figure 2. Condom Use Doubled in Cambodia, Mozambique, Uganda, Zambia, and Zimbabwe



Nevertheless, with SEATS' support, counterparts in Cambodia, Uganda, Zimbabwe, and Mozambique managed almost to double the use of condoms in the catchment areas of SEATS subprojects (Figure 2). Through peer education and training providers in youth-friendly services, SEATS made a special effort to increase condom use among young people who are in potentially high-risk situations and for whom condoms are often the most appropriate method. This initiative led to impressive increases in condom use by youth populations.

> *"This information is vital for my child's existence, especially in this AIDS age."*
>
> A parent in Gweru after visiting a city clinic's youth consultation room

SEATS succeeded in countries coping with change because it had the range and flexibility to meet a broad variety of challenges.

Kyrgyzstan and Zambia were both undertaking radical health-sector reform. Albania, Kyrgyzstan, and Russia were countries in economic transition after many years of communist rule, and had inadequate or non-existent FP/RH services. Cambodia and Mozambique were

[2] *The QIQ is a methodology developed by the MEASURE-Evaluation Project and the M&E subcommittee of USAID's MAQ Initiative. SEATS helped field test the methodology at all project sites in Zimbabwe.*

recovering from years of war and Eritrea was actually at war. A dedicated local staff was able to keep services going or even expanding in periods of civil strife and other disruption. This was a remarkable accomplishment in Eritrea, where many service personnel were called to the front.

Albania and Cambodia suffered severe civil unrest during the time SEATS worked in these countries. In fact, there were mandatory evacuations of US personnel from Albania, Cambodia, and Eritrea.

SEATS also improved relatively longstanding FP/RH programs—established over 10 years ago—in Russia, Turkey, and Zimbabwe. SEATS, in partnership with MotherCare, contributed much to the Russia family planning program, changing outdated practices, integrating family planning and maternal health care, and introducing the concept of client-centered services (see box). Training and a longstanding relationship with the Zimbabwe National Family Planning Council (ZNFPC) and local city councils, led to such outcomes as a 34 percent increase in CYP, improved quality as a result of broader method choice and training in counseling, and HIV prevention measures.

> *"Introduction of the client-centered approach is observed to lead to an increase in client satisfaction and motivation to select and use a contraceptive method."*
>
> Director, Oblast Family Planning Center, Novosibirsk Oblast

SEATS worked with governments in large-scale national efforts to bring quality family planning and other reproductive health services within reach of large numbers of people, often for the first time. More than 50 percent of SEATS spending was devoted to these national scale projects.

Working with AVSC in Cambodia and alone in Eritrea and Albania, SEATS advised on national policies and standards, provided protocols, guidelines, and curricula, and assisted in developing program plans and strategies. SEATS also supported the corresponding training, procurement, and commodity logistics.

4. SEATS Achievements

The data collected through SEATS II monitoring and evaluation activities suggest that the project succeeded in expanding access and improving quality.

- In all, SEATS established or improved 2,982 **service delivery points** (Figure 3), resulting in the availability of family planning and other reproductive health care where none had previously existed, or enabling existing sites to offer more methods, or broader reproductive health services.

Figure 3. Types of New and Improved Service Delivery Points

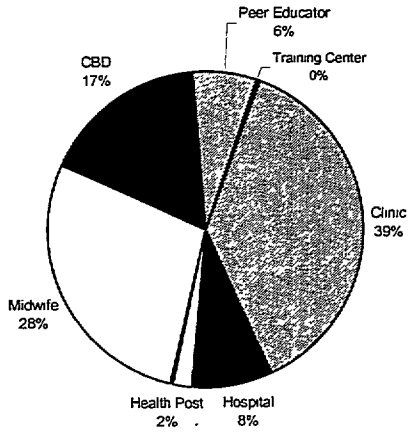


Figure 4. SEATS Cumulative CYP, New Users, and Revisits, 1995-99

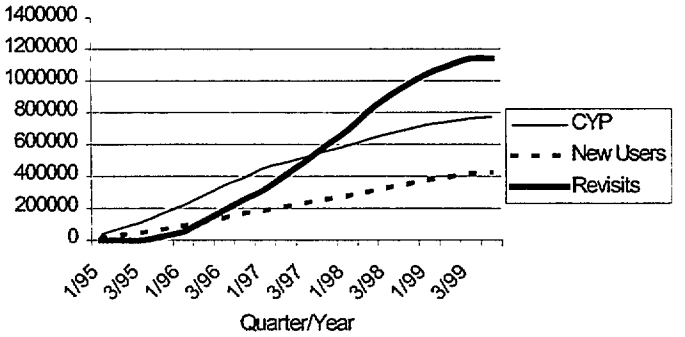


Figure 5. CYP Method Mix, Beginning and End of Project

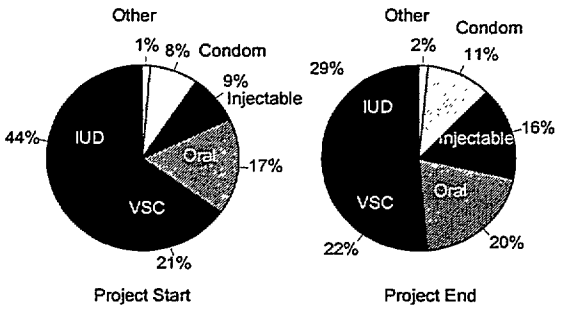
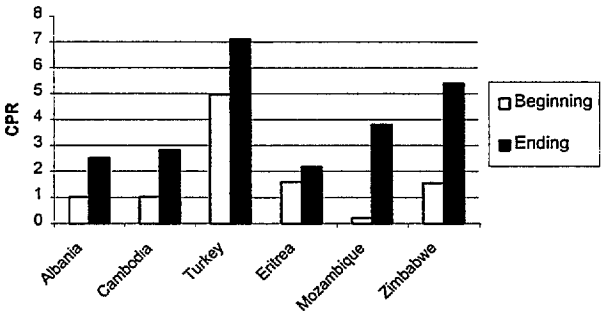


Figure 6. Contraceptive Prevalence Rates for Selected SEATS Subprojects, Pre- and Post-Interventions



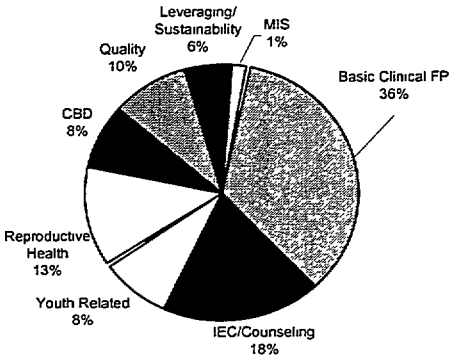
- Through December 1999, 773,943 **Couple Years of Protection** were provided, 424,828 **new users** had been served, and 1,143,128 **revisits** had been attended. Figure 4 shows cumulative CYP, new users, and revisits for all subprojects, by quarter. The relatively high level of revisits is encouraging as it suggests that large numbers of new users are continuing with family planning
- Most subprojects increased outputs over the course of their interventions. If the first-quarter CYP data for all subprojects are aggregated and compared with the aggregated last-quarter CYP data for all subprojects, the average increase is 15 percent.
- Another result of interest is the **broadening of the method mix**. Figure 5 shows the overall method mix of the first quarter of each subproject (left-hand pie) compared to the last quarter of each subproject (right-hand pie). At the beginning of SEATS most users—82 percent of CYP—opted for intrauterine devices (IUDs), voluntary surgical contraception (VSC), or orals. By the end of the project, the use of injectables, mainly Depo-Provera, and condoms had increased substantially and contributed over 10 percent of total CYP each. This reflects the popularity of injectables as relatively new methods in many SEATS countries of all regions and the appropriateness of condoms as a primary or dual-protection method in high-HIV settings.
- The increase in service use also resulted in a 44 percent increase in the **Contraceptive Prevalence Rate** among women of reproductive age in SEATS' catchment areas. Estimated CPR increased from 2.72 percent at the beginning of the subprojects to 3.92 percent at the end.[3] This is small in absolute terms, but SEATS was working in countries

[3] *CPR values were calculated for all subprojects using SEATS' Family Planning Program Monitoring and Evaluation system (FPPMES) system. FPPMES estimates CPR using service statistics and an estimated "catchment area" representing the population served by the project. The aggregate values cited in the text are calculated from total estimated users at the beginning and end of each subproject, divided by the number of women of reproductive age in the sum total of all subproject catchment areas in their first and last quarters. The*

with very low CPR and often in regions of those countries where prevalence was even lower. In fact, the impressive percentage increase in CPR shows that the project succeeded in increasing family planning use in underserved populations, even though the average duration of subproject interventions was just two years!

- CPR increased in 15 out of 18 subprojects for which at least four quarters of data exist. A few examples are provided in Figure 6, which shows the baseline and endline CPR in SEATS catchment areas in Albania, Cambodia, Eritrea, Mozambique, Turkey and Zimbabwe.
- In general, longer subprojects achieved more positive results than shorter ones. For example, CYP in the 10 subprojects that lasted 2½ years or more increased by an average of 39 percent between their first and last quarters, while those lasting less than 2½ years increased CYP by 2 percent. More time not only allows for more interventions but also offers a better opportunity to see results of interventions that take time to develop.
- Overall, 632 **training courses** were held, and 11,099 people were successfully trained in a variety of technical areas that were key to developing and expanding sustainable, quality services (Figure 7). These included: basic family planning; specific method introductions; STI prevention and treatment; integrated primary health care; IEC/counseling; youth-friendly services; and community-based distribution (CBD). Many of those trained were providers uniquely suited to reach underserved clients, such as youth peer educators, CBD workers in remote areas, and private midwives. This permitted new service delivery points to offer family planning, existing sites to offer more methods, and providers to reach new types of clients—youth and the underserved in urban and rural sites.

Figure 7. SEATS Trainees by Type of Training



4.1. Reaching the Underserved

These statistics cannot completely convey the richness and excitement of the SEATS experience—things that cannot be measured easily. Nor do they adequately convey that, despite the context or the situation in country, SEATS consistently succeeded in reaching underserved clients.

SEATS empowered city leaders in Senegal, Zambia and Guinea, midwives in Uganda, Zambia and Zimbabwe; PVOs and NGOs in India, Mozambique, and Zambia; and community-based paramedical personnel, peer educators, and policymakers everywhere. SEATS enhanced their capacity to extend services to adolescents and to the urban and rural poor and it did so largely through the **five Special Initiatives**. Through these initiatives SEATS reached new segments of the population, essentially starting from zero, so the numbers of new users and CYP, although

CPRs appear small mainly because large catchment areas were used. (Many subprojects intended to serve entire large cities or regions, when their true clientele was much smaller.) Had a more restrictive catchment area been used, the actual CPR levels would have been substantially higher, as would have the percentage point increase in CPR. This explains why the estimated CPR levels, both baseline and endline, are often well below levels measured through national surveys.

sometimes modest, were a true response to unmet need. Each of the Special Initiatives, their results and lessons learned, is the subject of a full, detailed report cited in the text. A brief description of the initiatives and their results follows.

The Youth Initiative [4] *(Albania, Cambodia, Eritrea, Guinea, Mozambique, Russia, Senegal, Uganda, Zambia, Zimbabwe)*

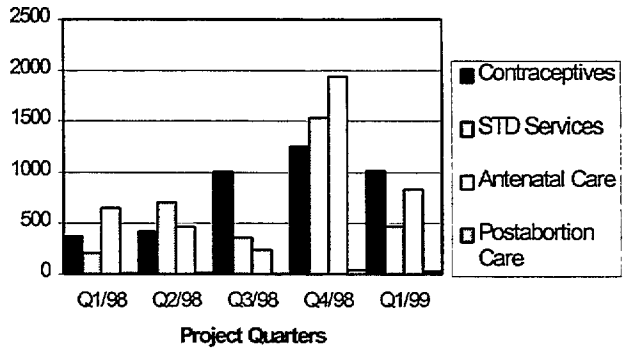
Reproductive health is a lifelong concern, yet health services often fail to consider the sexual and reproductive health needs of youth. Under its Youth Initiative, SEATS broke new ground in using multiple approaches to gain community acceptance and support for services that met the needs of adolescents and young adults. SEATS applied acknowledged best practices and novel approaches—outreach, peer education, community mobilization, and continuous quality improvement—and worked in a variety of settings—health care service systems, youth organizations and centers, military camps, schools, and communities. The aim was to:

- Build knowledge and skills for healthy decisions.
- Increase access to youth-friendly reproductive health services.
- Create a supportive environment for youth reproductive health information and services.

Most subprojects lasted two years or less but produced impressive results.

- 326 peer educators in six countries reached more than 200,000 youth in communities, schools, youth centers, and military camps in six countries with information, condoms, and spermicides.
- More than 25,000 youth received services for contraception, sexually transmitted infections, antenatal care, and treatment of abortion complications at youth-friendly clinics (Figure 8).
- Communities, providers, and governments supported youth reproductive health information and services. Support and funds were leveraged to enable expansion to other sites.

Figure 8. Services Provided to Youth in Lusaka, Zambia



Providing clinical services including contraception and STI treatment for young people is almost universally sensitive. However, SEATS found that a constituency for youth services can be built through careful process orientation early in the program, including advocacy, parent involvement, service provider training, and outreach.[5] Experiences with urban and youth programs in Russia, Senegal, Zambia, and Zimbabwe showed that even highly skeptical community members and leaders can become committed advocates when they hear young people's voices and see credible data outlining their needs.

Overall, SEATS found the public sector to be willing to pioneer new services for young people.

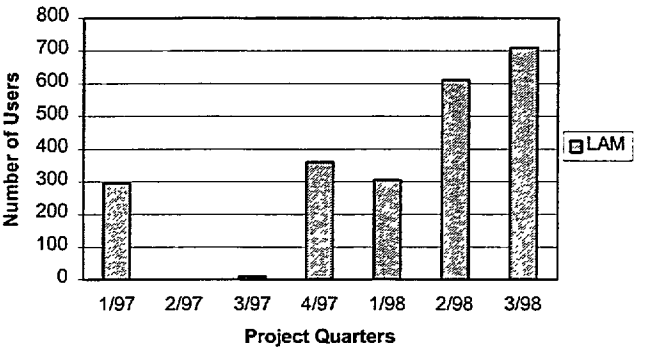
[4] *Newton. 2000.*

[5] *Newton. 2000 p. 52.*

The Midwifery Association Partnerships for Sustainability (MAPS) Initiative[6] **(Cambodia, Eritrea, Tanzania, Senegal, Uganda, Zambia, and Zimbabwe)**

Midwives, often the primary providers of family health services in urban and rural communities, are trusted by the populations they serve and have the potential to reach underserved populations with integrated reproductive health care. SEATS and ACNM assisted midwives to do this by strengthening their knowledge and skills, building the institutional capacity of midwifery associations, reducing policy barriers to private practice, and promoting quality and sustainability.

Figure 9. Senegal MAPS Subproject New Users Lactational Amenorrhea Method



This was a truly innovative program with huge potential for roll out in sub-Saharan Africa. Many midwives have transitioned into private practice—180 in Zimbabwe alone, established quality services, including youth-friendly services, in reproductive health, and attracted increasing numbers of clients in rural and poor urban areas. Use of FP/RH services increased substantially—private midwives in Zimbabwe served 52,121 new family planning users and generated 20,000 CYP—a rise of 144 percent in just over two years—while midwives in Senegal increased use of the lactational amenorrhea method (Figure 9). Strengthening the managerial and financial capacities of midwifery associations, leveraging community support and funds, and establishing national standards, accreditation, and monitoring was key to sustainability in Uganda, Senegal, Tanzania, Zambia, and Zimbabwe.

> *"When I am involved in my community, I am much more successful."*
>
> *"Being known and respected for providing quality care is the best part of being in private practice."*
>
> Zimbabwe Nurses Association members

This initiative has demonstrated that, when well trained and supported, private-sector midwives are a dynamic force for increasing access to high-quality, sustainable FP/RH services. However, continuing barriers to private practice severely limit the expansion of this program and their removal is key to the future expansion of this approach.

The Urban Initiative[7] **(Guinea, Senegal, Zambia, and Zimbabwe)**

Africa has the highest rate of urban growth of any region in the world. Rapid urbanization can undermine the ability of national and local governments to plan for and satisfy current and future demand for health and social services. SEATS focused on increasing the capacity to provide sustainable, high-quality reproductive health services to the growing volume of clients in ten African cities, using a variety of innovative tools (see page 14) and strategies:

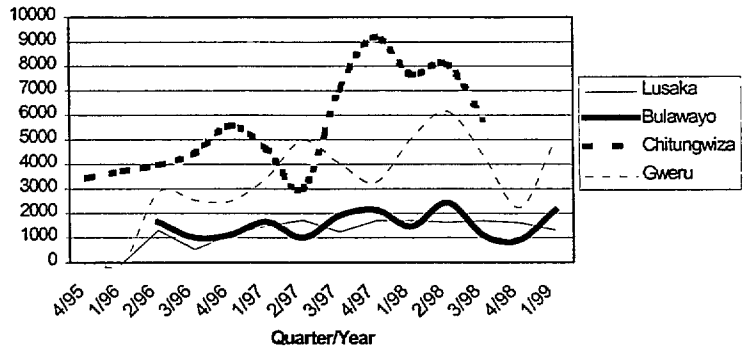
- *Partnerships with municipal and local authorities:* Developed the skills of elected officials and staff of city health departments for more effective program planning and management.

[6] *Houde Quimby and Mantz. 2000.*

[7] *Rossi. 2000.*

- *Evidence-based planning and management:* Collected and used data to identify underserved populations and weaknesses in services and to design interventions.
- *Coalitions of public-sector and private-sector organizations.*
- *Multisectoral advocacy partnerships:* Promoted reproductive health and leveraged funds from governments and donor agencies.
- *South-to-South exchange* for technical assistance and shared experiences.

Figure 10. SEATS Urban Subprojects CYP



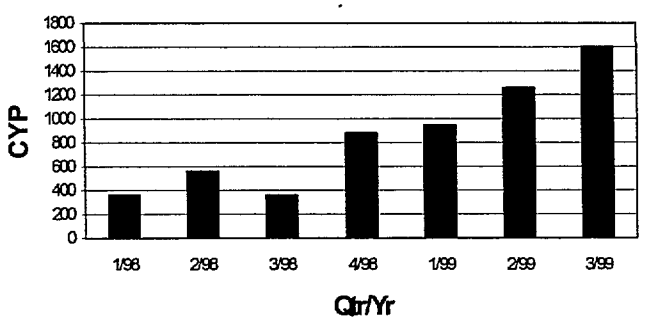
In the ten cities where SEATS worked there are now more than 100 new or improved service delivery points where clients have access to a wider variety of contraceptive methods; methods increased from one to eight in Lusaka. Statistics available for four cities where the Urban Initiative resulted in SEATS subprojects, show 81,000 new contraceptive users were served and 221,000 CYP were generated (Figure 10), 126,000 youth were reached with reproductive health information and 5,000 young people received contraceptive services.

The Urban Initiative showed that partnerships among municipal governments and public- and private-sector groups could use urban resources effectively to extend access to quality reproductive health services despite increasing urbanization.

The Integration Initiative[8] *(India, Mozambique, and Zambia)*

PVOs and NGOs have been implementing high-quality, community-based activities for many years in such sectors as rural development, health, education, and water and sanitation, serving populations that are often not reached by government or other service providers. While health has been an important intervention for many PVOs and NGOs, family planning has not been a focus for most. Through the Integration Initiative, SEATS specifically helped PVOs and NGOs, including those not already involved in health activities, to incorporate high-quality, client-centered FP/RH care into their existing programs, thereby expanding services to the underserved.

Figure 11. CYP Provided by Save the Children Subproject, Mozambique



The work resulted in two integration handbooks, a trainers' guide, and a quality improvement package. They outline step-by-step methodologies for integration and an increased capacity to provide sustainable FP/RH services. Such services are now provided to communities in Mozambique (through World Relief Corporation (WRC), Health Alliance International, Save the Children, and Terre des Hommes), India (PLAN/India), and Zambia (World Vision).

[8] *JSI. 2000.*

In the WRC/Mozambique subproject area, 98 percent of residents now live within 5 kilometers of a family planning service delivery point, compared to 54 percent at baseline. Figure 11 shows the increase in CYP provided by Save the Children over the period of collaboration with SEATS. In Zambia, 18 new service delivery points have been established by training CBDs who are the primary source for contraceptives in the project area. CPR among women of reproductive age in SEATS catchment areas increased from 0.2 to 3.8 percent in Mozambique, and 8 to 36 percent in Zambia.

Overall, SEATS showed that it is possible to effectively integrate FP/RH programs into ongoing PVO/NGO activities, even when these are not already health related.

The Literacy Initiative (Mozambique and Senegal)

SEATS, with World Education, Inc., sought to provide models and materials to link women in literacy programs with reproductive health information and services. The experience led to developing and distributing *Vital Connections: Linking Women's Literacy Programs and Reproductive Health Services*, which offers practical guidance for linking literacy activities with reproductive health services (see box).

Literacy program facilitators and learners welcomed efforts to introduce health information through sound literacy practices. Despite the timeliness and potential benefits of this initiative, however, it got off to a slow start. In part, this was because it was difficult to mobilize the field support needed to implement cross-sectoral activities. Competing priorities and resources among partners and donors restricted the initiative's success. However, much was learned about how to bridge literacy and reproductive health services in the process, and the enthusiastic reception of the initiative's activities in Senegal and Mozambique and the handbook demonstrated that there is demand for linked literacy/RH services.

Building bridges between the health sector and the literacy sector requires careful attention to financial, administrative, and bureaucratic requirements as well as to technical issues.

Stronger support for cross-sectoral strategies by donor agencies could open an important channel for increasing access to reproductive health services. In the new climate of cross-sectoral collaboration, there is reason to be optimistic about the future of this approach.

> ***Vital Connections: Linking Women's Literacy Programs and Reproductive Health Services***
> This informational and "how-to" handbook explains both why and how literacy and family planning and reproductive health can be linked. It facilitates an understanding of the unique features and needs of both literacy and reproductive health programs and suggests a variety of approaches for linking the two. Program sponsors and developers are encouraged to devote resources to undertake such innovative cross-sectoral activities.

5. Products of the SEATS Project: Tools for Access, Quality, and Sustainability

SEATS developed and used a variety of tools, models, and methodologies described below. We believe they will be a lasting legacy of the SEATS project, with continuing importance to future generations of service delivery projects.

- *Integrating Reproductive Health into NGO Programs. Volume 1: Family Planning, Volume 2: Safe Motherhood*: Integrating elements of reproductive health into the work of NGOs/PVOs that are focused on other health programs or development sectors is a cost-effective and efficient method of increasing access to quality of reproductive health services to underserved populations. These handbooks focus on interventions that can be implemented at the community

level to complement and collaborate with existing public and private services. They describe the essential steps to consider in the process of integration.

- *Business Skills for Private Midwives Curriculum*: To increase the sustainability of private-sector midwifery services, this curriculum emphasizes the relationship among continuing education, improvements in the quality and scope of reproductive health care services, and business viability.
- *Community Mobilization Curriculum for Private Midwives*: To increase the effectiveness of private midwives, this curriculum gives private midwives tools to expand their active involvement in the community and to improve access through increased client awareness of their services.
- *Family Planning Program Monitoring and Evaluation System (FPPMES)*: This software application converts quarterly contraceptive supply data and population size and growth rate information into couple-years of protection to then estimate contraceptive prevalence rates. FPPMES has proven to be a useful and enormously popular tool.

Innovative tools for urban programming: Models and tools developed by SEATS have the potential to help cities worldwide ensure that all of their inhabitants, and especially the urban poor and youth, have access to reproductive health services. These contribute to improved evidence-based planning and more targeted use of existing resources.

- ***The Client Contact Estimator***. This software program estimates the number of client contacts an urban family planning program will have to support in the future so policy makers can decide when and where to open new sites and whether or not to introduce additional contraceptive methods.
- ***Socio-Sanitary Mapping***. These exercises produce new maps that identify potential resources, new places for outreach, and opportunities to work with non-health sectors.
- ***Best Practices Model***. This engages municipal health departments and private-sector partners in analyzing local reproductive health data and adapting best practices to address concerns of access, quality, and sustainability. Partners advocate for increased resources and use data to track progress.
- ***Empowerment Model***. Also known as the "Quick Study" model, this approach targets elected mayors and supports democratic institution building and decentralization policies. It encourages local officials to seek solutions to problems and increases their ability to mobilize and manage resources.
- ***Non-Traditional Sources of Technical Assistance***. Using locally and regionally available technical assistance reduces costs, strengthens partnerships, and fosters sustainability while building skills. Mayors and municipal health authorities draw upon consulting firms, university professors, retirees, employees from other ministries, business owners, and local politicians.
- ***City-to-City Collaboration and Technical Assistance***. Technical exchanges of municipal officials and family planning specialists involved in urban subprojects promote skill transfer, self reliance, empowerment, and sustainability.
- ***Reproductive Health Open Door Days***. Citizens visit the mayors and their staff to discuss health priorities and focus attention on reproductive health. Open Door Days make a direct link between locally elected officials and their staff, the community, and health service providers within their neighborhoods.

- *Guide to Leveraging: Mobilizing and Diversifying Resources for Reproductive Health*: This handbook helps managers analyze, design, and implement approaches to leveraging resources.
- *Vital Connections: Linking Women's Literacy Programs and Reproductive Health Services*: This guide builds the case for connecting reproductive health and literacy programs and provides steps for doing so.
- *The Program Improvement Review (PIR) Package*: The PIR Package outlines and provides tools for implementing a continuous quality improvement process for community-based programs.

SEATS also built upon the tools and techniques of other CAs, including:

- *Clinical Protocols Resource Book*: Used in developing or revising clinical protocols for FP/RH programs, this book includes numerous state-of-the-art materials from other CAs and organizations.
- *Essentials of Contraceptive Technology*: Distributed to all subprojects and, as part of the NGO/PVO Integration Initiative, to all child survival PVOs supported by USAID's Bureau for Humanitarian Response.
- *MotherCare Curriculum and CARE Youth Program Model*: Used in the Zambia Youth program.
- *JHPIEGO Family Planning Guidelines*: Used in Kyrgyzstan, Russia, and Turkey.
- *Maximizing Access and Quality (MAQ) Client-Provider Interaction Guidelines*: Incorporated in SEATS counseling training as a best practice.
- The *QIQ* methodology developed by the *MEASURE-Evaluation Project* and the Monitoring and Evaluation (M&E) Subcommittee of the MAQ Committee: Collaborated with MEASURE to field-test these tools for monitoring family planning quality of care in the 39 clinical sites supported by SEATS in Zimbabwe. Modified versions of the tools were also used in two subprojects in Mozambique and in Eritrea.
- *Population Council's Situation Analysis Study*: Used a streamlined version of this methodology in Urban Initiative sites.

6. Innovations, Best Practices and Lessons Learned

SEATS' innovations include the numerous tools, guidelines and curricula detailed above and those in monitoring and evaluation listed on page 35. Innovative approaches and lessons learned can rapidly become adopted as best practices, making the distinction among these rather artificial. SEATS often used documented approaches gained through the collective experience of programs worldwide, and confirmed their value as best practices for increasing access, quality and sustainability. For instance, SEATS, the Lusaka Urban District Health Management Team and USAID/Zambia replicated the successful CARE Community Family Project already operating in eight clinics in Lusaka in seven more urban health centers, working to refine methodologies and programming to become a best practice for implementing youth services in that setting. The SEATS experience has also brought to life the real world of managing support for service delivery in a post-ICPD world. The lessons learned support the approaches endorsed at the ICPD and reaffirm what many in the reproductive health community have learned over the last five years, a reassuring endorsement of the strategies adopted. For all of these reasons, the following sections on access, quality, and sustainability do not distinguish among best practices, innovations, and lessons learned, but rather highlight the main insights SEATS has gained that can help future projects and programming.

6.1. Access—Making Services Available to Clients

Increasing access to FP/RH services, is a fundamental goal of almost all FP/RH projects, including SEATS, and is typically the first program component to be addressed. Much more is known about it so there are likely to be fewer new lessons that SEATS can offer. In fact, SEATS' experience with increasing access underscores the lessons of implementing more comprehensive reproductive health programs—a key goal of the ICPD.

Access encompasses more than physical availability of services, and barriers to access still exist

> *"All participants indicated that the health station was inaccessible because they had to travel either on a camel or donkey for a whole day to get there."*
>
> Report on focus group findings
> Eritrea

SEATS learned early in the project that expanding access meant more than simply increasing the number of family planning sites for married women. This does not diminish the importance of physical access as a variable that determines whether or not clients obtain services. In many countries where SEATS worked, lack of geographic or physical access to services was one of the key reasons for not using FP/RH. For example, in Eritrea over 30 percent of women of reproductive age lived over 30 kilometers from the nearest health center and women in some zones complained that it took a full day to reach the sites.

Different Types of Access Barriers Exist:

Physical: *"The central area of the clinic was flooded. The roof and several windows were broken, and it was very dark inside... The manager [said] jokingly that the only thing lacking was seeds to plant rice."*
Baseline study of quality in two Mozambique subprojects

Economic: *"We don't know the price, but whatever it is, we can't buy them. We are jobless."*
Focus group participant, Albania

Psychosocial: *"My husband doesn't know that I'm using FP because I think he wouldn't approve of it, but I have eight children already and I want to rest."*
Family planning user, Mozambique

While physical access is essential as a first step in meeting client needs, there are many other reasons why potential clients may not use services, even if they are available. For example, user fees might put services out of reach for low-income clients, or administrative policies like age restrictions or clinic hours could prevent other potential clients from obtaining services. Even if good services are physically within reach, people may not know where or how to access them. Or even if they are aware of them, they may be reluctant or opposed to using them for attitudinal or societal reasons. SEATS therefore categorized access into five main types of barriers: geographic/physical, economic, administrative, cognitive, and psychosocial. This shows that different types of access barriers call for different responses or interventions. Table 1 summarizes the different types of access barriers, those found most commonly in SEATS subprojects, and the main interventions that SEATS used to address them.

The barriers described in Table 1 would apply even in programs exclusively focused on family planning, but in the post-Cairo era, programs must reach out to new types of clients, with more comprehensive reproductive health services, often using new types of providers and service delivery points. While this may eventually provide opportunities to increase access, in the near term it mainly reveals the extent to which clients lack truly comprehensive reproductive health care. As just one example, a family planning user whose contraceptive needs have been adequately addressed for years may now be at risk of HIV or other STIs, leaving her with serious unmet needs from a broader reproductive health perspective. SEATS found that the best way to address this broad range of access issues was by taking a strategic approach where a unique set of interventions was tailored to the needs of each country (see Section 1.3). This was done by conducting needs assessments in each country that examined the existing situation and access barriers, and determining the most appropriate service mix for the groups to be served. In this

way, the most important types of barriers received the greatest emphasis. The following are just a few examples of how SEATS addressed different types of access barriers.

Table 1. Types of Access Barriers Defined and Encountered by SEATS, and Main Interventions to Address Them

Type of Barrier	Examples From SEATS Subprojects	Main SEATS Interventions
Geographic/Physical: The extent to which distance to services or poor condition of sites prevents potential users from obtaining services	Still a major reason for non-use in countries with rudimentary health systems or where FP is new—for example, Eritrea, Mozambique, Albania	Open new sites Add FP/RH to existing sites Train more providers Renovate and repair sites in poor condition
Economic: The extent to which costs inhibit FP/RH use—including cost of travel and waiting as well as the actual service	Common barrier in low-income countries such as Albania, Cambodia, Eritrea, Mozambique, Uganda, and Zambia	Use appropriate pricing strategies Leverage resources from other donors Use market segmentation
Administrative: The extent to which unnecessary rules and regulations, including medical barriers, inhibit use of FP/RH among certain clients	Restrictions on contraceptive use by young, unmarried clients Clinic hours	Collaborate with policy makers to improve policies Improve management systems
Cognitive: The extent to which potential clients lack knowledge of where to get services	In Albania, Eritrea, and Mozambique, 15-25 percent of non-users cited lack of knowledge as the main reason for non-use	Launch IEC campaigns that focus on where to obtain services
Psychosocial: The extent to which potential clients are constrained by attitudinal or social factors	Among youth, fear of being "scolded" at unfriendly service sites Fear of partner disapproval of use of FP Fear of FP method side effects	Use IEC campaigns that address potential fears of FP/RH services Train providers in counseling skills

Geographic/Physical—The main way SEATS addressed geographic and physical barriers was through training new service providers and by opening or improving new service delivery points. As a result, more service providers were available to offer new and improved services at more sites. Clinic renovations helped make services more appealing to potential clients—for example by speeding client flow, reducing waiting time, improving the quality of waiting time, improving privacy. Overall, SEATS opened or improved 2,982 service delivery points over the course of the project.

Economic—Economic barriers to access are discussed in the section on sustainability.

Administrative—Under SEATS, removing legal and regulatory barriers to access was primarily achieved through policy revisions that reinforced or expanded the services providers were allowed to offer. In Zimbabwe, MAPS and the Independent Clinics Organization (ICO) of the Zimbabwe Nurses' Association advocated for giving private midwives access to commodities. They also achieved a policy revision allowing them to bill social security for reproductive health services. Together, they continue to advocate for the right of private-sector midwives to dispense

family planning commodities. In Russia, SEATS/MotherCare and state-level health officials in two sites worked to bring about a number of service policies with a direct impact on access, quality, and sustainability. These included issuing a government decree specifying that the SEATS/MotherCare training fulfilled continuing medical education requirements, approving rollout training plans to be implemented with oblast funding post-project, and approving rooming-in and support to early initiation of breastfeeding as official policy for maternitiès. In several countries, SEATS worked with service providers, the community, and policy makers to improve policies, often unofficial, that restricted provision of services to unmarried youth.

Cognitive—In most subprojects, SEATS helped implement information, education, and communication (IEC) campaigns to link clients with desired services. The campaigns were designed with local involvement to make the messages appropriate within local settings.

Psychosocial—The IEC campaigns also sought to address negative attitudes or fears among potential clients that could prevent them from using FP/RH services. Training in counseling and interpersonal communication skills also was tailored to address such attitudes. Special efforts were made in several countries to make services for young people more friendly, addressing the barrier of fear that many youth experience in going to primarily adult clinics where they may be scolded for their behavior. To better understand the most prevalent psychosocial barriers to service use, providers were assisted with appropriate and simple assessment methodologies—such as exit interviews and focus group discussions. The need to understand and act on the clients' perspective and reproductive rights was particularly appealing in countries in transition, such as Albania, Kyrgyzstan, and Russia. Those subprojects repeated small client satisfaction studies of their own after being introduced to simple study techniques by the project. Private-sector midwives in Zimbabwe and Uganda also implemented community mobilization plans and client satisfaction reviews as part of their efforts to make services more responsive to client needs.

> ***Lusaka Youth speak on peer educators:*** *"When I suspect that I have an STI, I go to the peer educator who also refers me to the clinic where nurses give proper medication."*
>
> *"In the past we were so nervous to go to the clinic after contracting STIs. We feared being shouted at by the health worker and we were denied proper treatment. But nowadays, we go to the peer educators in confidence, who discuss problems and fears and give us the information we need about sex. In cases of STIs, they write referral letters to the clinic."*
>
> Zambian youth in focus groups

All basic components of service delivery should be in place to ensure access and use

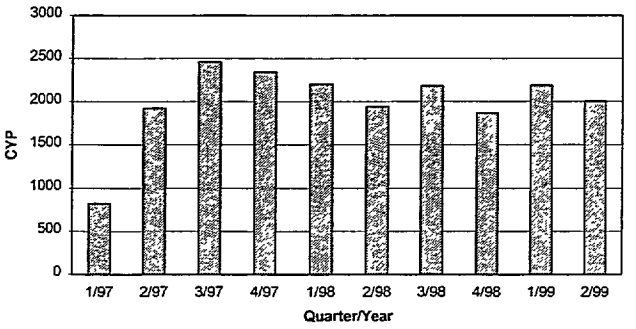
Some program components are so vital to success that without them, an entire package of interventions can be rendered ineffective. In SEATS' experience, the most vital component, or perhaps the one most subject to disruption, was commodities. Indeed, in Turkey, Zimbabwe, Mozambique, and Cambodia, commodity restrictions or shortages of various types severely affected service provision. Other key service components include well-trained service providers and program managers, well-equipped facilities, community awareness of services through effective promotion, and favorable policies and guidelines. These can be considered the basic building blocks of programs, and the lack of any one of them can seriously affect project results.

Given the challenge of coordinating so many potentially disparate components, a broad-based project such as SEATS can be an effective way of mobilizing the range of skills needed to

manage all aspects and ensure that they are effectively coordinated (see page 37). Specific measures taken by the project to ensure this coordination are described below.

Commodities, procurement, and logistics—A reliable supply of contraceptive commodities is a key element in the quality of care and essential to the sustainability of family planning services, once access is established. SEATS experience in commodity supply as viewed through a quality lens is mentioned on page 26, while the importance to sustainability is discussed in some detail on page 31.

Figure 12. Zimbabwe Nurses Association (ZINA) CYP



Zimbabwe provides an interesting example of the impact of a shortage of commodities on access. As donors began phasing out their support of commodities, the public-sector family planning agency, ZNFPC, stopped supplying the private sector and instituted charges for municipalities. This had a negative impact on most SEATS subprojects in the country, but was especially damaging to private midwives, who faced policy restrictions on contraceptive provision in addition to the price increases. In mid-1997, the ZNFPC restricted private midwives from distributing pills and Depo Provera unless a doctor was present in the clinic. SEATS helped the midwives overcome this obstacle near the end of the project, through extensive advocacy and policy work, and the restriction has recently been lifted. Figure 12 shows the adverse effect that lack of or restricted commodities can have. CYP increased dramatically for the first three quarters, then decreased from the third quarter of 1997 onward, despite the fact that the number of midwives practicing continued to increase.

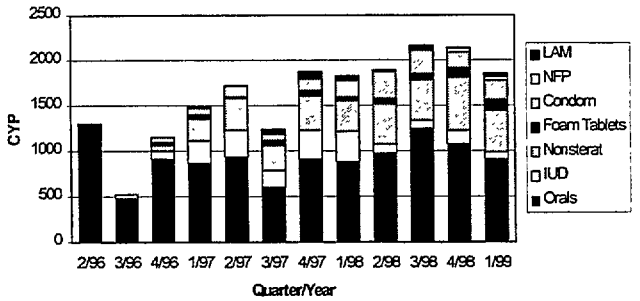
Because commodities are essential to family planning services, SEATS often worked with the United Nations Population Fund (UNFPA) and USAID's FPLM Project to improve logistics management. For example, in Albania, SEATS worked with both agencies, the Ministry of Health (MOH), and the Albania Family Planning Association to develop a logistics management information system, to deliver commodities to service sites, and to train MOH officials and staff in the system. This ensured regular, adequate contraceptive supply despite the instability and unsafe travel conditions, temporary shortages due to the crisis in neighboring Yugoslavia, and the needs of the many Kosovar refugees in Albania that existed during the life of the project. In Cambodia, SEATS fielded a full-time Logistics Advisor who worked with the MOH Essential Drugs Bureau to develop an integrated logistics management information system to monitor supply and more accurately procure commodities, including contraceptives. Stock surveys taken pre- and post-intervention showed improvements of up to 21 percent in satisfactorily stocked facilities.

Method choice—Increasing the number and variety of available methods is known to have an impact on contraceptive prevalence and overall continuation.[9,10] In Russia, client and provider satisfaction improved markedly with the introduction of mini-pills, Copper T IUDs, and the lactational amenorrhea method (LAM). Women traveled from districts outside the project area to

[9] *Jain. 1989 p. 2.*

[10] *Bruce. 1990 p. 66.*

Figure 13. Expansion of Method Mix in Lusaka, Zambia



reach clinics that provided these methods.[11] Midwives in Zimbabwe also participated, in collaboration with Population Services International, in the successful launch of the female condom. In Zambia, a remarkable expansion of the method mix contributed to increased CYP (Figure 13). At baseline, oral contraceptives (OCs) represented more than 99 percent of the method mix among new and continuing users; at the end, users were choosing from among OCs, condoms, injectables periodic abstinence, among others. Figure 5 shows, the IUD, barrier methods, and summary data on changes in method mix across all subprojects.

Referral systems—Most subprojects had referral systems in place at the outset but, sometimes, special effort was required to ensure service continuity. In Zambia, a two-way referral system was established between CBDs and clinic nurses originally skeptical of CBD. CBDs referred for clinical services and the nurses referred to CBDs for routine family planning services. Nurses became much more enthusiastic about this referral system—and CBDs in general—when they noticed it reduced the client load at public-sector clinics. The ICO developed a referral system for private-sector midwives in Zimbabwe when they could not obtain commodities themselves. Youth peer educators in Zambia operated out of Youth Corners in family planning clinics and were linked to a trained youth-friendly nurse at the clinic. As a result, referrals were greatly facilitated for treating sexually transmitted infections, prenatal care, and gynecological and clinical family planning services. New youth users of clinical services rose from 339 in fourth-quarter 1997 to 1,019 in first-quarter 1999.

Community awareness of new services—There is little point in adding new services or improving existing ones if clients do not know about them. In Albania, formative qualitative research showed an almost complete lack of awareness of family planning and strong suspicions about contraceptive safety. Mass media campaigns then promoted services through a national quality logo, prompting private television stations not included in the original campaign to request the spots for wider broadcast. The MAPS Initiative trained members of the Uganda Private Midwives Association in community mobilization. Within six months, 170 service delivery points served by 145 midwives reported a 10 to 20 percent increase in family planning clients per month.[12] In a good example of South-to-South cooperation, midwives from Uganda then conducted this training for midwives in Zimbabwe to promote awareness of services there.[13] In Bulawayo, Zimbabwe, in contrast, little was done to inform the public of new sterilization services—the rate of clients seeking these services remained steady, but did not go up.

Policies, procedures, and protocols—MAPS and the Zimbabwe Nurses' Association developed a handbook for midwives aspiring to private practice to provide clarification to Zimbabwean and Ugandan midwives uncertain about their rights and responsibilities as private practitioners. The

[11] *Haffey, Cappa, and Beitrishvili. 1997 p. A-5.*

[12] *Houde Quimby, and Mantz. 2000 p16.*

[13] *Ibid. p. 12.*

Uganda Private Midwives Association and MAPS also developed standards for private practice. In Cambodia and Eritrea, SEATS helped the MOH develop national safe motherhood policies and implement a national safe motherhood strategy and action plan. Eritrea also, with SEATS' assistance, put a national quality assurance policy and program in place. In Russia, with the assistance of SEATS/MotherCare, a number of policies were put in place to institutionalize the project's training program as fulfilling continuing medical education requirements, to sanction rooming-in as the preferred practice in maternity hospitals, and to extend the amount of time allowed each client for counseling, thus ensuring client-centered services. Also, as a result of the project's work with policymakers, trained mid-level health care providers were allowed to provide family planning services in rural areas for the first time.

6.2. Quality of Care—Meeting Client Needs[14]

Build a client orientation among service providers

While there is a widespread understanding in the FP/RH development community that services need to be client-oriented, this was a new concept to most of SEATS' counterparts in the field. Services were generally structured more around providers' convenience than clients' concerns and providers tended to view QOC in terms of supervisory visits for assessing their competence based on checklists. They had rarely considered how clients perceived their services. When providers were exposed to clients' perspectives, however, they usually wanted to respond. When *multiple* methods were used to encourage providers to see the client's perspective, the impact was greater.

> *"The attitude of a doctor to a patient has changed drastically. We are now aware that the client plays the main role in this process while a health worker provides assistance. The client can enjoy her rights at last."*
>
> Director, Oblast Family Planning Center, Novosibirsk Oblast

> *"After quality training, I learned how to identify problems and solve them. Quality is not a static thing; we must keep trying to improve."*
>
> Midwife in Zimbabwe

The findings of focus group research undertaken early in a number of subprojects spotlighted client and community concerns. These results surprised many providers and managers—most notably, those in the former Soviet Union, who had never considered how clients viewed their services. In Russia, family planning training gave trainees first-hand exposure to clients' views by having them conduct client focus groups or exit interviews. Providers were taken aback, and sometimes moved, by what clients had to say. Another strategy SEATS used was to conduct client exit interviews during supervisory visits—as was done in Cambodia, Russia, Zambia and Zimbabwe. This provided strong motivation to encourage providers to respond to clients' concerns.

By the time SEATS ended, over 90 percent of service delivery subprojects had conducted some sort of formative research with clients or community members, to get their perspective on services—and used that research to respond to client concerns. Overall, clients in SEATS' subprojects were satisfied with the quality of care they received. A few examples:

- In Chitungwiza, Zimbabwe, 98 percent of clients reported in client exit interviews after training that they would return to the health center if they had problems with their FP method.
- In Kyrgyzstan, in sites where providers had been trained in basic family planning and interpersonal communications, improvements were dramatic: 82 percent of clients said they

[14] *JSI. 2000a*

would come back to the facility for FP information and services, and 93 percent would support their friends getting advice and services at the facility.

- At RHAC, the average client satisfaction score in home interviews with clients a few days after their visit to a RHAC clinic was 3.9, out of a possible 5, at the end of the project. Home interviews resulted in considerably lower scores than are generally obtained in client exit interviews but yielded more honest feedback, and hence more useful information, to improve QOC.

Mainstream continuous quality improvement (CQI)

The project sought to institutionalize CQI in most of its subprojects, so they would use the process to improve the QOC on a continuing basis. More than three-quarters set up quality improvement teams that identified local quality problems and made improvements. CQI proved to be a powerful methodology to bring about improvements in QOC in a variety of settings, ranging from large maternity hospitals to small clinics, CBD programs, and midwives' private practices. Moreover, once the quality improvement process takes hold, it can be sustained, since many improvements can be made at little or no cost.

SEATS found that the key to mainstreaming CQI is to keep the tools and measurement systems simple initially, until the quality teams have experienced the gratification of seeing results and have become enthusiastic about the process. The process was most successful where it was introduced over several months, with new tools and approaches presented as they became relevant, as in Senegal, Turkey, and the Zimbabwe Nurses Association.

CQI in Zimbabwe: Private midwives of the Zimbabwe Nurses Association were enthusiastic about CQI. After CQI training, the Queen of Peace clinic in Harare introduced a suggestion box and soon found several complaints from clients about lengthy waits. The quality team investigated and found clients to be unhappy about the average waiting time of 40 minutes and the length of the consultations themselves. The team worked with the clinicians to speed up consultations by avoiding small talk. Waiting time for clients was reduced to 10 minutes.

A follow-up client survey found that clients now felt that providers were rushing them, or that they did not seem to be listening. Consultation time—and thus waiting time—was increased, but steps were taken to make the wait more pleasant. Inspired by another midwife, the clinic started showing health videos, serving beverages, and set out IEC materials. The waiting time increased to 20 minutes—half the original time—and 95 percent of clients were satisfied. In fact, the problem became that clients often wanted to finish watching a video rather than go and see the provider!

Building a quality-orientation among service providers, however, involves a paradigm shift in their thinking because they have been so accustomed to their work being measured by the numbers of service users. Front-line managers and service providers, particularly in the public sector, faced such a difficult working environment that they saw little reason to make things better for their clients until their own situation improved. Often, they were poorly trained, ill-equipped, had not been paid for several months, were over-worked, and/or received little or no supportive supervision.

SEATS and its counterparts identified several motivating factors to help overcome these obstacles:

- *Give providers a reason to provide quality care.* In the former Soviet Union, changes in the health care system made providers acutely aware of the importance of quality. As the health sector downsized and became more competitive, providers recognized that they needed to attract

and retain clients if they wanted to keep their jobs. Private midwives in Zimbabwe quickly recognized that they needed to provide quality care if they were going to make a living in fee-for-service practices.

- *Expose providers to client perspectives.* The results of client surveys or focus group discussions can serve to introduce providers to new concepts of quality and motivate them to improve services. First-hand exposure to client perspectives by having providers themselves conduct focus groups or exit interviews was even more effective, as seen in Russia.

> ***Expanded Quality Improvement:*** SEATS brought a new dimension to CQI by expanding quality teams at some sites to include clients and/or community members, representatives of referral sites or community organizations. The aim of this Expanded Quality Improvement (EQI) process was to help quality teams in low prevalence countries work with their communities to address reasons for non-use of services and make service improvements accordingly.
>
> This process was used in Senegal and Mozambique and shows great promise. In Zambia, SEATS used a modified version of the PLA approach developed by CARE that was similar in many ways to the EQI approach. The focus was on finding out from young people how to make services more youth-friendly and training clinic staff to respond. The number of young people availing themselves of services grew substantially, even over a very short project period. For example, the number of new FP acceptors increased from 368 in the second quarter of the subproject to 1,018 just over a year later. The number of FP revisits increased from 430 to 1,380 and the number of young people using STI services grew from 207 to 468 over the same time period.
>
> The EQI approach merits further refinement and careful evaluation.

- *Measure QOC periodically.* Through repeated use of quantified supervisory tools, providers have an incentive to improve their performance, as seen in RHAC (Cambodia) or in World Vision's CBD program in Zambia. Most staff want to be perceived as doing a good job by whatever measurements are applied.
- *Build a sense of empowerment and job satisfaction.* At many subproject sites, including Senegal, Turkey, and Zimbabwe (ZINA), the CQI process helped staff bring about change at the facility level, giving them intense satisfaction in being able to resolve problems on their own. This was particularly true when quality improvement efforts created a team mentality and when clients expressed their appreciation of the changes made.

> *"The most interesting part of EQUIPE (the French translation of CQI) was its focus on democratic participation which gives importance to everyone's contribution, from the gardener to the Executive Director. That allowed us to feel confident—that we were part of a solution—and that made us feel we could discuss real problems with our group and our management."*
>
> Staff member at a Dakar clinic

Overall, data collection and use was the most problematic aspect of mainstreaming CQI. Although a few subprojects were able to undertake some simple data collection, analysis, and application, most relied heavily on technical assistance for these functions. Such technical assistance will likely need to be built into CQI efforts in future, at least in the early stages.

A workable approach to measuring quality

Over the five years of the SEATS II project, leaders in the FP/RH community made much progress in measuring the QOC. SEATS' approach also evolved. The project's early efforts in measuring quality tended to focus on process indicators, rather than on actual improvements in the QOC. In the latter part of the project, however, a two-pronged approach emerged. The essence of this approach was to measure quality on at least two levels:

- *At the system level—country, municipality, or NGO*—surveys and other tools, such as client observation, proved a valuable way to meet the needs of donors, evaluators, and higher-level administrative entities for reliable data on QOC. The QIQ methodology, developed by the MEASURE-Evaluation project and USAID's MAQ Initiative, and field-tested by SEATS in Zimbabwe, gives FP programs a core set of indicators and a practical methodology to use in measuring quality. To be useful locally, however, results need to be fed back to stakeholders promptly in a way that makes the implications for services clear and provides an opportunity to discuss the findings and how to respond to them.
- *At the local level*, simple measurement strategies are needed to help providers and managers identify problems in the QOC, determine their causes, and later assess whether improvements have occurred. SEATS found that, with some training or technical assistance, providers adopted tools such as suggestion boxes, simple exit interviews, focus group discussions, and timing studies to measure quality on their own, without outside support.

As already noted, measuring quality was the aspect of CQI that subprojects found hardest to use. Methodologically sound surveys could not have been conducted without outside technical assistance. And, at least initially, subprojects needed training or technical assistance to use even simple studies to collect baseline and endline data for their CQI activities.

Self-supervision reduces the need for outside supervision

Supervisory systems in developing countries often fall victim to a lack of resources to undertake supervisory visits, poorly trained supervisors, and other potential obstacles. Subprojects in Cambodia and Eritrea recognized this problem and sought to adopt more sustainable approaches, illustrating that self-supervision can be used to improve quality in fact and quality in perception at the facility level and reduce the need for outside supervision.

The MOH in Eritrea sought to reinforce the technical QOC with self-assessment checklists for front-line service providers to help them review their own compliance with protocols. RACHA in Cambodia used staff meetings to review and discuss clinical protocols with providers, helping them to practice in line with current protocols. And RHAC was starting to decentralize its CQI system, with clinic managers taking the lead in monitoring the QOC in their facilities. These innovative systems to monitor quality in fact went hand-in-hand with systems to improve the QOC from client and provider perspectives.

Final evidence on how well self-supervision works is not yet available. However, in many settings, it has the potential to improve the QOC, while reducing the need for outside supervision.

Some of the current and emerging best practices that SEATS used in its technical assistance to subprojects included:

- Building a client orientation.
- Using state-of-the-art approaches to training.
- Making counseling and interpersonal relations more client-centered.
- Improving the integration of services.
- Introducing Continuous Quality Improvement.

Quality must be built in from the beginning

SEATS sought to build in quality from the beginning of subprojects. As the project staff developed subprojects, they looked through a quality lens—provided by the Bruce-Jain framework and the MAQ checklist. Subproject activities then addressed the key needs identified, such as obtaining better equipment, improving staff training, broadening the method mix,

enhancing a client orientation, or addressing policy issues. The result was improvements in quality. For example:

- Staff knowledge and skills improved as a result of training. Trainee follow-up undertaken in many subprojects showed high levels of retention several months later. For example, at Health Alliance International in Mozambique, nurses' average scores on the pre-test before family planning counseling training was 18 percent; that increased to 79 percent at the post-test and was found to be 70 percent 11 months later.
- Facilities were better equipped.
- Logistics systems were improved, as in Cambodia, where the percent of facilities with satisfactory contraceptive stock levels increased from 12 percent in 1998 to 27 percent a year later.
- The method mix was broadened in many subprojects and project-wide as shown in Figure 5.
- Public attitudes improved, as in the Lusaka Youth project where baseline focus group data found communities and health care providers unsupportive of FP/RH services to youth but endline focus groups found them actively involved in supporting and providing these services (see box).

> *"...youth-friendly services should be supported because they educate and motivate youth to talk and discuss freely on matters related to sexuality among themselves"*
>
> *"This is where our children seek help on sexual and reproductive health issues and problems affecting them. They find it easy to express themselves fully as they are attended by their fellow youths called peer educators."*
>
> Lusaka District Health Management Team

- The policy framework for a national quality assurance program was put into place in Eritrea.

The capacity for continuous quality improvement must also be built

In most subprojects, SEATS also sought to build the in-house capacity of its counterparts to improve the QOC on their own through CQI. CQI relies on those who work in an organization or facility and who are most familiar with its strengths and weaknesses to identify problems in quality of care and develop and implement solutions. SEATS worked with subprojects to build quality teams with members drawn from all ranks of an organization or facility, from the director to the janitor. Subproject work in CQI also brought about improvements in the QOC. For example:

- At the Reproductive Health Association of Cambodia, providers' average scores in nine RH skill areas, ranging from specific contraceptive methods to infection prevention, increased from 87 to 95 percent over a six-month period in 1999.
- At World Relief in Mozambique, the percentage of women who had never heard of FP declined from 13 to 2 percent over a one-year period in 1998 and 1999.
- In the Senegal Quality Initiative, the average length of a client visit at selected clinics that addressed this problem was reduced from 2 hours 50 minutes to 1 hour 40 minutes.

Quality of care has three core aspects

SEATS encouraged each subproject to identify and address its own quality problems and objectives. The result was a large number of different problems and solutions addressing a plethora of local needs. While this was extremely valuable in institutionalizing quality improvement activities, it was a challenge for SEATS as a project to provide technical support on such a range of issues and to aggregate the results, since each subproject used different indicators and evaluation instruments. Most subprojects' quality objectives fell into one of three broad categories:

- Improving the capability, or "readiness," of facilities to provide quality services.
- Improving provider knowledge and skills.
- Increasing client satisfaction.

Future efforts to improve the QOC could focus on these three core aspects of quality. They could help projects and programs to identify areas for quality improvement and facilitate the job of technical assistance. Simple tools in these core areas can measure most proposed indicators.

QOC needs to be continuously monitored and measured—at different levels of the system

The QOC can disappear overnight, for example, when key commodities or supplies become unavailable or if trained personnel leave, as SEATS witnessed in Zimbabwe. Thus, constant vigilance of QOC is needed.

Moreover, problems at the *local* level, such as poor logistics or a lack of training or equipment, often need to be addressed at a higher level of the system. For example, in Zimbabwe, the QOC delivered by private midwives was undermined when contraceptive supplies became unavailable—a problem that needed to be addressed at the national level. Through advocacy activities, the Zimbabwe Nurses Association managed to reverse this situation, at least as far as securing verbal sanction from the Ministry of Health and the Drug Control Authority for private midwives to purchase, stock, and dispense class C drugs, including family planning commodities, and to offer immunizations.

SEATS also found that while many local providers were enthusiastic about addressing quality problems they or clients identified, they had difficulty identifying deficiencies in the technical quality of services. These weaknesses needed to be drawn to their attention by supervisors from higher up in the system or researchers sharing the results of QOC assessments. For example, it was not until SEATS conducted a wide-scale survey on the QOC in SEATS-supported sites in Zimbabwe, that providers recognized that they were not providing clients with adequate information about STIs, HIV, and AIDS.

Just as quality needs to be monitored and improved at several levels, it also needs to be measured, as outlined above.

Attention to quality pays

Attention to quality pays in a number of different ways. First, as seen above, efforts to improve the QOC do, in fact, result in improvements.

> *The best way to assure tomorrow's market is to make today's quality absolutely dependable. We offer quality care here in order to be assured of tomorrow's market.*
>
> Sign in the Sunridge clinic in Harare, Zimbabwe

Second, the CQI process empowers providers and clients. It builds confidence, fosters creativity, and supports democratic decision-making among those involved in the process—key elements in making providers more effective. Providers tackle problems that might well have been ignored in the past. It also gives clients a voice by listening and responding to their concerns.

> *"The quality meetings that are being held with the support of the project have contributed significantly to our motivation and the improvement and expansion of the quality of services."*
>
> Staff member at an SSK hospital in Turkey

Third, the project found that clients are willing to pay for quality services.

- In Zimbabwe, private midwives were able to

attract fee-paying clients for RH services in the face of almost-free services in the public sector, because they offered quality care.

- In Cambodia, midwives who had been trained by SEATS in client-centered maternity care were able to charge more for their services.

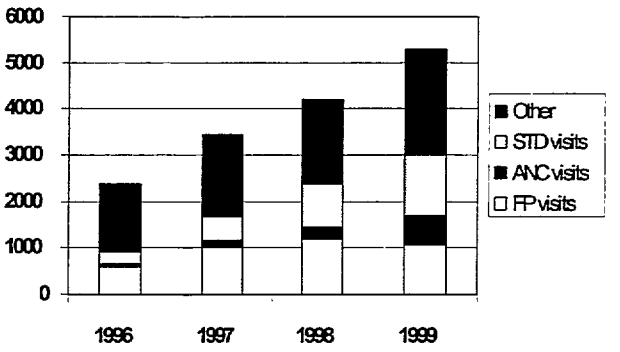
6.3. Sustainability—Continuing to Serve Clients[15]

Investment from the outset in institutional planning and management capacity is fundamental to sustainability

> **SEATS definition of sustainability:** The capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid.

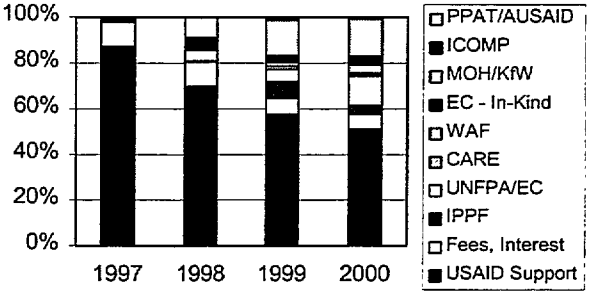
The importance of this lesson cannot be overstressed. Perhaps the greatest constraint SEATS faced in working with partners to enhance sustainability was the limited time available—typically less than two years. Pressure to get services operational as quickly as possible limits the time available for capacity building and the absorptive capacity of partners. In many subprojects, SEATS built some sustainability elements—for example, no funding of recurrent costs—into the design, but focused initial technical assistance on strengthening and expanding the services. As a result, direct management-related and finance-related capacity building fell toward the end of the project, often with little time remaining. While this responded to the need for rapid increase in access to quality services, it may have hindered the subprojects' ability to sustain programs after SEATS' departure.

Figure 14. Growth in RHAC's Clinic Visits 1996-1999



Given enough time and support, significant institutional development can be achieved. SEATS' collaboration with RHAC in Cambodia was sustained for nearly three years, supplemented with additional USAID Mission financial resources, and guided by a long-term Resident Advisor. The initial focus on institution building—strengthening its basic management, financial, and marketing operations—proved extraordinarily fruitful. RHAC was able to expand the scale and reach of its operations, quadrupling STI and antenatal care visits between 1996 and 1999 (Figure 14), and achieve its 2001 leveraging target of reducing USAID support to 60 percent of total costs two years ahead of schedule (Figure 15).

Figure 15. RHAC Sources of Support



An example of what **can** be done within the constraints imposed by inadequate time frames comes from SEATS'

[15] *JSI. 2000b.*

experience in Senegal. USAID/Senegal requested that SEATS assist a Senegalese NGO—Santé de la Famille (SANFAM)—to meet the PVO registration requirements with less than nine months remaining in the subproject agreement. With SEATS' assistance, SANFAM developed a solid business plan that outlined approaches to increase local income, improve financial management, and diversify its funding base. But implementation and achievement of its financial break-even point for its income-generating activities will most likely take several more years.

Less dramatic, but no less important for sustainability, SEATS encouraged its partners to think as social entrepreneurs—identifying ways to continue providing quality services despite the constraints and threats arising from constantly changing operating environments. For example, in a Zimbabwe private clinic and in the Lusaka Youth subproject, SEATS partners demonstrated their ability to turn a threat—declining service statistics—into an opportunity to learn more about their clients and improve their services. But to the extent that such adaptive behaviors are relatively new, developing these capacities also takes time.

The inherent tensions among rapid service expansion, service to the poor, and long-term sustainability can be managed effectively

A need to move rapidly in promoting service expansion is not always compatible with requirements to achieve long-term sustainability. There are tradeoffs, and the poor are especially vulnerable to the consequences of this conflict. Sensitivity to such unavoidable tradeoffs during the design stage can help to limit their more negative consequences for organizations and their clients. The following are examples from the SEATS experience:

- *Nonsupport of recurrent costs*—for example salaries—avoids excessive dependence on donors, but limits donor agency participation in decisions on how and where a partner organization's staff resources will be assigned. For SEATS, this often resulted in frequent transfers of a partner's trained staff, thereby limiting service expansion.
- *Diminishing support or nonsupport of commodity procurement and other supplies* establishes the partner organization's responsibility for these inputs, but local funding may be no more reliable than that provided by external donors. For SEATS, local political and economic developments that limited or disrupted local funding commitments resulted in stock-outs of key commodities and supplies that worked against achieving programmatic objectives.
- *Provision of capital equipment* can be key to enhancing the quality or effectiveness of the partner organization's administrative and programmatic operations, but local funding for

> ***Managing conflicting objectives in Mozambique:*** World Relief Corporation (WRC) in Mozambique provides an example of how the tensions between expanding access, enhancing sustainability, and serving the poor were managed, leading to an enduring source of reproductive health services. WRC/Mozambique had been implementing a child survival project in the Gaza Province for several years. Its child survival strategy included expanding provision of services to the entire project area by training a cadre of village health workers, called *socorristas*, to provide services, such as treatment for malaria, distribution of oral rehydration salts, treatment for minor wounds, etc., at fixed health posts. The child survival strategy had aspects that made it inherently sustainable—the MOH provided commodities and was responsible for supervision of the *socorristas,* and the *socorristas* received a fee-for-service from each client. WRC expanded the program to include family planning services by training *socorristas* to provide family planning. But unlike other care, family planning services would be free. By expanding services through *socorristas* that are already being paid, WRC was able to expand access to family planning from 54 to 98 percent of the population within 5km of services and maintain the integrity of its project.

maintenance or replacement may be less reliable than externally provided support, particularly if the equipment does not generate a new or enhanced revenue stream. Such maintenance and replacement costs strained a number of SEATS partner organizations, diverting their limited resources from programmatic uses.

- *Client fees* can be an important contributor to sustainability, but may deny service access to low-income groups. Several SEATS partner organizations addressed this issue, but none more dramatically than RHAC, where client fees were viewed as essential to reducing RHAC's dependence on donor funding. As a percentage of operating expenses, client fees and program income grew from 12 percent in 1997 to 16 percent in 1998. But this success ran counter to the high priority RHAC placed on ensuring access to quality services to the poorest segment of the population. Surveys of RHAC clients revealed them to be from better-off socioeconomic groups. Other studies indicated that people living in the very poorest areas were unaware of RHAC's services and unable to pay for services. RHAC management scaled back its revenue objectives from client fees, began offering more free care and encouraged those from the very lowest socioeconomic level to visit RHAC's clinics.

The SEATS experience points to a number of approaches to managing these tensions:

- *Adequate time must be devoted to capacity-building efforts*. Efforts to enhance the sustainability of existing organizations frequently must work against, or reverse, management orientations and behaviors developed over years, or for some, decades, of experience with donor-dependent development efforts. Such basic changes require time-intensive work with organizational leaders. Younger organizations need sustainability assistance that develops their organizational direction and systems, and that also takes time. Consequently, a commitment to enhance partner sustainability may mean accepting that tangible results in increased financial autonomy and the expansion of quality services may not be realized during the life of the project. To do less is to promote the appearance of a sustainability program, but not its substance. In practical terms, this means *emphasizing low-cost expansion approaches* such as outreach, when possible and practical, over increasing clinic sites and expensive technology, which adds recurrent management and financial costs. It also suggests that *programmatic flexibility* that allows support for initial recurrent and capital costs incurred in expanding services to underserved populations should be weighed against an implementing partner's ability to absorb the costs in the future. This requires careful medium- and long-term planning and sufficient time to support the partner's sustainability efforts.
- *No one approach will work in all settings, but there are sustainability activities that do work.* The key is to relate sustainability plans to the local context, and to consider the widest repercussions—positive and negative—that result from implementing each activity. *Developing services that are of value to the clients and the community* should be a cornerstone of all sustainability efforts because it increases the use of services and clients' willingness to pay for them.
- *Continuous quality improvement of management and service delivery operations contributes to long-term sustainability*. The emphasis CQI places on databased, client-centered, team decision making represents a basic organizational capacity to anticipate and respond effectively to an ever-changing operating environment (see next lesson, below).
- *Client populations must be appropriately segmented by their ability to pay for services.* Employer-based services, public-private partnerships, private-sector entities, and avenues that tap diverse market segments have shown promising results and need to continue to be explored and developed. The SEATS Urban Initiative in particular offers numerous examples of mayors and other municipal officials who built partnerships with the private sector as a way to increase

access of the working poor to health education and to include them as active participants in needs assessments.

Many sustainability issues are effectively addressed through the continuous quality improvement process of team-based problem solving

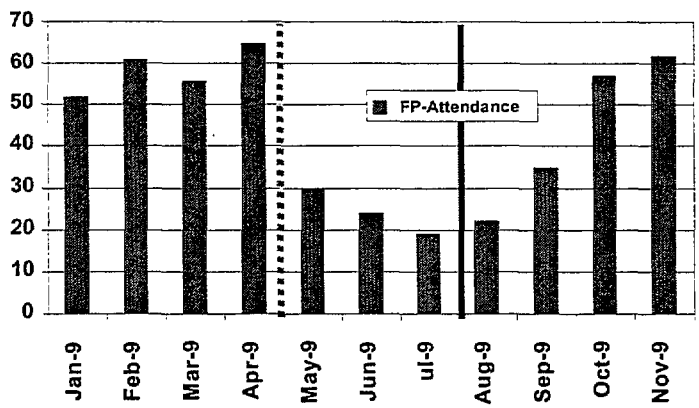
SEATS' MAPS Initiative used CQI strategies to ensure quality of care, as described earlier. CQI enables staff at all levels to function as a team, analyzing the systems and processes in which they work and using the information to design and implement activities to improve services. It is data-driven and client-oriented. The extent to which CQI methodology becomes part of the everyday working methods of an organization, however, can also enhance its ability to respond to environmental challenges not directly related to actual service quality. This ability to respond effectively to a rapidly changing environment is a hallmark of organizational sustainability.

Houghton Park Clinic Letter to Clients

"Dear valuable client,
Houghton Park Clinic wants you back. Pills are only Z$15 per packet. This may sound expensive, but if you buy elsewhere...You need to catch a lift, imagine the stress of waiting...the queue at the public clinic. By the end of the day, you will have paid Z$20 and 4 hours of stress. You could save this by walking to HP where you get served coffee, tea or a cold drink while you wait. Or watch the 6 o'clock news on our TV. Time spent is less, amount paid only Z$15."

The experience of the Houghton Park Private Clinic in Harare, run by one of the members of the Zimbabwe Nurses Association, illustrates this relationship between the CQI methodology and an effective response to external challenges. Increased costs of oral contraceptives led to client complaints and a decline in client numbers in the four months following the increase in April 1998 (see the dotted line in Figure 16). A client survey revealed that although clients were happy with the services the clinic provided, they preferred to purchase their oral contraceptives from public-sector sources at half the private-sector price. A letter to the clients (see box) sent in August 1998 (solid line in Figure 16) explained that when hidden costs were considered, the public-sector price for oral contraceptives was higher than that in the clinic. This response proved effective—family planning client volumes returned to levels achieved before the price increase.

Figure 16. Houghton Park Clinic Attendance



Access to contraceptive commodities is critical for program continuation

Access to low-cost family planning supplies is important to clients in judging the quality of services, and a steady supply of contraceptives is a critical part of any FP/RH program. Contraceptive supply, however, is often heavily donor dependent, yet it is frequently overlooked in sustainability planning efforts.

As external donors seek to transfer to local authorities the responsibility for funding commodity supplies, they need to consider the risks this poses to the sustainability of the organizations likely to be affected. Typically introduced as one part of a larger health-sector policy reform process, the actual transfer of responsibility is a high-risk venture, and its effects can quickly spread beyond the public sector.

Impact of the End of Donated Commodities on Rural Services in Zimbabwe: A midwife in a rural area of Zimbabwe ran two clinics in farming communities. Based on comments from clients, she began outreach activities, traveling to large communal farms weekly to provide basic services, including antenatal care, STI diagnosis and treatment, HIV counseling, family planning counseling and services, basic laboratory tests, and minor curative care. Farmers and farm workers found the services valuable—workers did not have to lose a day's wages and farmers did not lose laborers. Other farmers asked the midwife to expand her outreach to their farms. Unfortunately, the outreach services came to an abrupt end once donated commodities were no longer available through ZNFPC. The District Medical Officer would not let her dispense drugs and commodities without a physician present and told her she had to stop her mobile clinic. The farmers appealed the decision, but it held. More than a year has passed, and the farms remain interested in the resumption of mobile services. As a result of lobbying by the midwifery association, the MOH has verbally ended the restrictions. Written authorization is expected from the Drug Control Agency in early 2000. The midwife is already planning her first mobile visit.

Zimbabwe, which has one of the highest contraceptive prevalence rates in Africa, is a good example of a mature program threatened by an end to donated commodities. As described earlier, donated commodities were phased out and ZNFPC began charging providers for supplies. This affected private midwives (see box). A number of midwifery practices closed, while others developed referral systems and relations with physicians to get around the restrictions. Given the scale of the current HIV/AIDS epidemic, donors are reviewing their phase-out of support. This may be an effective short-term response, but the need remains to develop a long-term strategy.

In Turkey, SEATS was clear that donated contraceptives provided to the Turkish Social Security Agency (Sosyal Sigortalar Kurumu, or SSK) would be discontinued when the subproject ended. To convince SSK decision-makers that the purchase of commodities was a valuable investment, SEATS conducted a cost-benefit study that demonstrated a saving of nine dollars for every dollar spent on family planning.[16] SSK executives proceeded to include funds in their budget for the contraceptive procurement and bought their own commodities from 1996. Subsequent changes in SSK leadership, coupled with budget reductions after a national economic downturn, delayed procurement, however. By late 1997 there were system-wide shortages of IUDs, oral contraceptives, and condoms. The inevitable decline in the level of contraceptive use among SSK clients quickly followed: new acceptors dropped from 61,069 in 1996, the last complete year of SEATS' assistance, to 28,288 in 1998[17]. Even more serious for the system's long-term sustainability was the demoralizing effect this experience had on the ongoing quality improvement program of the professional staff.

Public-sector and adolescent programs require special approaches to sustainability

Public-sector programs: The limited policy, administrative, and financial autonomy of public-sector reproductive health providers requires sustained technical assistance to identify and develop untapped local resources that can enhance program sustainability. SEATS typically

[16] *Çakir, Fabricant, and Kircalioglu. 1996 p. 269.*

[17] *Sosyal Sigortalar Kurumu. 1999.*

worked directly with clinics and hospitals operated by municipalities. As a result, its range of sustainability efforts was limited to those areas in which the health facility had direct control.

Approaches that worked best were simple and practical, including targeted technical assistance and training for strategic planning, use of data for monitoring and revising programs, financial management, logistics management, diversification of funding sources, and marketing—in its broadest sense of understanding client demand and tailoring services appropriately. Particularly important were activities that sought to identify and mobilize underused existing resources, even unconventional ones: engaging retired health workers as advisors to mayors in Senegal, for instance, or recruiting and training adolescents as peer educators in Zambia.

Opportunities are limited for public-sector service providers to leverage additional resources as part of a larger sustainability plan: Municipal health facilities receive their budgets from city councils. All fees earned go direct to city treasuries and may not be used to support further health services. In such cases, SEATS and its partners can neither set fees nor improve the financial management of the city treasury. Also, public and private organizations may be required to go through the ministry of health or finance to receive outside funding, and bureaucracy can then stall requests for support.

Again, SEATS used relatively simple and practical approaches to overcome such constraints. In Senegal, for example, SEATS facilitated the formation of coalitions of municipal officials, health authorities, and private-sector partners that were able to advocate for additional local and international resources to support high-priority reproductive health services. Technical assistance focused on evidence-based decision-making—providing local public authorities with the planning and proposal development skills needed for leveraging additional resources.

Adolescent programs: Adolescent reproductive health programs not only require specific advocacy skills to create political and financial support for a sensitive area, they also serve young people who have limited financial resources to pay for services. Those programs that use peer educators must also address the need for continuous training of new educators as existing ones age out of the peer group and to balance peer volunteerism with the need to earn income in an extremely poor environment.

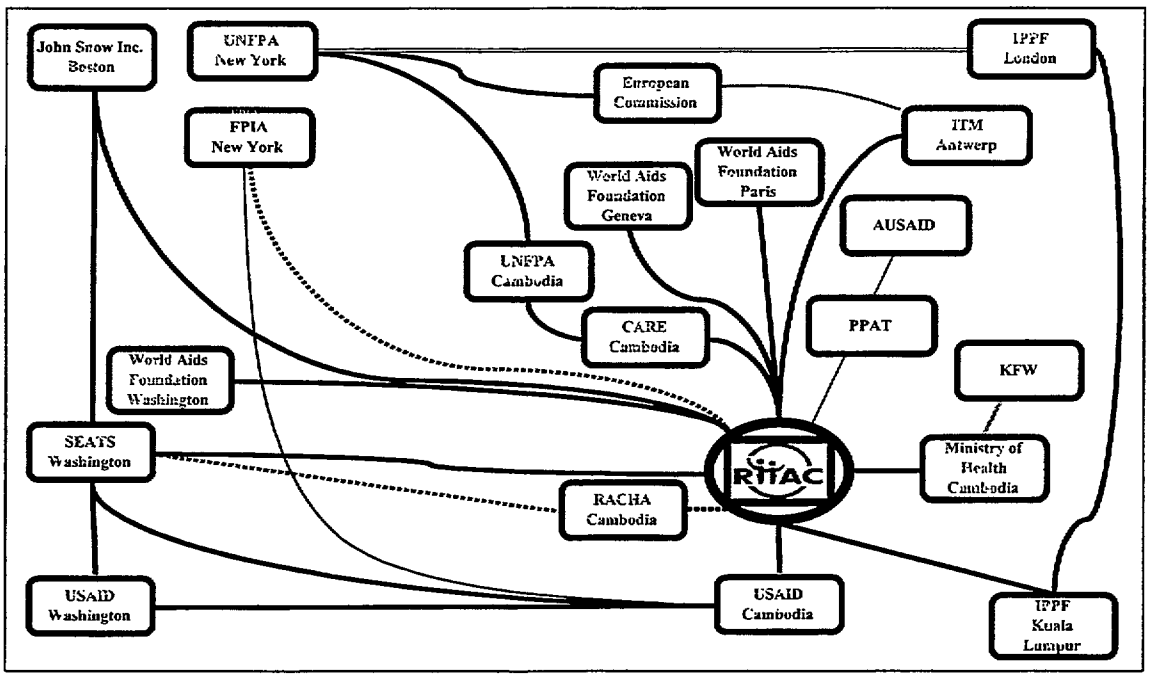
In the Lusaka Youth project, SEATS was successful in building support for adolescent services in the community and at the municipal level, using a participatory, evidence-based approach. The peer educators were also able to generate some limited income from selling newsletters, renting out space at a donated building, and showing videos for a fee—not enough, however, to address the pressure they felt from their families to contribute to the family income. Within six months of the end of SEATS support, half the peer educators had either dropped out of the program or significantly reduced the time they spent on program activities. While the clinic-based adolescent services continue, and the district health management team and the neighborhood health committees remain committed to adolescent reproductive health services, additional opportunities to provide some financial support for the peer educators need further exploration. Advocacy to develop political and financial support for adolescent services should be a part of all youth programs.

Successful leveraging of additional resources can also create new organizational challenges

SEATS' subproject partners were successful in leveraging resources in support of their programs, obtaining additional support from local and international sources, and from the public, NGO, and commercial sectors. Besides the obvious sustainability benefits of diversifying the donor base, the increased administrative burden of managing multiple funders is not insignificant. Funds from one donor will often flow through several channels, clouding channels of communication in different aspects of programmatic and administrative operations. Responding to donor requirements may distract the organization from its core mission activities.

> ***Leveraging at the Reproductive Health Association of Cambodia:*** RHAC expanded its number of donors from two to nine within little more than one year. As Figure 17 shows, RHAC's relationships with its multiple donors became increasingly complex. For example, RHAC's UNFPA/EC grant is funded jointly by the European Commission (EC) and UNFPA. The EC funds are made available through the International Planned Parenthood Federation. All three organizations have either regional or country offices that also interact with RHAC so that requests for information can originate from several levels. The reporting burden is increased, channels of communication are confused, and senior RHAC staff have less time to devote to internal program planning and management.
>
> Furthermore, with each additional donor grant and clinic established, RHAC's financial management became more complex. Accurate tracking and reporting of income and expenditures by funding source required RHAC to strengthen its financial planning and management capacities through increased staff skills, improved accounting and audit systems, and enhanced understanding of its cost structure. Now RHAC carefully weighs each opportunity to add to its donor portfolio and negotiates with the donors to minimize reporting requirements.

Figure 17. RHAC: Complexity of Funding Flows



Having multiple donors increases the complexity. Reporting requirements differ in content, format, and timing. Lines of communication can be as varied and as complex as the different organizational structures and political mandates of donors. Effectively managing these increased demands results in additional costs to the organization, including the demands made on

management time, and the increased recurrent costs of upgraded administrative systems and additional staff.

6.4. General

Unmet need is most effectively addressed through simultaneous, synergistic improvements in access, quality, and sustainability

In the past, as family planning programs got started, they typically focused on narrow improvements in physical access. In contrast, many of SEATS' interventions to increase access actually came about through the project's work on quality and sustainability. In Albania, for example, where family planning services were virtually new, SEATS found through focus group discussions that women wanted access to high-quality services or no services at all because of fear of side effects. This added to evidence that, in many countries, the primary contributor to unmet need is less the lack of physical access, but rather lack of knowledge about contraceptives and services, concerns about side effects, and other psychosocial barriers.[18,19,20]

Most SEATS' subprojects developed quality and sustainability plans. Quality plans typically identified facility infrastructure, staff skill levels, interpersonal communications, or service provision policies as areas for improvement. While these clearly relate to quality, they also fall under SEATS' broadened definition of access, as described above. Likewise, many sustainability plans recognized that their purpose was to ensure long-term continuity of services. Sustainability plans in Albania, Eritrea, Cambodia, and Mozambique identified ways to make commodity supplies more reliable, which will benefit future access in those countries. Similarly, subprojects that introduced user fees improved their ability to continue providing services in the future, even if these fees restricted access to low-income clients in the short term.

SEATS focused on improving access, quality, and sustainability simultaneously and synergistically, interweaving these three driving themes in subproject development. The SEATS' experience demonstrated the inter-relatedness of these three core elements—how they can affect one another, positively and negatively—and that, by working on them simultaneously, it is possible to leverage the positive while controlling the negative.

Most important is that through a carefully managed approach to all three, as in Cambodia for example, SEATS has shown that it is possible to balance the sometimes competing demands of expanding access, reaching the poor, and achieving long-term sustainability. There does not appear to be a recipe for success that is equally applicable in all situations, but the demonstration that this balance is achievable is itself a significant step forward.

Reinforcing evidence-based programming encourages ownership of problems and solutions and appropriateness of interventions

Information can be highly persuasive in motivating community leaders, program managers, and service providers to address the needs of underserved groups. Locally gathered data can encourage ownership of problems and solutions, support advocacy, and make interventions

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[18] *Zappel., 1997 p. 27.*

[19] *Robey, Ross, and Bhuhan. 1996 p. 2.*

[20] *One analysis of data from Demographic and Health Surveys in 18 developing countries found that lack of physical access accounted for only 4.1 percent of unmet need, while lack of knowledge, at 24.9 percent, and health concerns, at 20.4 percent, were the primary contributors. Bongaarts, J. and J. Bruce 1994 p. 10.*

appropriate. SEATS found that the successful use of data depends on a small number of people taking ownership, which happens when the usefulness of these data is understood.

In its programs in African cities, for example, SEATS found many urban leaders were unaware of the unmet need of their citizens, particularly adolescents, for quality FP/RH care and unconvinced of the importance of doing something about it. But these same leaders became enthusiastic champions for reproductive health when their attention was drawn to the issues, and above all, when they saw local data that highlighted unmet need. Those data became the basis of their efforts to advocate for more funds from national or international sources.

While existing data can be gathered and reviewed, small focused studies are often needed to provide a complete picture. In Urban Initiative sites in Senegal and Guinea, and in youth programs in Zambia and Zimbabwe, for example, SEATS needed to work with counterparts to collect data on youth because standard surveys frequently had omitted this important group.

Future programming, particularly in systems undergoing decentralization, needs to build in a permanent capacity to collect and use data

Community leaders and program managers, however, need to be able to use data, not only for advocacy but also for planning and management to meet the challenges of growing demand for services. This is especially important in the context of reforms that promote greater responsibility at the local, as opposed to the national level. It is essential to build this capacity from the beginning if results are to be used for program improvement.

SEATS Innovations in Monitoring and Evaluation

- Refined the FPPMES system developed under SEATS I, which allows use of service statistics to estimate CPR, a simple and innovative way to estimate this important project outcome. The program, including an interactive demonstration, is available on the SEATS Web site.
- Developed the Urban Initiative's Quick Study Model, which takes a "quick and clean" approach to data collection and analysis, relying as much as possible on existing data and minor primary data collection before program planning and launch.
- Used innovative M&E strategies to measure new programmatic approaches. For example, youth peer educator activities required indicators and tools different from standard family planning service delivery programs. In addition to CYP, for peer educator programs, SEATS tracked such indicators as number of youth reached, further broken down by male/female; old/new contact; and group/individual counseling, and number of youth referred. For clinical services for youth, SEATS tracked new users by method, number of STI cases by male and female, number of antenatal visits, and number of abortions or abortion complications.
- In collaboration with the FOCUS on Young Adults Program, adapted and tested a low-cost methodology developed by FOCUS. Through this method, peer educators applied a simple questionnaire among a sample of their contacts every quarter. The approach helped youth reproductive health programs understand the strengths and weaknesses of their peer education activities. Tested in Gweru, Zimbabwe, it identified what types of clients peer educators reached, what services they delivered, and what effect their activities had on demand for clinical services.[21]

SEATS—particularly in its Urban, Youth, MAPS, and Quality Initiatives—had some success in building local capacity for measurement and evidence-based decision making. For example, cities in Senegal calculated CPR for the first time and, in Zimbabwe, facilities used the results of over 700 exit interviews and observations of client-provider interaction to carry out quality

[21] *Mueller, Gundrum, Bond, and Williams. 1999*

improvements. In general, however, while counterparts were able to use data for advocacy, they much less frequently used data for planning and management.

In fact, data use to assess and improve performance rarely occurred without SEATS technical assistance. Encouraging local use of M&E data is difficult. Even if M&E findings are well presented, some decision-makers view the process as donor driven and may be disinclined to maintain it.

M&E specialists should make a special effort to include managers in early stages of M&E activities, eliciting managers' input on what kinds of data would be useful to them, and briefing them in advance on what kinds of data will be collected. In this way, a good data system responsive to needs at all levels can be put in place at the outset, with assistance provided, if needed, in ways to use data at the local level.

Integrating family planning and other reproductive health services responds better to what clients and countries are demanding

In the past five years SEATS has seen a steady increase in demand from the field, from USAID Missions, from local partners, and from clients, for assistance in programming family planning in the context of reproductive health—which could mean incorporating selected reproductive health services into family planning programs, or vice versa.

SEATS' counterparts were committed to the idea of integrated services providing a full range of reproductive health care. Virtually without exception in the countries where SEATS worked, clients, managers, and service providers all perceive the need for integrated services and value family planning more highly when it is placed in the context of reproductive health. In many instances, SEATS found that family planning services were enhanced by providing other reproductive health services. In Russia, linking improvements in family planning programming to the promotion of LAM, breastfeeding and rooming-in, and clinical updates on STIs, enhanced the acceptability of the family planning component to service providers as a key part of quality reproductive health services for women.[22] Focus groups and exit interviews with clients of private midwives in Uganda, Zambia, and Zimbabwe revealed that they wanted STI treatment services. Young people coming to youth-friendly clinical sites in Senegal, Zambia, and Zimbabwe—particularly boys—were primarily interested in STI, HIV, and AIDS information and services. Postpartum and postabortion family planning counseling and services were a major part of SEATS' work with SSK in Turkey. The governments of Cambodia, Eritrea, and Kyrgyzstan asked SEATS to assist in developing a national safe motherhood policy and life-saving skills training as well as family planning programming.

> ***Reproductive health and human rights:*** SEATS' focus groups and anecdotal evidence showed that providers, clients, and young people in Albania and Russia often came to share the conviction that access to quality reproductive health services was the right of people of all ages. In these countries, the concept of rights clearly served as the basis for ensuring that efforts to improve and expand services incorporated the special needs and concerns of youth. In Cambodia, reproductive rights were a specific theme of peer educators' outreach activities.

Countries in transition were particularly open to starting with state-of-the-art approaches and the recommendations from the ICPD. In Albania, Cambodia, Eritrea, Kyrgyzstan, and Russia, reproductive health program managers insisted on programming family planning in the context

[22] *Haffey, Cappa, and Beitrishvili. 1997 p. 8.*

of reproductive health. They readily integrated relatively new methods and tools, such as emergency contraception and incorporation into family planning counseling of the client-provider interaction guidelines put forth by USAID's MAQ Initiative.[23]

Developing and implementing integrated services, however, is not easy and there is no universal agreement on how best to do it. There is a need to design integrated services that are compatible with local providers' understanding and that can actually be done given the specific local constraints.

Family planning programs that seek to meet the needs of their clients for reproductive health—and particularly those programs trying to address HIV/AIDS—will need to think well beyond the contraceptive needs of healthy, married women.[24] They will need to:

- Address individual lifestyles, sexuality, and risk, extending providers' skills to overcome discomfort in discussing issues of sexuality—especially extramarital sexuality—risk and disease.
- Reach out to men and promote condom use and safer sexual behavior.
- Scale up proven approaches to young people—the most vulnerable group—building on good progress in establishing youth-friendly programming.
- Overcome obstacles to cross-sectoral programming and build effective partnerships with non-health sectors, particularly those that aim to improve women's social status and eliminate gender inequities.

At the global level, demand is high for a responsive, broad-based capability that combines proven approaches with new strategies

Generally, Missions sought SEATS' in-country support in two situations. The first demand was to fill a large, multi-faceted role, typically where the Mission did not have a bilateral program—perhaps because the situation was too uncertain, for example, because of civil unrest or war. Missions valued SEATS' ability to respond quickly and comprehensively to a large and diverse number of needs, its flexibility with program slow-downs and evacuations, and its ability to offer intensive capacity-building where needed. The variety of challenges in countries described in Section 3 offer good examples of this responsiveness.

The second demand from Missions was to fill a specific niche that was not being addressed by either their bilateral or other Cooperating Agency programs, including work with midwives, youth, and in municipalities. This played to SEATS ability to develop creative new strategies to address pockets of unmet need and reach the underserved, as described in the Special Initiatives.

The link, within one project, between the tried and tested and the innovative enabled new strategies to be integrated into standard responses as soon as their value was recognized. For example, the early success of the approaches to expanding access to services for youth, and to mainstreaming of quality, led to their rapid integration into broader subprojects—the institutionalization of what had been a creative new program effort.

Sufficient time should be allowed in countries for programs to be effective

SEATS found that USAID field missions were often more interested in activities with a longer-term investment horizon than immediate service delivery output—activities such as the establishment of a foundation of enabling policy; commodity security; and the development of

[23] *Murphy and Steele. 1997.*

[24] *Shelton. 1999.*

management capacity, systems management, and human resource development. These activities provide a foundation upon which bilateral projects and others can build.

To achieve substantial results, to address adequately the challenge of sustainability, and especially to develop the necessary partnerships across sectors, requires a long planning horizon—much longer than SEATS experienced.

Even when the focus was on service delivery, the funding cycles under field support were often too short to achieve a measurable impact on a large scale. The short time-frame for projects is a problem familiar to all contractors and it seems likely to continue. SEATS' experience suggests that, under these circumstances, contractors should:

- Concentrate subproject start-ups in the first 18 to 24 months of each five-year project, and try to avoid starting new things that need time to get started in the last half of the project.

- Design each subproject with the appropriate timeline needed to achieve maturity and results, say 10 to15 years. Expect USAID commitment to the initial two to three years of that process, and to what can be achieved during that time. Then, if the project looks promising, seek support from USAID and other donors to pick up the next three- to five-year segment.

7. Conclusion

The SEATS II project, which began in 1995, provided one of the first opportunities to test the practicality of ideas endorsed by the ICPD and to learn the realities of the challenges that they presented. In bringing to life the real world of managing support for service delivery in a post-ICPD world, SEATS has leant legitimacy to the concept of quality, client-centered services that address the needs of people at different stages of their lives, and of the benefits to the individual of integrating family planning with other aspects of reproductive health care. Many SEATS' lessons reaffirm what others in the reproductive health community have learned over the last five years, providing a reassuring endorsement of the strategies adopted.

SEATS demonstrated the inter-relatedness of the three core elements of access, quality, and sustainability—how they can affect one another, positively and negatively. A key lesson is that, through a carefully managed approach to all three, it becomes possible to balance the sometimes competing demands of expanding access, reaching the poor, and achieving long-term sustainability. Many believe that these three objectives are in such conflict that success in one can only be achieved at the expense of another. There is no universal solution to achieving this, but the fact that it can be done at all shows that we are on the right track.

Overall, in SEATS experience, a client focus is key. This concept, commonplace in the development community, was new to many in-country partners. Once equipped with the appropriate understanding and skills, however, they became enthusiastic proponents. Services flourished, and long-term sustainability became a real possibility. There are now proven approaches and the tools required to make profound changes in service delivery systems and providers. These approaches and tools offer the opportunity to make 'client focus' not just a consultant mantra but a cornerstone of the day-to-day activities of reproductive health services everywhere.

References

Bongaarts, J. and J. Bruce. 1994. *The Causes of Unmet Need for Contraception and the Social Content of Services,* Working Paper No. 69, Population Council, New York.

Bruce, J. 1990. Fundamental Elements of the Quality of Care: A Simple Framework. *Studies in Family Planning*. Mar-Apr 21(2): 61-91.

Çakir, H. V., S. Fabricant, F. N. Kircalioglu. 1996. Comparative Costs of Family Planning Services and Hospital-based Maternity Care in Turkey. *Studies in Family Planning*, Sept-Oct 27 (5): 269-276.

Haffey, J., L., Cappa, L. Beitrishvili. 1997. *Final Report: Russia Project Assessment and Dissemination Conference Preparation,* Arlington, VA: JSI/SEATS..

Houde Quimby, C. and M. L. Mantz. 2000. *Expanding Access to Reproductive Health Through Midwives: The MAPS Initiative.* Arlington, VA: ACNM/JSI/SEATS. Jain, A.K. 1989. Fertility Reduction and the Quality of Family Planning Services. *Studies in Family Planning*. 20(1): 1-16.

JSI. 2000. *Integrating Reproductive Health Into NGO/PVO Programs: A Summary of SEATS' Experience.* Arlington, VA: JSI/SEATS.

JSI. 2000a. *Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services Delivery: Context and Case Studies.* Arlington, VA: JSI/SEATS.

JSI. 2000b. *Enhancing the Sustainability of Reproductive Health Services: Lessons Learned From the SEATS II Project.* Arlington, VA: JSI/SEATS.

Mueller, L., K. Gundrum, K. Bond, and T. Williams. 1999. *Outcomes of a Low-cost Strategy for Monitoring an Adolescent RH Program.* Presentation at annual meeting of the American Public Health Association, Chicago, Illinois, November 1999.

Murphy, E. and C. Steele. 1997. Client-Provider Interactions in Family Planning Services: Guidance From Research and Program Experience. *USAID MAQ Task Force Recommendations for Updating Selected Practices in Contraceptive Use, Vol. II.* Chapel Hill, NC: INTRAH.

Newton, N. 2000. *Applying Best Practices to Youth Reproductive Health: Lessons Learned From SEATS' Experience.* Arlington, VA: JSI/SEATS. Robey, B., Ross, J., and Bhuhan. I. 1996. Meeting Unmet Need: New Strategies. *Population Reports*, Series J, No. 43. Baltimore, MD: Johns Hopkins School of Public Health, Population Information Program.

Rossi, E. 2000. *Meeting the Growing Demand for Quality Reproductive Health Services in Urban Africa: Partnerships with Municipal Governments. Lessons Learned From the SEATS' Urban Initiative.* Arlington, VA: JSI/SEATS. Shelton, J. 1999. Prevention First: A Three-pronged Strategy to Integrate Family Planning Program Efforts Against HIV and Sexually Transmitted Infections. *Family Planning Perspectives*. Vol. 25, No. 3.

Sosyal Sigortalar Kurumu. 1999. *Service Statistics 1997 and 1998.* Ankara, Turkey. United Nations Population Fund (UNFPA). 1995. Summary of the Programme of Action of the International Conference on Population and Development. New York: UNFPA.

Zappela, M. 1997. Beyond Access: Addressing the Unmet Need for Family Planning. *People and Development Challenges.* May 4(7): 27-28.

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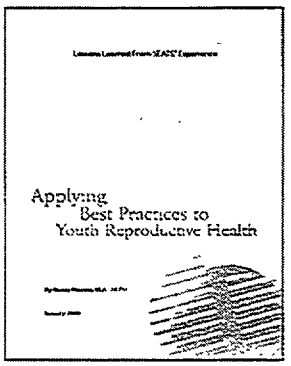
Proven Approaches, New Strategies: Innovations, Best Practices, and Lessons Learned From the SEATS II Project

by SEATS, January 2000.

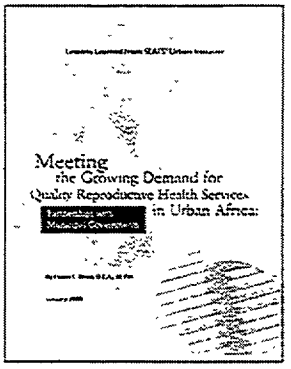
This document summarizes the innovations, best practices, and lessons learned from the SEATS II Project. It draws key lessons from several analytic exercises involving both field and headquarters staff as well as from many of the other papers available on this list. In addition to summary data on achievements in improving access to and the quality of family planning/reproductive health service delivery, the document includes programmatic findings related to access, quality, and sustainability. It also points to the future for family planning/reproductive health service delivery programs.



Applying Best Practices to Youth Reproductive Health: Lessons Learned from SEATS' Experience

by Nancy Newton, M.A., M.P.H., January 2000.

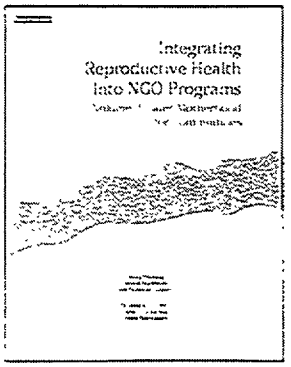
Meeting the complex and diverse sexual and reproductive health needs of young people was a focus of SEATS' subprojects in eight countries: Albania, Burkina Faso, Cambodia, Eritrea, Russia, Senegal, Zambia, and Zimbabwe. This report describes subprojects' experiences in applying documented best practices and novel approaches to promoting, protecting, and improving young people's sexual and reproductive health, including integrated clinical services, peer education, community mobilization, and continuous quality improvement.



Meeting the Growing Demand for Quality Reproductive Health Services in Urban Africa: Partnerships with Municipal Governments

by Elaine E. Rossi, D.E.A., M.P.H., January 2000.

As decentralization and democratization gain footholds in urban centers throughout Africa, the role of municipal officials in both planning and resource allocation for social services is growing. *Meeting the Growing Demand for Quality Reproductive Health Services in Urban Africa: Partnerships with Municipal Governments* details how the SEATS Project improved the ability of municipalities to implement projects and activities aimed at local leaders to meet the increasing demand for accessible, high-quality family planning and reproductive health services. The paper presents key lessons learned from the project's Urban Initiative activities in ten urban areas within Guinea, Mozambique, Senegal, Zambia and Zimbabwe, and identifies the diversity of city-specific needs by each municipal/national team involved in the work. It also describes the origins and experiences of the Urban Initiative's eight years of work developing program models, tools, and innovations that should be applicable to municipal leaders, in Africa and other regions of the world, striving to meet the rapidly increasing demand for quality services.



Integrating Reproductive Health Into NGO Programs Volume 2: Safer Motherhood for Communities

by Jenny A. Huddart, Joyce V. Lyons, and Donna Bjerregaard, January 2000.

As organizations with strong ties to their communities, NGOs and PVOs are ideally suited for facilitating community level interventions. *Integrating Reproductive Health Into NGO Programs Volume 2: Safer Motherhood for Communities* handbook provides guidance to organizations about accessing the resources of the formal health system, but primarily focuses on interventions appropriate at the community level. Its objective is to assist interested NGOs to help communities assess, organize, and implement "safer motherhood" strategies.

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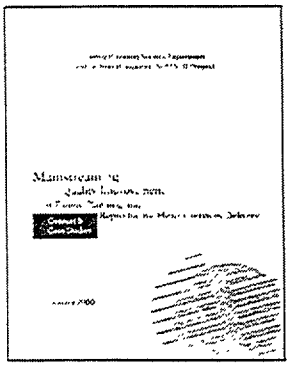
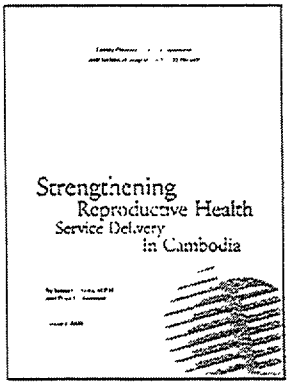


Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services Delivery: Context and Case Studies

by SEATS, January 2000.

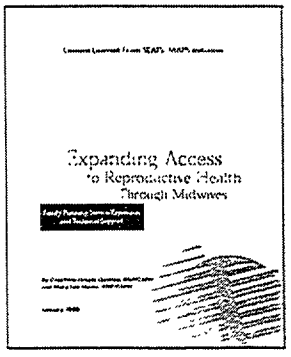
This document summarizes SEATS' experience in improving the quality of family planning and reproductive health services in a wide variety of settings. It outlines how SEATS approached "mainstreaming" continuous quality improvement in its subprojects, with special emphasis on making services more responsive to clients' concerns. It shows how the project's approach to improving and measuring the quality of care evolved and suggests how to build on the project's experience. The report includes brief case studies from Albania, Cambodia, Eritrea, Russia, Senegal, Turkey, Zambia and Zimbabwe, and describes how the program improved the quality of care in hospitals, public and private clinics, community-based distribution programs, and private midwifery practices. This report is intended for program managers at the systems level, such as those involved with national, regional, or municipal activities, or in institutions such as NGOs or hospitals.



Strengthening Reproductive Health Service Delivery in Cambodia

by Janne C. Hicks, M.P.H., and Priya E. Mammen, January 2000.

This paper explores SEATS' contribution to improving family planning and reproductive health care in Cambodia. It illustrates how SEATS implemented a broad strategy including the public and private sectors, national and community-level interventions, and clinical and educational programs through its three partner organizations: the Reproductive and Child Health Alliance, the Reproductive Health Association of Cambodia, and the Cambodian Midwives Association. The report details work conducted in five technical areas deemed necessary for strengthening reproductive health care in a country that suffers from a severe lack of trained manpower and decimated infrastructure. The technical interventions include safe motherhood, service expansion and outreach, logistics management, quality improvement, and organizational development. Lessons learned are presented to guide future program operations in Cambodia.



Expanding Access to Reproductive Health through Midwives: The MAPS Initiative

by Charlotte Houde Quimby, RNP/CMW, and Mary Lee Mantz, RNP/CMW, January 2000.

Midwifery Association Partnerships for Sustainability (MAPS) is implemented by SEATS' partner, the American College of Nurse-Midwives (ACNM). The Initiative promotes the development of midwives, a normally underutilized human resource, as a way to address unmet needs for family planning and reproductive health care. This paper explains how MAPS works with midwives, in both private and public sectors, through their professional associations. The report details the Initiative's successful strategic approach using three levels of association development, its model for capacity building of associations and members, its efforts to create a more enabling practice environment by integrating quality and sustainability, its launch of model clinic sites, and results of its policy initiatives. The document also includes case studies of MAPS efforts since 1995, involving collaboration with associations in Senegal, Uganda, Zambia, and Zimbabwe.

Vital Connection – Linking Women's Literacy Programs and Reproductive Health Services

by SEATS' partner World Education, Inc., 1999.

The *Vital Connections* handbook grew out of the Women's Literacy Initiative, an effort that aims to create new and stronger links among women's literacy programs, the local and international agencies that sponsor them, and the international family planning and reproductive health community. The book builds the case for establishing an integrated health/literacy program and offers guidance on steps to do so. It responds to the Program of Action of the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women by reinforcing calls to eradicate illiteracy and promote gender equity. The intended audience for this document includes managers in organizations offering literacy courses or reproductive health services, policymakers, donors, and others involved in community work to promote informed decision making among women.

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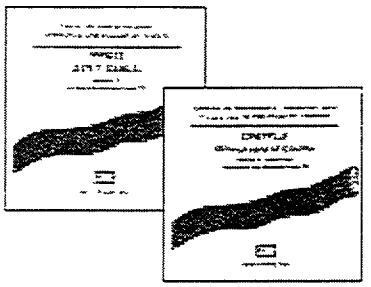

Family Planning Program Monitoring and Evaluation System (FPPMES)-Manual and Spreadsheet Application for Lotus or Excel,

1999. (Also new- Excel version available in Spanish)

Family planning program managers, researchers, and others can use FPPMES to convert quarterly contraceptive supply data and population size and growth rate information into estimates of couple-years of protection and contraceptive prevalence rates. The output consists of tables displaying each statistic by contraceptive method and by quarter and graphs that can be designed by the user. The original FPPMES was published in 1996 for Lotus and owing to its popularity, was recently published for Excel and in Spanish.

Forthcoming from the SEATS Project...

SEATS II Guide to Leveraging: Mobilizing and Diversifying Resources for Reproductive Health

by Lisa Hare, Joseph Sclafani, Beth Daly, Maggie Huff-Rousell, John Holley, and Margaret Phillips.

This handbook was written to assist in building the capacity of reproductive health organizations to analyze, design, and implement approaches to leveraging resources—attracting the support necessary to continue or expand services through use of the organization's assets (facilities, skilled personnel, experience, programmatic expertise, successes). The guide presents leveraging as a marketing challenge—marketing of an organization, its programs, services, and products to attract sufficient financing for current and future plans. The guide includes annotated references that cover various topics in more depth. Case examples, figures, and worksheets run throughout the guide to both illustrate aspects of leveraging and to assist the reader to think through critical aspects of leveraging. The guide will be published in March 2000.

Enhancing the Sustainability of Reproductive Health Services: Lessons Learned from the SEATS II Project

by SEATS.

The sustainability of its in-country development partner organizations and their activities has been critical to SEATS' work. Defining sustainability as *the capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid,* SEATS II's collaboration with its partners has included assistance to: (1) strengthen their institutional and financial capacity; (2) increase the attractiveness of their program/services to their clients and potential investors (government, donors); and, (3) expand their non-USAID funding from a combination of donor and local resources. This paper describes both the SEATS multi-dimensional approach to sustainability and the lessons learned from the project experiences.

The Performance Improvement Review (PIR) Package: A Quality Assurance Tool for Community-based Organizations

by SEATS' partner Initiatives, Inc.

The PIR, developed by SEATS' partner, Initiatives, Inc., is a set of quality assurance tools to support PVOs/NGOs as they integrate FP/RH activities into their existing portfolios. It is an approach that helps community-based programs conduct self-directed program reviews, identify key problems and develop corrective action plans. It can be an effective monitoring and evaluation system providing data for tracking progress and also can help establish a culture of quality as it builds relationships with implementing partners and involves them in problem solving. A structured process like the PIR helps organizations recognize and understand program quality holistically within the context of their program rather than as an isolated element.

The Reproductive Health Integration Initiative Performance Study and its Results

by SEATS' Initiatives, Inc.

SEATS' Reproductive Health Integration Initiative (RHII) aimed to expand and improve FP/RH service delivery by providing support and guidance to NGOs/PVOs wishing to integrate FP/RH activities into their existing portfolios. Multiple resources were developed, including RHII handbooks, a trainer's guide, and the Performance Improvement Review Package. A series of regional integration workshops was conducted in Africa and Asia. To further study the process of integration, SEATS offered additional technical assistance to four organizations (World Vision/ Zambia; the Christian Children's Fund/ Zambia; CASP-PLAN/ India and the Kunzwana Women's Association in Zimbabwe) implementing community-based family planning services. This paper focuses on the use of the PIR tools to monitor progress at these four sites.

Integrating Family Planning/Reproductive Health into NGO and PVO Activities: Experiences and Lessons from the Field

by SEATS.

PVOs and NGOs—key partners for SEATS' Integration Initiative—have shown that it is possible to work collaboratively with the most needy communities to provide services to populations not reached by government or other services because of logistical, cultural, or economic constraints. While health has been an important intervention for many PVOs and NGOs, family planning has not traditionally been a focus. By partnering the technical expertise of SEATS with the community experience and contacts of the PVOs and NGOs, SEATS was able to develop and implement a strategy to successfully integrate family planning activities into the ongoing programs of several PVOs and NGOs, expanding services to underserved populations. This report describes the SEATS experience with and lessons learned from five field projects.

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Also Available from the SEATS Project...

Programs in Countries Coping with the Effects of War and Civil Strife: Experiences in Albania, Cambodia, and Eritrea
by SEATS, September 1999.

Client Perceptions of Reproductive Health Services in Vladivostok and Novosibirsk, Russia
by SEATS MotherCare; Department of Public Health, Novosibirsk Oblast; Department of Health Services, Primorsky Krai, 1998.

Integrating Reproductive Health Into NGO Programs, Volume 1: Family Planning Second Edition
(available in English and French) — Trainers Guide also available.
by Joyce V. Lyons and Jenny A. Huddart, 1997.

Plan for Sustainability: Guidelines to Strengthening Institutions and Recovering Costs
by SEATS, 1997.

Strategy for Quality of Care in Family Planning and Reproductive Health
by Linda Ipppolito, Nancy Harris, and Don Lauro, 1996.

Comparative Costs of Family Planning Services and Hospital-based Maternity Care in Turkey
by H. Volkan Çakir, Stephen J. Fabricant, and F. Nilgun Kircalioglu, 1996.

Findings from the Sub-Saharan Africa Urban Family Planning Study Blantyre, Bulawayo, Mombasa City Reports and Overview Report
by The Centre for African Family Studies, Nairobi, Kenya; John Snow, Inc., SEATS Project, Washington, DC; Center for Population and Family Health, Columbia University, NY, 1995.

Management of Community-Based Family Planning Programs: A Manual for Trainers and Trainees
by The Centre for African Family Studies; John Snow, Inc., SEATS Project, Washington, DC; Center for Population and Family Health, Columbia University, NY, 1992.

Designing a User-Fee System
(available in English, French, and Spanish)
by Lawrence M. Day, 1992.

User Fees for Sustainable Family Planning Services
(available in English, French, and Spanish)
by Lawrence M. Day, 1992

Final Country Reports:
Albania
Eritrea
Kyrgyzstan
Mozambique
Uganda
Zambia
Zimbabwe

Gweru, Zimbabwe Youth Baseline and Endline Survey Results.
(June 1999 forthcoming)

Lusaka, Zambia Youth Baseline and Endline Survey Results.
(1999 - forthcoming)

Baseline Assessment Conducted in Mabalane and Guija Districts Gaza Province Mozambique September 1998.

Eritrea Quality and Access Survey Baseline Results.
(forthcoming)

These publication can be obta[illegible] from the following:

Development Experience Clearinghouse
1611 N. Kent Street, Suite 20[illegible]
Arlington, Virginia 22209

or, they can be downloaded [illegible] following websites:

www.dec.org

www.seats.jsi.com

APPENDIX 2

Family Planning Service Expansion & Technical Support (SEATS II): Activities in countries

Africa	Service Expansion	Method mix expansion	Long-term permanent methods	Clinical training	Counseling	Supervision/referral	Monitoring & evaluation, MIS	Logistics	Equipment procurement	Safe motherhood	LAM/Breastfeeding	Post-abortion care	STIs/HIV/AIDS	Dual protection methods	FGM	IEC/Demand creation	Quality of care	Sustainability	Leveraging	CBD	Working with NGO/PVOs	Institution building	Strategic planning	Management training	Policy development	Business development	Focus on youth	Focus on urban	Focus on midwives	Focus on integration	Focus on literacy	Partner Organization
Eritrea	✓	✓		✓	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓	✓		✓	✓	✓	✓		✓		S		✓			MOH, HUEYS(NGO)
Guinea	✓																✓	✓			✓	✓	✓		✓		S	S			S	Municipalities, MOH
Mozambique	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓		✓	✓	✓			✓		S	✓		S	✓	MOH, CSPVOs(4), Municipalities
Senegal	✓	✓			✓	✓	✓		✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	S	S	S		S	MOH, SANFAM, ASBEF, ANSFS, (NGOs), Municipalities
Uganda	✓	✓		✓	✓	✓	✓		✓	✓			✓			✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	S		S			UPMA(NGO), MOH
Zambia	✓	✓		✓	✓	✓	✓		✓	✓			✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	S	S	S	S		Municipalites, ZNA(NGO), CARE(PVO), MOH
Zimbabwe	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	S	S	S	S		ZNFPC, Municipalities, ZINA(NGO)

S = SEATS Special Initiatives in these areas
✓ = Activities in these areas
* SEATS worked in Burkina Faso and Cameroon during PY01

Family Planning Service Expansion & Technical Support (SEATS II): Activities in countries

ANE	Service Expansion	Method mix expansion	Long-term permanent methods	Clinical training	Counseling	Supervision/referral	Monitoring & evaluation, MIS	Logistics	Equipment procurement	Safe motherhood	LAM/Breastfeeding	Post-abortion care	STIs/HIV/AIDS	Dual protection methods	FGM	IEC/Demand creation	Quality of care	Sustainability	Leveraging	CBD	Working with NGO/PVOs	Institution building	Strategic planning	Management training	Policy development	Business development	Focus on youth	Focus on urban	Focus on midwives	Focus on integration	Focus on literacy	Partner Organization
Albania	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓			✓			✓			✓	✓	✓	✓		MOH, AFPA, UNFPA, Institute of PH, Medical Institute
Bangladesh																									✓							
Cambodia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		MOH, RHAC, CMA, RACHA
India	✓						✓									✓	✓	✓			✓	✓	✓							S		PLAN (PVO)
Jordan																									✓							PRB
Kyrgyz Rep	✓			✓	✓		✓		✓		✓		✓			✓	✓	✓			✓	✓								✓		MOH, WORLD BANK, UNFPA, ABT, FGP Association (FGPA)
Russia	✓	✓	✓	✓	✓		✓		✓		✓		✓			✓	✓	✓							✓		✓	✓	✓	✓		MOH, Municipalities, Medical Institutes & Colleges
Turkey	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓			✓	✓	✓		✓		✓	✓	✓	✓							SSK, MOH, Turk – Is
West Bank/Gaza							✓	✓		✓							✓	✓			✓	✓	✓									CARE, Pop Council, UPMRC, UHWC, PFS, HDIP, PNA

S = SEATS Special Initiatives in these areas
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