
The Best Practices Compendium:

Conclusions and Lessons Learned from the Advisory Group

July 21, September 20, and December 6, 2002

December 2002
Advance Africa



The Best Practices Compendium :
 Conclusions and Lessons Learned from the Advisory Group Meetings
 July 21, September 20, and December 6, 2002

TABLE OF CONTENTS

Executive Summary	3
I. Introduction	4
Process of Developing the Compendium	4
What is the purpose of the Compendium of Best Practices?	4
What is the niche for this Compendium?	5
How are these practices assessed?	5
What are Advance Africa and other agency Roles in the Compendium?	5
II. The Process	7
1. Overall Objectives of the BPAG:	7
2. Objectives for BPAG meeting #1:	7
3. Objectives for BPAG meeting #2:	7
4. Objectives for BPAG meeting #3:	8
III. OUTCOMES OF BPAG	9
A. Criteria for Assessing Best Practices	9
1. Evidence of Success	9
2. Transferability: Successful Application in New Settings	11
B. Pyramid of Practices	12
1. Structure	12
2. Terminology	12
D. Dissemination, Use and Shared Ownership of the Compendium of Best Practices	14
Additional Comments/Concerns from Advisory Group	17
Conclusions	18
The Consensus Building Process: Lessons Learned from BPAG: ___ Error! Bookmark not defined.	
Looking Ahead: Next Steps	19
Appendix	20

Appendix I: Agendas for all 3 Meetings	21
Appendix II: BPAG Participant List	25
Appendix III: Organizations Participating in BPAG	27
Appendix IV: Presentations by Advance Africa Staff	28
Appendix V: BPAG #1 Brainstorming “What are the criteria for a best practice?”	29
Appendix VI: (BPAG #1) Name that Term Brainstorming Session	30
Appendix VII: Definition of Terms	32
Appendix VIII: Pyramid of Practices	34
Pyramid 1: July 23, 2002	34
Pyramid 2: September 20, 2002	35
Pyramid 3: December 6, 2002	36
FINAL Pyramid of Practices	37
Appendix IX: Definition of Terms	40



Executive Summary

To provide countries in Africa and throughout the world with appropriate technical assistance to improve or expand reproductive health programs, Advance Africa has initiated the identification, documentation and promotion of Best Practices in family planning and reproductive health. The *Compendium of Best Practices* focuses on public health interventions or program models, not medical practices. The purpose of the *Compendium of Best Practices* is to make previously implemented program models easily accessible to program managers who seek to meet the needs of family planning/ reproductive health programs. Advance Africa's role is to act as an unbiased coordinator for gathering and managing information from various sources and involving other organizations in the assessment process.

Advance Africa has invited experts committed to the field of Family Planning/ Reproductive Health from seventeen organizations to offer technical guidance on this Best Practices initiative. This group convened as the Best Practices Advisory Group (BPAG) which met three times this year (*July 23, September 20, and December 6*) and will continue annually hereafter.

Several key outcomes were achieved at these meetings. This report presents the outcomes in terms of the following main topics:

- Criteria for Assessing Best Practices:
 - Evidence-based success & Transferability
- The Pyramid of Practices
- Dissemination, Use and Shared Ownership of the *Best Practices Compendium*

From the start, a clear definition of the role and tasks of the Best Practices Advisory Group was established. A general consensus was reached that the *Compendium of Best Practices* must be a 'joint' process, not owned solely by Advance Africa. The BPAG discussions also supported the need for a simplified two-tiered *Pyramid of Practices*, reduced from the original five-tiers. Criteria for identifying Best Practices must be evidence-based: evidence of program success and transferability. The group supported the development of a multi-agency Review Board to evaluate each practice/program model in the *Compendium* based on various technical areas.

This report summarizes the conclusions and lessons learned discussed in the three meetings, the outcomes achieved and future steps to be undertaken in support of the *Best Practices Compendium*.

I. Introduction

What are best practices? What criteria can be used to define a Best Practice and how can they be used? How can we promote the use of Best Practices by program managers in the field?

Organizations implementing international family planning and reproductive health projects have documented three decades of successes in the form of what are commonly known as “best practices.” Although these demonstrate innovative and successful approaches to meeting the challenges of family planning and reproductive health needs of populations, only occasionally is this information easily accessible to program managers. Increasingly country leaders and donors want to ensure that successful program models and the lessons learned from implementation of these are used in other situations where this is appropriate.

Process of Developing the Compendium

As part of Advance Africa’s overall program to promote best practices, an Advisory Group was established to develop standardized, unbiased criteria for the evaluation of best practices in family planning/ reproductive health. The Advisory Group is intended to provide critical input into the design of the compendium, the process of classifying program models, and effective ways to promote utilization of the compendium. Between July and December 2002, forty Advisory Group members from seventeen organizations gathered with Advance Africa staff for three **Best Practices Advisory Group (BPAG) Meetings** to discuss these issues. ([Appendix I- Agenda](#), [Appendix II- Participant List](#)).

What is the purpose of the Compendium of Best Practices?

The Compendium:

- Enables program managers in the field to quickly find tested program models to meet specific program needs so they can successfully implement evidence-based programs
- Recognizes and publicizes information about successful program models to program managers, including lessons learned
- Promotes higher standards and brings rigor to the evaluation process.

Why create a Compendium of Best Practices?

The Compendium makes previously implemented program models easily accessible to Program Managers who have identified program gaps, needs or opportunities and seek to address these or who are seeking proper models that will address these identified needs. Program Managers must first use a Strategic Mapping process in order to accurately identify such program gaps, needs or opportunities. Upon doing

so, the second step is to identify best practices to address these needs¹. The Compendium of Best Practices evaluates practices in terms of the evidence of success and replication. Program Managers can have greater confidence that the practices they choose to implement will lead to improved program performance. Additionally, the Compendium allows for search by multiple technical areas.

Findings suggest that best practices are heterogeneous—they can be case studies, models, products or technologies, specific interventions, tools, frameworks, etc. While all of these have potential as best practices, the standards used to select them as “best” for program application are not consistent. This means that Program Managers may be taking significant risks in choosing them for implementation in their programs, unless there is a standardized evaluation process to codify the success of the program models.

What is the niche for this Compendium?

The Best Practices compendium is unique in several aspects:

- It is a collaborative effort by multiple agencies
- It includes public health interventions, not medical practices
- It reviews and evaluates program models in FP/RH service delivery according to evidence on successful outcomes and replication.
- It enables searching by multiple topics

The Best Practices Compendium focuses on program models or public health interventions rather than medical practices. The Compendium may also include **tools** used in program models.

How are these practices assessed?

The Advance Africa Best Practices Unit, with the help of an inter-agency Review Board, will work to critically analyze the nature of those program models that have been labeled “best practices”. Advance Africa has worked with the Advisory Group to create standardized criteria that can be utilized to objectively assess each practice consistently and fairly. A clear distinction has been made between untested, risky interventions and those backed by evidence and experience. Thus, Advance Africa’s criteria include the evidence of the program’s success as well as the successful replication by the program.

What are Advance Africa and other agency Roles in the Compendium?

Advance Africa will:

- Act as an unbiased clearing house for BP database compendium
- Actively collect/ facilitate the collection of Best Practices in FP/RH to document in the database compendium
- Manage and facilitate the BPAG

¹ See reference: Strategic Mapping Manual, Advance Africa, 2003.

- Manage a Review Board of multi-agency members to evaluate submitted program models
- Disseminate successful program models/ best practices
- Facilitate future ownership of the Best Practices Compendium by other organizations.

Other agencies will:

- Collect Best Practices in FP/RH to document in the database compendium
- Help disseminate successful program models
- Support future ownership of the Best Practices Compendium by other organizations.



II. The Process

1. Overall Objectives of the BPAG:

Advance Africa has invited a select group from multiple organizations of committed experts in the fields of Reproductive Health and Evaluation to offer guidance on the Best Practices initiative. Their role will be to advise the Advance Africa team on developing the Best Practices Compendium by:

1. Reviewing existing criteria and determine new criteria for the evaluation of each submitted program model
2. Examining and agree upon indicators to assess each practice
3. Identifying appropriate terminology for each pyramid level
4. Clearly defining the review process
5. Identifying potential review board members and determine review board procedures.

With each progressive BPAG meeting the objectives changed as ideas gradually evolved, as shown below.

2. Objectives for BPAG meeting #1:

- a. To discuss criteria for evaluating and classifying program models by degree of impact and replicability
- b. To define the factors involved with classification by five categories (access, demand, quality, sustainability, replicability)
- c. Examine current terminology

Key questions addressed at meeting #1 (as related to objectives above):

- How would you define a best practice/ program model as used in public health and reproductive health service delivery?
 - What should be the criteria for assessing best practices?
 - What is the best way to measure the success of an intervention, using these categories (Demand, Access, Quality, Sustainability, and Replicability)? How can these 5 factors be measured?
 - How can we define “Replicability” or “Transferability”?
 - What is the best terminology to use when describing different levels of program models?
-

3. Objectives for BPAG meeting #2:

- a. Reach a final consensus on essential criteria for assessing reproductive health and family planning interventions

- b. Review the process for the assessment of public health practices and brainstorm effective standards for the BP Review Board
- c. Define methods to increase knowledge, use and ownership of Best Practices through: USAID missions, CA Community, and Local NGOs.

Key questions addressed at meeting #2:

- **How should we evaluate public health practices?**
How should we consider context? Should the assessment depend on context?
What are the constraints to assessing public health programs? What are the *best criteria* for assessment based on the constraints?

 - **How can Best Practices be reported, disseminated and utilized by program managers?**
How can we increase knowledge of the Best Practices Compendium?
How can we increase the use of the Best Practices compendium by program managers?
How can we increase the ownership of the Best Practices Compendium?
-

4. Objectives for BPAG meeting #3:

- a. **Establishing the Peer Review Board:**
 - Determine criteria and process for member selection
 - Create a list of possible members
 - Agree upon list of technical area topics for experts

 - b. **The Review Process- Ensuring Rigor:**
 - How will Peer Review members assess and report?
 - Establish procedure for assessment

 - c. **Shared Ownership of Compendium:**
 - Determine steps to assure dissemination and shared ownership of the compendium
- 

III. OUTCOMES OF BPAG

The following issues were discussed while ideas developed by the group in three successive BPAG meetings. After each meeting, Advance Africa staff worked to incorporate the new concepts into the existing Best Practices framework.

- A. Criteria for Assessing Best Practices
 - 1. Evidence of Success
 - 2. Evidence of Transferability
- B. The Pyramid of Practices
- C. Dissemination, Use and Shared Ownership of the Best Practices Compendium

A. Criteria for Assessing Best Practices

1. Evidence of Success

OBJECTIVES:

The concept of a best practice was examined and criteria discussed for evaluating/classifying program models by degree of impact and replicability.

- How would you define a best practice/ program model as used in public health and reproductive health service delivery?
- What should be the criteria for evaluating best practices?

KEY DISCUSSION POINTS:

At the first meeting, in a short brainstorming session participants created an extensive list of criteria, which could be used to determine a best practice. The current definition used by Advance Africa is consistent with many of the opinions held by others. Key concepts identified by BPAG included: evidence-based, adds value, replicable/transferable, community acceptance, as well as, cost effective, practical, ethical, works with the existing programs and system, and promoted by outside organizations. (See [Appendix IV](#) for a complete list of criteria proposed in BPAG#1).

Questions were discussed at many levels, in broad terms with the entire group and at the detailed level of indicators in small group discussions. The open-discussion brought about many responses.

Identifying success factors

The importance of identifying success factors was highlighted:

- Identifying evidence of success is critical. We must support managers in the field by reporting why a project was successful in one case yet unsuccessful in a different area.

- Program managers must understand that evidence is needed to move a practice up the pyramid from promising practices to best practices.

Enabling Factors

Several enabling factors were discussed as key evaluation criteria. These factors were termed “Contextual factors”, “Enabling Factors” or “Additional Success Factors”.

Questions asked included: Where does “scale” fit into this evaluation/process? What about commitment and/or partnerships? Several ideas were suggested. We could include these as “additional success factors”, which could be weighted together with “evidence” and “replicability” factors. Additionally, these factors could work to define and evaluate the evidence of “replicability”.

Assessment Process

- A standardized assessment of practices is necessary. This should be undertaken by a Review Board of technical experts in the field of FP/RH.
- Should not be “overly scientific” by insisting on evidence from randomized clinical trials. We need to find ways to rigorously evaluate practices already implemented. It becomes unproductive to falsely strive for precision.
- The compendium is not static; programs are constantly changing. Thus, we will anticipate continued need for evaluating the programs regularly.

SESSION CONCLUSIONS: Criteria for a best practice must be evidence-based, show transferability, and show that the program provides a practical, efficient, effective solution to the situation. Success factors are important in terms of describing the environmental context in which the program is a success. To contribute to the unbiased assessment process, a multi-agency Review Board will be established to assess each practice/program model in the Compendium.



2. Transferability: Successful Application in New Settings

OBJECTIVE: The concept of Replicability and/or transferability was explored and defined in terms of environmental context, country geography, and populations.

KEY DISCUSSION POINTS:

The concept of replicability was discussed throughout the three BPAG meetings. The term “replicability”, as defined below, soon came to be replaced by the term “transferability”.

Transferability: *Successful application of a program in new settings; the ability to successfully apply a procedure or program successfully across cultures, sectors, or geographic areas.*

Replicability: *The ability to reproduce a performance of an experiment or procedure more than once. The program may be repeated across cultures, sectors, or geographic areas. Serves as a model for generating policies and initiatives elsewhere, with the potential for replication.*

The second of Advance Africa’s two original criteria for defining a Best Practice included the concept of “transferability”. A program is most valuable to the Program Manager if it is easy to replicate or transfer to different types of settings. The setting may be described in terms of social, cultural, economic, differences in the target population, geography, or environment.

The question asked in assessing programs was ‘has this been replicated?’ not, ‘is this program replicable’. Replication was measured on a sliding scale in terms of: ‘Replicated in the same province’, ‘Replicated in the same country’, ‘Replicated in different countries’, ‘Replicated on different continents’. The concept of “replicability” evolved throughout these three BPAG meetings. This evolved from “evidence of replication” to a more fully defined “evidence of transferability or having been transferred.

To properly determine “transferability” of a program, the assessment will consist of two segments. The evidence of a successful transfer of this program will be reviewed. Secondly, if a program has not been documented successful replication, the Review Board may assess the program and determine that it is easily able to be transferred although no evidence of transfer is available.

CONCLUSIONS: The ability for a program to be replicated or transferred to a different setting is critical to evaluate the usability of a program, its effectiveness and its value. Multiple factors must be considered when evaluating the transferability for a practice/program model including if it has ever been replicated and where.

B. Pyramid of Practices

1. Structure

OBJECTIVE: The *Pyramid of Practices* was developed to provide a simple graphic means to show the various levels of practices. The initial Pyramid had five levels. The BPAG helped clarify and simplify this pyramid down to two levels. The *Pyramid of Practices* was assessed by the BPAG in each meeting successively.

KEY DISCUSSION POINTS:

(See Appendix for the evolution of the three Pyramids)

CONCLUSIONS:

The diagram “Pyramid of Practices” was refined to reflect these substantive changes. The Pyramid has two levels (Promising Practices and Best Practices), connected by Lessons Learned. These levels are determined by the two criteria: Evidence of success and Transferability in multiple contexts. The concept of “Principles” is an encompassing circle which engulfs the entire pyramid. The Principles which may be present in all programs are factors for which to strive, but are not necessary criteria for assessment as a Best Practice.

2. Terminology

OBJECTIVE: The terminology used in the Pyramid of Practices was examined and alternative terms suggested for the following terms: Risk, Principles, Best Practices, Better Practices, SOTA (State of the Art), Innovations, and Lessons Learned.

KEY DISCUSSION POINTS:

- **Confidence:** It was suggested that “Confidence” should replace “Risk” as a term to describe the Program Managers. The connotations with Confidence are more positive than associations with Risk. Confidence/risk is a function of all other factors; confidence merges the level of evidence with replicability.

Are all innovations high risk/ low confidence?

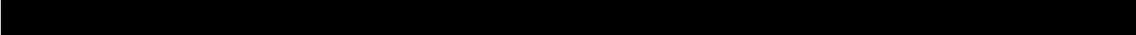
Not necessarily, however they must be considered high risk because they are untested and uncertain.

- **Principles:** As an overall structure, the pyramid should be in reverse with principles underlying the other practices.
- **Failures:** A distinction must be made between the failures and the successes, but the Lessons Learned from failure are often as important as those learned from success. It was proposed that Advance Africa find a way to add a section on failed programs to the compendium.

(See [Appendix V](#) for BPAG #1 Brainstorming Session on Pyramid Terminology)

CONCLUSIONS:

The BPAG concluded that the long “Laundry List” of criteria as previously formulated in BPAG#1, needed to be revised. (See Appendix for BPAG Meeting Report #1). Several criteria listed can be considered “Principles” which program managers should strive to meet, but are not mandatory for consideration or assessment as a Best Practice.



D. Dissemination, Use and Shared Ownership of the Compendium of Best Practices

OBJECTIVE: To discuss the possible approaches to increase the knowledge, increase the use and increase the ownership of BP and the compendium.

USAID missions; Local African Groups, CA community. The following questions were addressed:

1. How can we increase **knowledge** about BP in public health?
2. How can we increase **use** of BP by program managers?
3. How can we increase the **ownership** of the BP compendium in Africa?
(see Appendix ___ for complete grid of suggestions)

KEY DISCUSSION POINTS:

How can we increase *knowledge* of BP compendium in public health?

USAID Missions:

- There needs to be leadership endorsement, and relationship identification to other quality improvement and/or knowledge management efforts (i.e. CDIE, MAQ).
- The communication and sharing efforts need to be grouped together, perhaps disseminated through periodic 'BP Gems'.

Local African groups:

- Utilization of CA, USAID, donor, and foundation communities in an umbrella network fashion is necessary.
- Link to portals, websites, and personal networking (i.e. email) is essential as well.
- Presentations at conferences (i.e. knowledge cafes)
- Targeted mailing to universities, MOH, local NGOS, etc. (i.e. 'press release') which can be rolled in with other mailings.

CAs:

- There should be more participation marketing activities between HQ and country-level such as 'blow ins' with Pop Reports and The Manager to serve as advertisement.
- Duplication should be avoided, while linkages should be promoted.
- It is important to have USAID as the principal owner and promoter.

Further comments: Coordinate user channels—marketing, branding; Identify existing user channels; Update periodically, keep it fresh; Value added—make it a clear statement, communicate what makes it different; Find niche—find what's out there; Get "stickiness"—something that grabs on the 1st page; Competitor analysis—feature, how this differs and value added

- **How can we increase *use* by program managers?**

USAID Missions: Incorporate the compendium into RFAs and RFPs, and use CAs and projects as part of the ‘sales force’. It can also be built into project design and review, and Pop Tech and other consultants should be utilized more. There is further need to put up mission bilateral practices, and encourage CAs to submit BP.

Local African groups: CAs should encourage local partner organizations to use BP in project design and implementation. Further research needs to be undertaken in “usable moments” with target groups. User guidelines need to be established. There is also a need to advocate for donors to require review of BP’s for project design.

CAs: Participation needs to be incorporated into the process and BP in the database, with an emphasis on quality of content. Peer review aspects should be highlighted, and CAs can promote BP through project designs (i.e. use the compendium as a reference). AA acts as ‘bird-dogging’ staff, while there are TA/guidelines for use as well as access to grey literature.

Further Comments: User Guideline—Guidelines for TAs; TA; Go out there—help people use it; Make relevant to user.

- **How can we increase *ownership*?**

USAID Missions: BP entries could be solicited from missions and local CAs, creating research services that will address USAID’s key issues for special studies, and develop ‘pride in ownership’ through features of ‘BP from Country X’. In addition, Bureaus should partner with country teams, and seek to incorporate specific topics, and what works elsewhere. This should be made a part of strategic planning, and be included in Bureau packages.

Local African groups: There is a need to input more practices in the database. Perhaps there could be a “problem posted” and a subsequent “call for action/solutions”. Contact information needs to be on the website, as well as brand building of the site. There needs to be a geographically diverse board, with local ‘editors’ and point people. Getting their signature on the line is critical. Perhaps there could be a “program problem of the month”.

CAs: There is a call to create incentives. Two categories for submission would be useful, such as evidence vs. not enough evidence. There should be links to CAs websites, and a network of board members. Further clarification of value added and niche is necessary. CAs should be involved in the process, and the CAs need mini-guidelines on how to introduce organizations.

Others: Other organizations can be identified to create a quality brand.

Further comments: Emphasize the people—networks/geographical content, leveraging access to individuals; Have to create a community; Keep the three groups separate, keep segmentation of donors, CAs, local organizations.

Ideas for Program Managers:

- It is the responsibility of the Program Manager to pre-test BPs, and to recognize the obstacles in using the compendium: lack of technology, human, and social resources. What resources are needed? Make sure there is an incentive/award system in place
- Create guidelines for using databases that will aid in: assembling “packages of interventions” and repackaging, guidance for adaptation, transferring tools (are they already available?), information exchanges, efficiency and transferability of interventions, management groups and training.

Things to consider

- What exactly does ‘information exchange’ consist of?
- What information will be shared and published?
- If efficiency and transferability are documented better, perhaps the compendium will be used more.
- Training is essential for a management group, perhaps a manual that would allow a manager to gain knowledge without using the database initially.

SESSION CONCLUSIONS:

- How can we increase knowledge of BP Compendium in public health?
 - Incorporate BP into quality improvement and knowledge management efforts
 - Use links, personal networking, targeted mailings and presentations to increase knowledge of BP
 - Marketing activities with CA Headquarters and country level
- How can we increase use of BP Compendium by program managers?
 - Use existing systems and project design
 - User guidelines/manual
 - Hi-light peer review
 - CA participation in the process
 - Find niche; keep it fresh
- How can we increase ownership of BP Compendium?
 - Create ownership by soliciting BP and getting organizations’ practices in database
 - Featuring BP
 - Brand building of site
 - Create incentives
 - guidelines

Additional Comments/Concerns from Advisory Group

The following additional issues were raised by the BPAG:

1. Ownership and community participation are essential. Beneficiaries should be represented.
2. A practice/ program model included in the compendium should be identified by topic and not be specifically identified with a particular person or organization; these should become more generic as they are replicated.
3. Ease of access and use are critical components for ensuring the use of the compendium. The compendium will be field tested to ensure usefulness and usability. Field testing is critical. Advance Africa will be testing the use of the BP Compendium with several African-based organizations, including CAFS, FAWE (an Advance consortium member organization) and Partage (a group of African organizations working with Advance Africa).
4. The compendium must be simplified and transparent in order for it to be used effectively.

Conclusions and Next Steps

The three meetings of the Best Practices Advisory Group were a most successful venue for obtaining input from various CAs, USAID, and other International agencies. The BPAG facilitated the exchange of ideas and guided the process of refining The Compendium of Best Practices in Reproductive Health. New ideas were formulated through group brainstorming sessions, small group sessions, and large group discussions.

The key outcomes from BPAG include:

- This group established a clear definition of the role and tasks of the Best Practices Advisory Group in guiding the process of evaluating, disseminating and using Best Practices.
- The development of the *Compendium of Best Practices* will be a 'joint' process with various organizations, not owned solely by Advance Africa. Advance Africa will act as manager of the Compendium to facilitate its functionality.

Criteria for Assessing Best Practices

- BPAG members agreed that criteria for identifying Best Practices must include:
 1. Evidence of success and,
 2. Evidence of transferability/ successful applications in multiple settings.The second criteria may be assessed based on evidence of successful program replication or by appropriate assessment by the expert Review Board.
- To contribute to the unbiased evaluation process, a multi-agency Review Board will be established to evaluate each practice/program model in the Compendium. Reviewers will be chosen based on specific technical area expertise.

The Pyramid of Practices

- The *Pyramid of Practices* will be simplified from the original five-tiered pyramid to a two-tiered structure. Levels of practice in the final version are "Promising Practices" and "Best Practices", linked by Lessons Learned. As a program moves up the pyramid, the level of confidence for Program Managers increases.

Dissemination, Use and Shared Ownership of the Best Practices Compendium

- Dissemination of the Compendium will be done openly with multiple partners on a continual basis. Leadership, stewardship and utilization of best practices cannot be implemented without strong champions. We must look to stakeholders and committed individuals to coordinate the country-wide programs and promote the best practices for that region.

Looking Ahead: Next Steps

Looking ahead, Advance Africa intends to work with the BPAG in continuing the process to effectively document, disseminate and globally promote utilization of best practices. The BPAG will be called to meet as a group on an annual basis as well as periodically via individual and/or email-based interactions.

Several next steps were determined from the BPAG. Overall, Advance Africa will continue to act as facilitator and manager for the Best Practices Compendium.

Documenting best practices: Advance Africa will initiate this process through its on-line database, while also gathering submissions from various other organizations via the on-line submission form. Advance Africa and BPAG will be proactive in promoting documentation of best practices through this forum.

The Peer Review Board: This will be facilitated by Advance Africa, though feedback at each phase will be solicited from BPAG members. This process will begin in stages by selecting experts in various technical areas.

Disseminating Best Practices: The dissemination process will be initiated by Advance Africa via conferences, meetings, workshops, and collaborations with other organizations at both the headquarter-level and with field offices internationally. Information on the compendium will be distributed through concise 2-pg summaries, distribution of the “Best Practice of the month/year”, website linkages and partnerships, and presentations.

Finally, in order to ensure a dynamic, non-static Compendium of current Best Practices the Compendium must be reviewed on a continuous-basis to capture timely ideas which carry the most relevance for promotion in the field. As new programs are practiced and evaluated with new evidence of success, programs are able to move up or down the pyramid. With this challenge, Advance Africa and its partners in the BPAG seek to create a useful tool for Reproductive Health program managers practicing in the field.

Appendix

Appendix I: Agendas for all 3 Meetings	21
Appendix II: BPAG Participant List	25
Appendix III: Organizations Participating in BPAG	27
Appendix IV: Presentations by Advance Africa Staff	28
Appendix V: BPAG #1 Brainstorming “What are the criteria for a best practice?”	29
Appendix VI: (BPAG #1) Name that Term Brainstorming Session	30
Appendix VII: Definition of Terms	32
Appendix VIII: Pyramid of Practices (#1, #2, #3)	34
Pyramid 1: July 23, 2002	34
Pyramid 2: September 20, 2002	35
Pyramid 3: December 6, 2002	36
FINAL Pyramid of Practices	37
Appendix IX: Definition of Terms	40

Appendix I: Agendas for all 3 Meetings

Best Practices Advisory Group Meeting #1 July 23, 2002, 8:30am-4:30pm

8:30- Coffee and sign-in
9:00 am- Welcome
Issakha Diallo

Review objectives for this meeting and expectations of outcomes
Susan Palmore

Introductions *Sharon Rudy,*
Facilitator

Presentation: Review of Criteria set by multiple organizations *Lauren*
Pindzola

Name your Criteria! Brainstorm of Criteria for Determining a Best Practice

Presentation: Review of Advance Africa's Approach to Best Practices *Issakha Diallo*

Large group discussion- Criteria for a best practice

11:00 – Coffee/tea break
Optional BP Online Database demonstration

Small Group Discussions: Criteria for a best practice

1:00-2:00 pm-- Lunch Break

Small Groups Report Out

Large group discussion- Criteria for a best practice

Presentation: Advance Africa Terminology and Definitions *Susan*
Veras

Name that term! Determining the best terminology and definitions

4:30- Wrap-up and Next Steps
Complete the Evaluation

Best Practices Advisory Group Meeting #2

September 20, 2002 8:00am-4:30pm

Update For New Members

8:00 am- Welcome and Introductions

Presentation: Review of Advance Africa's Approach to Best Practices *Issakha Diallo*

Presentation: The Best Practices Compendium

Susan Palmore

The Best Practices Compendium niche and Advance Africa's role

Presentation: Background on Best Practices

Lauren Pindzola

Review of criteria set by various organizations and Review of BPAG #1 Outcomes

Activity: *Criteria Review!* Review list of 'ideal' criteria for determining a BP developed in Mtg #1, discuss 'constraints,' develop final list of 'realistic' criteria.

.....
For All Guests

10:00 –Sign In for All BPAG Participants— Coffee

10:30- Welcome and Introductions

Facilitator:

Hally Mahler

BP Online Database demonstration
Pindzola

Susan Veras and Lauren

Presentation: Updates and actions taken since BPAG #1

Lauren Pindzola

(Advance will present new Pyramid, etc.)

Presentation: The assessment process and role of BP Review Board

Issakha Diallo

What type of evidence should be used? How will practices/ program models be assessed? Review of the 'realistic criteria' as determined by the morning session.

Activity: Pairs compare and assess 3 case studies based on the Pyramid of Practices

Large Group Discussion on Evidence

Facilitator: ***Hally Mahler***

How should the Review Board evaluate these programs?

1:15-2pm Lunch Break

Presentation: Ensuring Utilization of Best Practices

Susan Veras

Small Group Discussions- Use of Best Practices in the field

Small Groups Report Out

Large group discussion

Wrap-up and Next Steps

4:30- Adjourn

Best Practices Advisory Group Meeting #3
Friday December 6, 2002, 9:30am-4:30pm

9:30 am Registration and Coffee

10:00 am Welcome and Introductions

10:15 am Updates from Advance Africa

10:30 am Working groups

All BPAG Members will meet in one of three working groups.

a. Establishing the Peer Review Board:

- Creating the list of possible members
- Selection of Review Board members
- Requirements for Review Board members
- Technical area topics for experts

b. The Review Process- Ensuring Rigor:

- How will Peer Review members assess and report?
- Criteria for assessment
- Protocol for Peer Review Board established

c. Shared Ownership of Compendium:

- Encouraging a forum for exchange of ideas
- Regional buy-ins: Increased submission of interventions and increased use of compendium by program managers
- Evaluation of use and usefulness of BP compendium

12:30 pm- 1:30 pm Lunch Break

1:30 pm- 4:30 pm Large Group Meeting

Presentation: Updates and Final Decisions on the Best Practices Pyramid

- Working Group Briefing- by the *Review Board Working Group*
- Working Group Briefing- by the *Review Process Working Group*

Presentation: Dissemination and Shared Ownership of the Best Practices Compendium

- Working Group Briefing- by the *Dissemination Working Group*

Large Group Discussion—Open Forum

Final Wrap-Up for BPAG- Next Steps and Future BPAG involvement
4:30 pm Meeting Adjourns

Appendix II: BPAG Participant List

	Organization	Invitees	Meeting Attendance		
			#1	#2	#3
1	AED	Chris Schultz	0	1	0
2	AED/Sara Project	Suzanne Prysor-Jones	1	0	0
3	AED/Sara Project	Holley Stewart	0	1	1
4	AED/Sara Project	Antonia Wolff	1	0	0
5	Catalyst	Taroub Faramand	1	1	0
6	DTT	Bapu Deolika	1	0	0
7	EngenderHealth	Jan Kumar	1	1	0
8	FHI	John Stanback	1	1	0
9	FHI	Matthew Tiedemann	1	1	0
10	FHI/Youth Net	Shyam Thapa	1	0	0
11	FHI/Impact	David Dobrowolski	0	1	1
12	FHI/ Youth Net	Nancy Williamson	0	1	1
13	FHI/Youth Net	Hally Mahler	0	1	0
14	PopCouncil/Frontiers	John Townsend	0	1	0
15	PopCouncil/Frontiers	Laura Raney	0	0	1
16	Futures Group	Karen Hardee	0	0	1
17	Futures Group	Jill Gay	1	0	0
18	Georgetown	Caroline Blair	1	0	1
19	Georgetown	Minna Nikula	0	1	0
20	Global Health Council	Terry Fisher	0	1	1
21	INTRAH/PRIMEII	Marcel Vekemans	1	0	0
22	INTRAH/PRIMEII	Boniface Sebikali	1	0	0
23	JHPIEGO	Aly Cameron	1	0	0
24	JHPIEGO	Ron Magarick	1	0	1
25	JHPIEGO	Chris Davis	1	1	1
26	JHPIEGO	Alain Damiba	1	0	0
27	JHPIEGO	Jennifer Macias	0	1	0
28	JHU/CCP	Marian Amoa	1	0	0
29	JHU/CCP	David Awasum	0	1	0
30	JHU/CCP	Michelle Heerey	1	0	0
31	Johns Hopkins University	Gbolahan Oni	0	0	1
32	MSH	Sallie Craig Huber	1	1	1
33	Pop Leadership Programs	Sharon Rudy	1	0	0
34	USAID	Jim Shelton	1	1	0
35	USAID	Jeff Spieler	1	0	0
36	USAID	Nomi Fuchs	1	1	1
37	USAID	Kellie Stewart	1	1	0
38	USAID	Shawn Malafcher	0	1	0
39	USAID	Daniel Kabira	0	1	0
40	World Bank	Tonia Marek		0	1
	17 Organizations				
		COUNT	25	21	13

Advance Africa Staff Participating:

Issakha Diallo	Director
Agma Prins	Deputy Director
Bruce Gatti	Director of Finance Administration
Charles Brimmer	Administrative Coordinator
Jeanne Brown	Senior Technical Advisor
Lauren Pindzola	Technical Officer, Best Practices
Susan Palmore	Director Strategic Dissemination
Susan Veras	Technical Officer, Best Practices
Uchechi Obichere	Administrative Coordinator
Youssouf Ouedraogo	Acting Director M&E

Appendix III: Organizations Participating in BPAG

**Advance Africa
AED
AED/Sara Project
Catalyst
DTT
EngenderHealth
FHI
FHI/Youth Net
FHI/Impact
PopCouncil/Frontiers
Futures Group
Georgetown
Global Health Council
INTRAH/PRIMEII
JHPIEGO
JHU/CCP
Johns Hopkins University
MSH
Pop Leadership Programs
USAID
World Bank**

Appendix IV: Presentations by Advance Africa Staff

For all presentations as indicated in meeting agendas, please contact Best Practices Unit.

Meeting #1

A summary of three presentations follows.

1. Review of Criteria set by multiple organizations

Objective of this presentation: To provide an overview for the definition of and criteria for determining a best practice as defined by various organizations. Additional feedback was given by the group.

Common criteria used by many of these organizations include:

- Measurable impact
- Sustainable
- Replicable
- Partnerships and Linkages
- Community-based Development

Organizations surveyed:

- **WHO**- Medical criteria perspectives
- **UNFPA** -Glossary definitions of Best Practices
- **UNDP** - Criteria on selecting Gender Best ('good') Practices/ IACWGE
- **World Bank** - Gender Criteria in identifying Best Practices
- **UNAIDS**- BP Compendium
- **Global Health Council** - BP Awards Criteria
- **AED**, Linkages: Cynthia Green, *Improving Breastfeeding Behaviors*, 1999
- **UNESCO** - MOST Clearing House of BP
- **Dubai International Award for Best Practices**- Criteria set by UN and 29 other international institutions
- **UNDP**- Knowledge Management: Guidelines for Identifying or Certifying 'Best Practice' or Comparative Experience

2. Review of Advance Africa's Approach to Best Practices

Objective of this presentation: To offer additional guidance to the group and increase the pool of ideas on best practices. A lively conversation followed this presentation.

3. "Name that Term" Discussion of Terminology and Pyramid Structure

Objective of this presentation: To present Advance Africa's current terminology and definitions for each "level" of practice included in the Pyramid. (See [Appendix VI](#) for Practice Definitions)

Appendix V: BPAG #1 Brainstorming

“What are the criteria for a best practice?”

At the first meeting of BPAG, a short brainstorming session resulted in the following outcome. **A best practice should be, or contribute to the following:**

Adds value

- **Adds value** to entire system
- Solves the identified problem

Works with existing system

- Reinforces (does not compete) with other **existing programs**
- Inspires other changes in the **system**
- Works with the health system
- Creates social movement for change

Community

- Accepted by the population/**community**
- Ownership (multiple parties)
- Stakeholders empowered

Evidence-based

- Evidence based; research based
- Evaluated
- Internally and externally valid
- Effective
- Incorporates existing fundamentals/ principles
- Greater impact than other programs tried

Replicable

- Transferable
- Concrete building blocks/tools/ steps for easy replication Can be scaled up, or there is evidence it has been scaled up
- Replicable (to many settings)
- Fits into existing context/system
- Flexibility built into the practice

Other

- Independently promoted by outside organizations
- Describable
- “A living practice”, constantly changing; dynamic
- Consistency
- Ethical
- Lessens inequities/ is fair
- It makes sense **in the context**
- Practical
- Sustainable
- Cost efficient

Appendix VI: (BPAG #1) Name that Term Brainstorming Session

At the first BPAG Meeting Several positive outcomes resulted from this interactive session, all of which provided feedback to guide Advance in minor reconstruction of the “Pyramid of Practices”. The revision of the pyramid and selected terminology will be presented at the second BPAG meeting.

Old Term Used By Advance	New terminology Suggested by Advisory Group
Principles	<ul style="list-style-type: none"> • “Wisdom of the Ages” • Take off pyramid and include with lessons learned or include separately (somehow) • “Best available” • Visual picture would be a pie cut in to 5 pieces for LL, BP, Better P, SOTA, Innovations
Best Practices	<ul style="list-style-type: none"> • 5 ***** in rating • Should be on the top of pyramid • Model Program • Metal Awards: <ul style="list-style-type: none"> ○ Titanium ○ Platinum ○ Gold ○ Silver • Restructure pyramid: <ul style="list-style-type: none"> ○ Best ○ Better ○ Good ○ Innovation
Better Practices	<ul style="list-style-type: none"> • improved “practice” or “program model /tool” • More confidence • 3*** in rating • “Promising intervention”
State of the Art	<ul style="list-style-type: none"> • 2 ** in a five-star rating system • Anecdotal evidence • “Collapse” categories to 3 • Merge with SOTA for a 3 level pyramid
Innovations	<ul style="list-style-type: none"> • 1 * in a five star rating system • “INNOVATION” • “Pilot tested” • “New”

Lessons Learned	<ul style="list-style-type: none">-Diagram arrows should go in both directions-Not at lower levels-Best practice because evidence is clear and objective-Doesn't need a new label-Rename "evidence" or "experience"
------------------------	---



Appendix VII: Definition of Terms

This section serves merely as a reference guide for those seeking to understand the process of classifying practices and program models which Advance Africa has begun. The terms used here and structure are in the process of being changed, thus, serving as background reference.

1. Principle

Principles are ideas and concepts that are “essential” to program success. They are overriding conclusions that have general applicability across sectors, geographic boundaries or technical areas for a program. These might be considered “truisms”, usually relating to policy. There is definitive quantitative and objective evidence from multiple implementation experiences supporting the practice. Principles do not necessarily come in the form of programs or interventions.

The following are some examples of principles that have been widely accepted in the field as important factors for program success:

- Political will and leadership increase the likelihood that family planning programs will have maximum impact.
- Community participation and social mobilization efforts strengthen program sustainability.
- Multi-sectoral programs involving partnerships and linkages expand program reach and impact.
- A Principle for Voluntary Counseling and Testing for HIV is that it is essential that anonymity and confidentiality be assured for the client

2. Best Practice

This is the “Gold Standard” of practices, activities, or tools that can be implemented to support program objectives. Evidence of impact and success is drawn from multiple settings, and is based on objective data. Best Practices involve limited risk because of their track record as exemplified by this evidence and successes of replication. Program managers can be more confident that adapting and implementing a best practice to their program needs and gaps will help achieve desired program objectives.

3. Better Practice

Better Practices are SOTA practices that have been improved based on lessons learned. The projects and interventions show promise for transfer to new settings. There is less risk associated with implementing Better practices than with SOTA or innovations because of clearer evidence of successes and lessons learned through experience. Evidence exists in both qualitative and quantitative form but is drawn from application of the practice in limited settings.

4. State of the Art (SOTA)

“State of the Art” or SOTA refers to practices that reflect new trends and current thinking in the field. These practices may be successful in localized settings but much of the evidence is preliminary or anecdotal. There is still a large degree of risk associated with implementation of SOTA practices as they may not have been replicated extensively.

5. Innovation

Innovations are cutting edge approaches that reflect new, possibly untested thinking. They are sometimes variations on an old theme. Innovations come in the form of pilot programs or experimental projects. There is little if any objective evidence that the practice will have desired impact. The promise of an innovation is based on speculation and lessons learned from other practices. A high degree of risk is associated with applying innovations to a program.

6. Lessons Learned

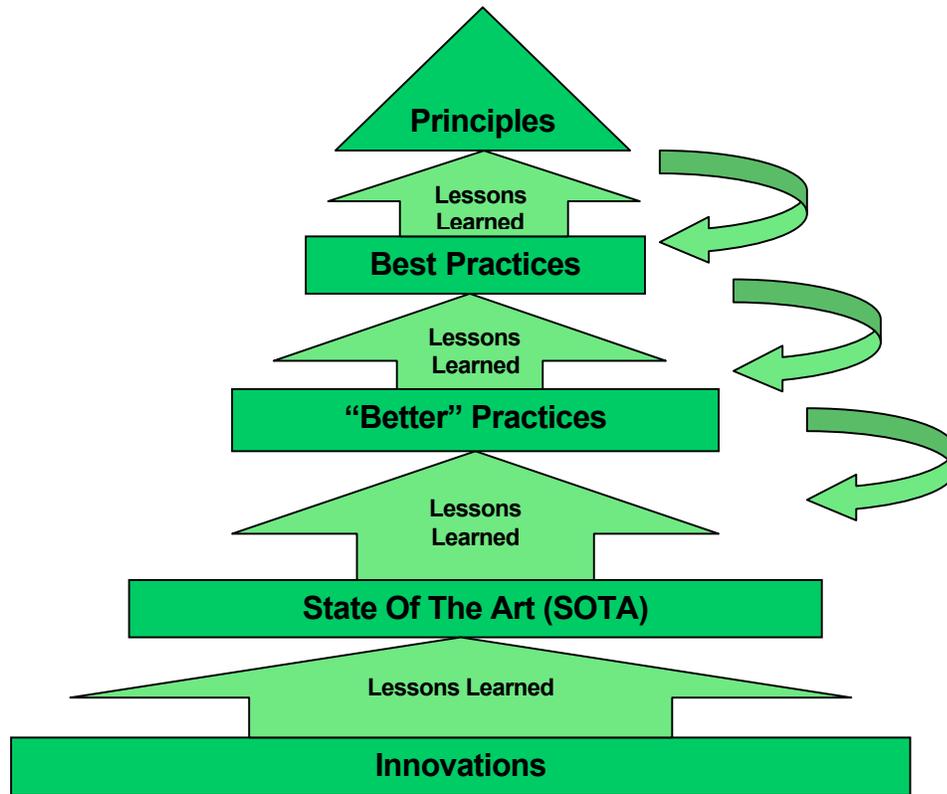
“Lessons Learned” are cross-cutting observations and conclusions that apply to a specific practice. The lessons themselves are extrapolated from experiences with an intervention or program. Evidence supporting the lessons is clear and objective.

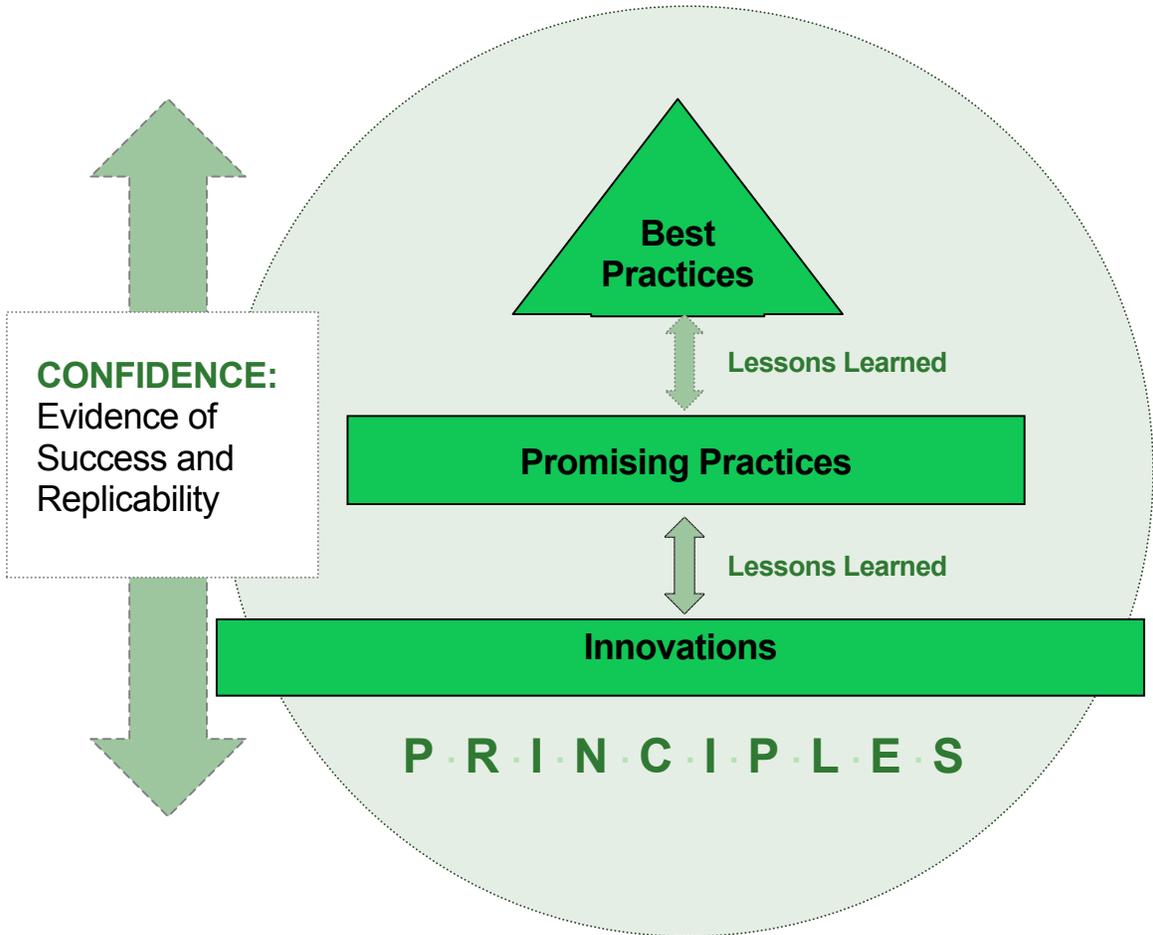
It is through the process of “Lessons learned” that a practice or intervention moves up the Pyramid to another stage. As time progresses, more evidence is found to support the program and to reduce the risk that it will not have the desired impact. The wealth of evidence increases as lessons are continually learned from experience and applied the next time around. As this process progresses, risk associated with application continues to diminish.



Appendix VIII: Pyramid of Practices (#1, #2, #3)

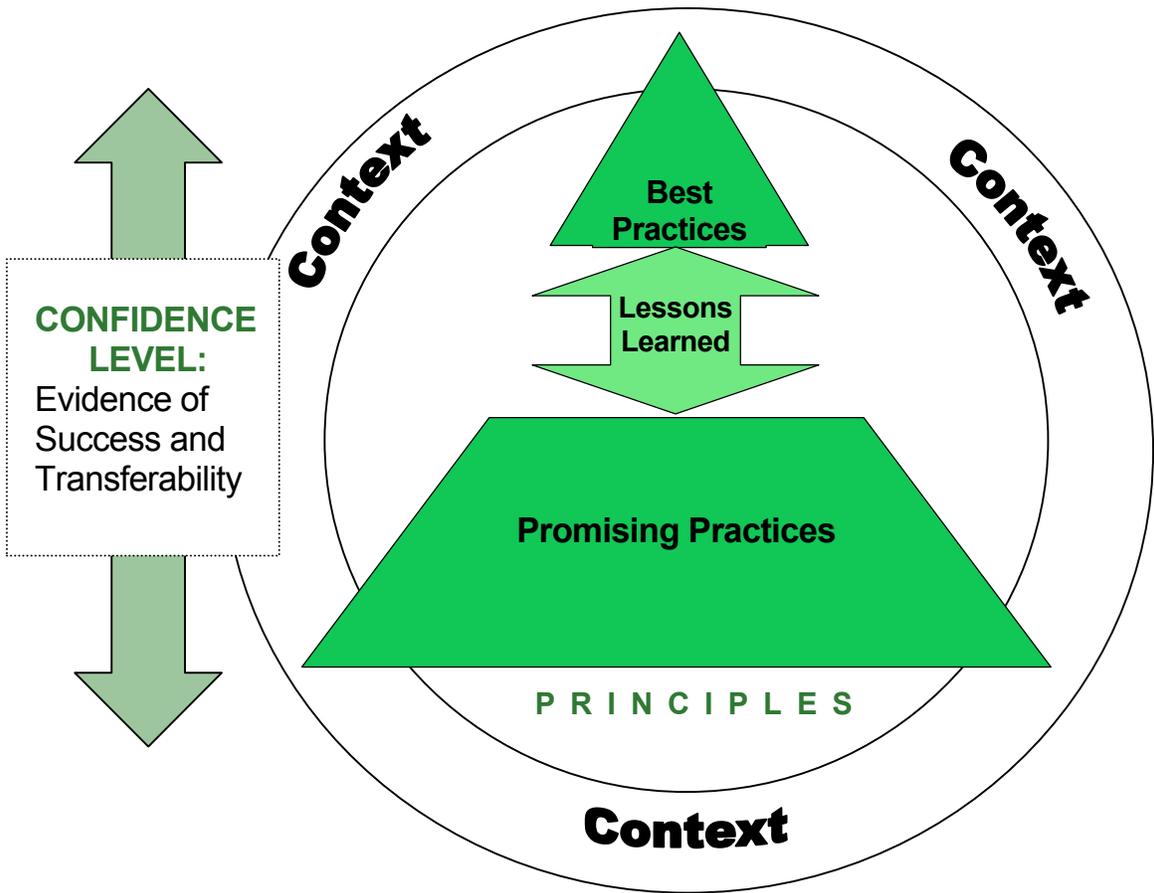
Pyramid 1: July 23, 2002







FINAL Pyramid of Practices



Appendix IX: Definitions of Success Factors (Small Group Exercises BPAG #1)

Access:

An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care.

Demand:

Willingness, desire and ability to purchase a commodity or service; the quantity of a commodity or service wanted at a specified price and time

Quality:

The degree to which delivered health services meet established professional standards and judgments of **value to the consumer**. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other outcomes, given the existing state of medical science and art.

Quality is frequently described as having three dimensions:

- quality of input resources (certification and/or training of providers);
- quality of the process of services delivery (the use of appropriate procedures for a given condition); and
- quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

Sustainability:

Durability of project results after the termination of the technical cooperation channeled through that project. Static sustainability – the continuous flow of the same benefits, set in motion by the completed project, to the same target groups; dynamic sustainability – the use or adaptation of project results to a different context or changing environment by the original target groups and/or other groups.

The capacity of the health system to function effectively over time with a minimum of external input (Financial self-reliance and technical, managerial, system or organizational capacity)

Replicability:

The ability to reproduce a performance of an experiment or procedure more than once. The program may be repeated across sectors, themes or geographic areas.

Serves as a model for generating policies and initiatives elsewhere, with the potential for replication.



Appendix IX: Definition of Terms

Below are summaries of the “Pearls” gleaned from each small group’s discussion.

Demand:

This group focused on demand, but also began to discuss factors for increasing utilization. Demand and utilization are not the same. They discussed the challenges with trying to measure the impact of demand, and when trying to identify which outcomes can be directly attributable to demand. It was decided that we must look at the *process level* data to create a logical set of outcomes. When identifying the *needs* of a population, both *met* and *unmet needs* must be addressed. Definition should include: “Willingness, desire and ability to purchase goods/services”.

Access:

What is best way to measure access?

- Availability
- Physical / geographical
- List of subtopics (additions) to describe Access
- Financial
- Socio-cultural
- Geographical
- Organizational/infrastructural
- Medical

Quality:

What is best way to measure quality?

- Replicability/ Transferability
- Client satisfaction
- Technical quality
- Outcome

Additional comments:

- The evidence needs to be examined with quantitative and qualitative data
- How much can you rely on information gathered by actual organization doing work?
- Some limitations/barriers exist in that practices do not always fit into categories

Sustainability:

This was defined as ‘a dynamic movement of practices to improve changes over time’.

Sustainability must be carried on without outsiders.

One participant noted that it is unrealistic to assume all projects will be sustainable.

- Indicators determine whether a practice is sustainable, thus we must utilize evaluation indicators.
 - Financial Sustainability factors: Diversity of funding by other donors, Trend of contributions by government
 - Community involvement: Consumer demand for appropriate services based on informed choice / percentage intended beneficiaries should be continually involved in the design
 - Coverage rate
 - Human capacity (Continued availability of trained and competent personnel to carry out technical/marginal needs)
 - Institutional capacity: Continued organizational support (eg. supervision)
 - Continued use of appropriate guidelines and tools
 - Continued institutional commitment and involvement in key/appropriate functions
 - Consume demand for appropriate services based on intended beneficiaries
- Gender specific

Much evidence is vague and hard to measure, however the more evidence provided the easier it is to determine.

Replicability:

In the **contextual** sense several factors are involved:

- Partnerships
- Socio-economic- Financial resources and costs (identifying efficiencies)
- Politics (government, providers, clients)
- Programmatic systems (Are the systems in place to make this sustainable?)
- Champion/leader
- Capacity (human resources, technical, skills; systems for maintaining these overtime)

Prospective vision (likelihood to be replicated, what is the chance of replicating this practice?)