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If final obligation, OP has no objection to the dereserving of the remaining funds. Amount of funds to be dereserved: _____

II. DOCUMENT IDENTIFICATION AND INFORMATION:

- A. Document No.: HRN-A-00-97-00007-00
- B. Modification No.: _____
- C. Buy-In/Add-On: Yes _____ No
- D. Document had been transmitted to recipient/grantee for signature. Date transmitted: 11/1/96
- E. Method of Financing (Check one only)
 - Letter of Credit
 - Periodic Advance _____
 - Direct Reimbursement _____

III. FM DISTRIBUTION

- One original signed copy to FM for recording obligation (FA/FM/A/PA, Room 612, SA-2) (Blue*)
- _____ Mission Controller: _____ (Designate)
- 1 copy to FM paying office (FA/FM/CMP/DC, Rm. 700, SA-2) (Pink*)
- _____ 1 copy to FM office (FM\CMP\IBU) attn: Teresita Hullinger

IV. TECHNICAL OFFICE/MISSION DISTRIBUTION:

- Technical Office: Jay Grew 6/PAN/11N
(Office Symbol, Name, Rm. No., Bldg.) (Copy*)
- _____ Mission: _____ (Specify)
- Program Office: Sue Anthony 6/PAN/11N
(Office Symbol, Name, Rm. No., Bldg.) (Yellow*)

V. OP DISTRIBUTION:

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VII. CONTRACT FILE:

- Original document signed by all parties for file (Blue*).
- *Purchase Order only.

A copy of this form goes with each copy of the document distributed and one copy remains in the official file.

Contract Specialist: Guessa Greitt 11/22/96
(date)

Contracting Officer: Michael B. Gushue 11/22/96
(date)

NOV 1 1996

Mr. John W. LeSar, M.D.
Senior Vice President
Academy for Educational Development
1255 23rd Street, N.W.
Washington, D.C. 20037

Subject: Award No. HRN-A-00-97-00007-00

Dear Mr. LeSar:

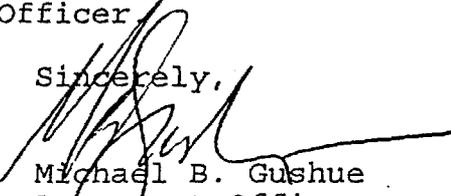
Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the U.S. Agency for International Development (hereinafter referred to as "USAID" or "Grantor") hereby intends to grant to the Academy for Educational Development (herein after referred to as AED or "Recipient"), the sum of \$37,999,596.00 to provide support for the program "Linkages", as described in the Schedule of this award and the Attachment 2, entitled "Program Description." As this award is incrementally funded, only the amount shown in Section 1.3.b. of the Agreement schedule has been obligated for use hereunder.

This award is effective and obligation is made as of the date of this letter and shall apply to commitments made by the Recipient in furtherance of program objectives during the period beginning with the effective date and ending 10/31/01. USAID shall not be liable for reimbursing the Recipient for any costs in excess of the obligated amount.

This award is made to AED, on condition that the funds will be administered in accordance with the terms and conditions as set forth in 22 CFR 226, entitled "Administration of Assistance Awards to U.S. Non-Governmental Organizations"; Attachment 1, entitled "Schedule"; Attachment 2, entitled "Program Description"; and Attachment 3 entitled "Standard Provisions."

Please sign the original and each copy of this letter to acknowledge your receipt of this award, and return the original and all but one copy to the Agreement Officer.

Sincerely,


Michael B. Gushue
Agreement Officer
M/OP/A/HRN

Attachments:

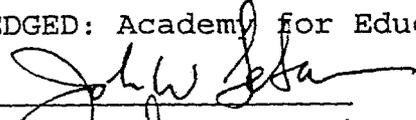
1. Schedule
2. Program Description
3. Standard Provisions
4. Standards for USAID Funded Communications Projects

ACKNOWLEDGED: Academy for Educational Development

BY:

Title:

Date:


Senior Vice-President
November 20, 1996

ACCOUNTING AND APPROPRIATION DATA

A. GENERAL

1. Total Estimated Amount:	\$37,999,596.00
2. Total Program Amount:	\$38,672,356.00
3. Total Obligated Amount:	\$ 1,100,000.00
4. Cost-Sharing Amount: (Non-Federal) 1.7% :	\$ 672,760.00
5. Project No.:	00000002
6. USAID Project Office:	G/PHN/HN USAID WASHINGTON, DC 20523
7. Tax I.D. Number:	
8. CEC No.:	07-204-138H
9. LOC Number:	

B. SPECIFIC

DV 96/97 417864	\$1,100,000.00
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ATTACHMENT 1

SCHEDULE

1.1 PURPOSE OF AGREEMENT

The purpose of this Agreement is to provide support for the program described in Attachment 2 of this Agreement entitled "Program Description."

1.2 PERIOD OF AGREEMENT

The effective date of this Agreement is the date of the Cover Letter and the estimated completion date is 10/31/01.

Funds obligated hereunder are available for program expenditures for the estimated period beginning the effective date of this Agreement through 10/24/97.

1.3 AMOUNT OF AWARD AND PAYMENT

(a) The total estimated amount of this Award is \$37,999,596.00.

(b) USAID hereby obligates the amount of \$1,100,000.00 for program expenditures during the period set forth in 1.2 above and as shown in the Budget below.

(c) Payment shall be made to the Recipient by Payment - Letter of Credit in accordance with procedures set forth in 22 CFR 226.22.

(d) Additional funds up to the total estimated amount may be obligated by USAID subject to the availability of funds, and 22 CFR 226.25.

1.4 BUDGET

The following is the Agreement Budget, including local cost financing items, if authorized. Revisions to this budget shall be made in accordance with 22 CFR 226.25.

COST ELEMENTS:

Direct Labor:	\$ 6,133,960
Fringe Benefits:	\$ 1,840,187
Subagreements:	\$11,800,000
Supplies/Equipment:	\$ 62,300
Travel/Per Diem:	\$ 3,805,306
Other Direct Costs:	\$ 7,882,008
Indirect Costs:	\$ 6,003,835
General & Administrative:	\$ 472,000

Total USAID Share: \$37,999,596

1.5 REPORTING AND EVALUATION**1.5.1 Financial Reporting**

In keeping with the requirements established in 22 CFR 226.52, the Recipient is required to:

- (a) Prepare a "Financial Status Report", SF 269a, on an accrual basis and submitted quarterly in an original and two copies to USAID/M/FM/CMP.

1.5.2 Monitoring and reporting program performance

- (a) Requirements. The Recipient shall submit an original and one copy of a brief quarterly program report to the address listed in the Cover Letter. In addition, one copy shall be submitted to USAID/CDIE/DI, Washington, DC 20523-1802. A final performance report is also required.
- (b) Contents. The Program report shall briefly present the information contained in 22 CFR 226.51(d).

1.6 SUBSTANTIAL INVOLVEMENT UNDERSTANDINGS**1.7**

The following provisions are considered to constitute the appropriate level of substantial involvement:

- a. Approval of key personnel - The USAID Project Officer must approve, in advance, the selection of any key personnel.
- b. Collaborative development and approval of an annual workplan and subordinate agreements, and all modifications, which describe the specific activities to be carried out under the agreement.

1.7 (Continued)

c. Any additional significant changes to the technical activities for which concurrence was previously required and obtained, will require reconcurrence by the Project Officer. Any technical activities which were not mentioned in the workplan will require concurrence. If a particular activity is approved in the annual workplan, it will not be necessary to seek additional concurrence prior to implementation.

d. Approval of monitoring and evaluation plans, and USAID involvement in monitoring progress toward the achievement of program objectives during the course of the cooperative agreement.

1.8 KEY PERSONNEL

The following positions and individuals have been designated as key to the successful completion of the objective of this award. In accordance with the Substantial Involvement clause of this Award, these personnel are subject to the Approval of the USAID Technical Officer.

1.9

Jean Baker, Project Director
Peggy Parlato, Deputy Director
James Gregory, Admin & Finance Manager
Sandra Huffman, Research Manager
Roy Miller, Evaluation Manager
Barbara Jones, Services Manager
J. Ross, Policy/Advocacy Manager

[End of Clause]

1.10 TITLE TO AND CARE OF PROPERTY

Title to all property financed under this award shall vest in the Recipient subject to the requirements of 22 CFR 226.30 through 37.

1.11 AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services under this award is 000.

1.12 INDIRECT COSTS

Pursuant to the Standard Provision of this Award entitled "Negotiated Indirect Cost Rates - Provisional (Nonprofits)," and indirect cost rate or rates shall be established for each of the Recipient's accounting periods which apply to this Award. Pending establishment of final or revised provisional indirect cost rates, provisional payments on account of allowable costs shall be made on the basis of the following negotiated provisional rate(s) applied to the base(s) which (are) set forth below:

Type	Rate	Base	Period
Fringe Benefits	30%	1/	1-1-95 until amended
G & A	4%	2/	1-1-95 until amended
Indirect	33%	3/	1-1-95 until amended

1/ Base of application: 1/ Total salaries less overseas employees paid in local currencies.

2/ Base of application: 2/ Subcontract expenses including Opexer personnel who are primarily employees of host countries governments and other administrated funds.

3/ Base of application: 3/ Total direct costs, excluding subcontract, opexer personnel and other administrated funds; awards; equipment; educational, post differential, and housing allowances; and participant expenses.

1.13 RESOLUTION OF CONFLICTS

Conflicts between any of the Attachments of this Agreement shall be resolved by applying the following descending order of precedence:

Attachment 1 - Schedule
22 CFR 226

Attachment 3 - Standard Provisions
Attachment 2 - Program Description

1.14 COST SHARING

The Recipient agrees to expend not less than 1.7% of non-Federal funds over the five year program period based on received federal funding. Cost sharing contributions will meet the criteria as set out in 22 CFR 226.23.

1.15 COMMUNICATIONS PRODUCTS (OCT 1994)

(a) Definition - Communications products are any printed materials (other than non-color photocopy material), photographic services or video production services.

(b) Standards - USAID has established standards for communications products. These standards must be followed

1.15 (Continued)

unless otherwise specifically provided in the agreement or approved in writing by the agreement officer. A copy of the standards for USAID financed publications and video productions is attached.

- (c) Communications products which meet any of the following criteria are not eligible for USAID financing under this agreement unless specifically authorized in the agreement schedule or in writing by the agreement officer:
- (1) Any communication product costing over \$25,000, including the costs of both preparation and execution. For example, in the case of a publication, the costs will include research, writing and other editorial services (including any associated overhead), design, layout and production costs.
 - (2) Any communication products that will be sent directly to, or likely to be seen by, a Member of Congress or Congressional staffer; and
 - (3) Any publication that will have more than 50 percent of its copies distributed in the United States (excluding copies provided to CDIE and other USAID/W offices for internal use.

1.16 PAYMENT OFFICE

M/FM/CMP/DC
USAID
Washington, D.C. 20523

ATTACHMENT 2

PROGRAM DESCRIPTION

The Recipient's proposal entitled "Linkages" and dated 10/1/96 is attached hereto as the Program Description (Attachment 2) and is made a part of this Award.

Linkages

Breastfeeding and Related Complementary Feeding and Maternal
Nutrition Program (BCM)

Volume I: Technical Application and Appendices

Updated Submission

October 1, 1996

In this proposal "Program" is used to describe the entire set of instruments (that is, cooperative agreements and grants) used to meet USAID's strategic objectives. Our submission in response to this RFA is referred to as the *Linkages* Project because USAID could develop other agreements under the overall program.

Academy for Educational Development, Inc.

List of Acronyms

ABC	Applied behavior change
AED	Academy for Educational Development
AIDSCAP	AIDS Control and Prevention Project
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BCM	Breastfeeding, LAM, Complementary Feeding, and Maternal Nutrition
BFHI	Baby-Friendly Hospital Initiative
BPNI	Breastfeeding Promotion Network of India
CDD	Control of Diarrheal Disease
CRS	Catholic Relief Services
CTTA	Communication for Technology Transfer in Agriculture
DHS	Demographics and Health Surveys
ECSA	East, Central, And Southern Africa
EPB	Expanded Promotion of Breastfeeding
EPI	Expanded Program on Immunization
FAO	Food and Agriculture Organization
FRC	Federal Resource Center
GreenCOM	Environmental Education and Communication Project
HEALTHCOM	Communication for Child Survival
IBFAN	International Baby Food Action Network
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
IIN	Instituto de Investigaciones Nutricionales
ILCA	International Lactation Consultant Association
ILO	International Labor Organization
IPPF	International Planned Parenthood Foundation
KAP	Knowledge, attitudes, and practices (survey)
LAM	Lactational Amenorrhea Method
LLLI	La Leche League International
MBF	Mother-Baby Friendly
MBFHI	Mother-Baby Friendly Hospital Initiative
MMHP	Mass Media and Health Practices Project
MSG	Mother Support Group
MSH	Management Sciences for Health
NABA	National Alliance for Breastfeeding Action
NCP	Nutrition Communication Project
NICHCY	National Information Center for Children and Youth with Disabilities
NIH	National Institutes of Health
OMNI	Opportunities in Micronutrient Interventions
ORANA	West African Food and Nutrition Organization
PHC	Primary Health Care
PSI	Population Services International
QAP	Quality Assurance Project
SANA	Sustainable Approaches to Nutrition in Africa
SARA	Support for Analysis and Research in Africa
URC	University Research Corporation
WABA	World Alliance for Breastfeeding Action
WIC	Women, Infants, and Children
WSI	Wellstart International
WV	World Vision

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- Staff Country Expertise
- List of Technical Advisors
- Start Dates of Proposed Staff

I. INTRODUCTION: AN OVERVIEW OF OUR VISION, STRATEGY, AND RESULTS

The AED Team has named our submission *Linkages* because this Cooperative Agreement plays a vital role in creating and strengthening linkages at many levels: among nutrition, health, and family planning programs; among private, public, and commercial programs; among local professionals, networks, and institutions working in these areas; and among USAID and other donors in the field. The goal of *Linkages* is to help achieve USAID's Results Package Strategic Objective, which is "Improved breastfeeding and related complementary feeding and maternal dietary practices." We understand that USAID intends for this Cooperative Agreement to be its principal technical leadership resource for breastfeeding and LAM and for related complementary feeding and maternal nutrition (BCM) as they relate to breastfeeding.

To accomplish this goal, *Linkages* will combine proven behavior-change methods with new strategies and partners to bring messages, products, and support materials to the places where decisions about breastfeeding, LAM, and other dietary practices are made - in the communities and homes where people are living. *Linkages* will do this by:

- Integrating activities to improve these practices within existing child survival, family planning, reproductive health, and food aid and emergency relief programs supported by USAID and other donors
- Developing new conceptual and operational models for reaching communities and actively involving women in these communities
- Strengthening the capacity of USAID's cooperating agencies (CAs), PVOs, NGOs, and government counterparts to design and carry out effective behavior-change programs on breastfeeding and LAM
- Advocating appropriate research and policy changes to support these activities
- Forming partnerships with a broad range of institutions and organizations to implement activities and to create cost-effective, self-supporting programs, and sustainable improvements in these health-promoting practices.

Linkages will support four types of activities:

- Training and technical assistance to improve BCM counseling, print, and media products; to change norms and policies that prevent positive practices and constrain behavior change; to use proven techniques and share successful experiences for actively involving women as leaders and decision-makers, and men as supporters, in behavior-change activities; and to improve the quality of breastfeeding/LAM, family planning and nutrition-related services.
- Program-driven research to test new strategies for working with the commercial sector, to identify new opportunities for reaching consumers with appropriate products, messages, and counseling, especially LAM as a social marketing tool for improving breastfeeding practice and contraceptive use after LAM; to test new models for community involvement in behavior-change activities; and to enhance and add to the reach of public-sector programs by linking them with nongovernmental and commercial-sector programs and services.
- Global technical leadership to advance policies and the state-of-the-art in BCM by participating in, cooperating with, and sometimes leading international efforts to further define appropriate practices for BCM; by engaging in policy dialogue and advocacy to increase investments in breastfeeding/LAM and its integration with health and population programs; by carefully documenting the costs and impact of our program efforts and using this information for decision-making and advocacy; by developing and testing new tools, especially for maternal nutrition and commercial-sector collaboration, that can be used to guide activities in the field; and by working in close contact with universities and institutions conducting applied research to develop research agendas with direct program links and programmatic value.

Throughout this proposal BCM is used to designate the key focal areas of the program, breastfeeding and LAM, as well as related complementary feeding, and maternal nutrition.

- Information sharing and dissemination to stimulate the use of new technologies to furnish information to the field and to communities; to ensure that our counterparts and collaborators are in communication with one another and that existing regional, national, and community networks and organizations have access to up-to-date scientific and program-related information, training manuals, educational materials as well as the information and results generated by *Linkages'* activities.

A. A VISION OF 2001 AND BEYOND

Our visions for this cooperative program with USAID are as follows:

Year 2001

1. A Typical Country Situation

In 2001, *Linkages* will have assisted ten joint programming countries for an average of two- and one-half years each. In a typical *Linkages*-assisted country, BCM will have been "mainstreamed" in many ways. For example, there will be observable improvements in government policies and programs concerning breastfeeding/LAM and financial flows for BCM components in government-financed activities. All relevant USAID-financed activities will have up-to-date BCM components in their programs and their activities will be synergistically linked with each other. In communities where USAID-financed PVOs and CAs are active, there will be measurable improvements in knowledge and skills of health workers and, more importantly, measurable improvements in community attitudes, norms, and practices; policies and resources; and access, availability, and quality of support services about breastfeeding/LAM and the related issues of complementary feeding and maternal nutrition. If field-support funds are available in a typical joint programming country, much broader changes in norms and attitudes will have occurred, and the government sector will be much further along incorporating up-to-date BCM components in its programs. Both USAID and *Linkages* will be knowledgeable about what happened, what worked especially well, what did not work, and the costs and effectiveness of different approaches. Programs will see changes in optimal breastfeeding prevalence and duration and increasing use of contraception.

Women participating in activities will be more knowledgeable about breastfeeding/LAM and will know and take specific actions they can take to prevent pregnancy and to improve their nutritional well-being. They will also behave differently during pregnancy because they will be more conscious about adequate weight gain, know what foods to eat to prevent anemia, have access to micronutrient supplements, and understand how diet affects their health and the outcome of their pregnancy. They will know about optimal breastfeeding practices, that water and formula feeds can make children sick, and that they are unnecessary to sustain adequate growth during early infancy. They will also have the needed support to breastfeed successfully, will know when and how to introduce complementary foods, and will have access to appropriate feeding practices for early childhood. They will know when to start contraception during breastfeeding. This support from their health workers, their spouses, and their neighbors will be translated into improved practices. They will see and hear consistent messages on the radio, at stores and pharmacies, and from various health workers. They may have some new products to try as well!

2. A Typical International Institution

In 2001, *Linkages* will have worked with more than 25 institutions to increase their capacity for BCM activities, including USAID CAs; U.S. PVOs receiving USAID funds; UNICEF, WHO, and UNFPA; international family planning organizations; and multilateral banks, including the World Bank.

In a typical *Linkages*-assisted institution, BCM will be "mainstreamed." The key people will have both skills and motivation about BCM and will have improved their policies, resource flows, and programmatic activities about BCM. In service-oriented institutions, most, if not all, of their field sites will have trained people and many of them will be implementing state-of-the-art BCM programs. These institutions will be knowledgeable about behavior-change planning and interventions, policy, and advocacy and how to use and benefit from the private and commercial sector. Many will have operated model BCM programs.

3. Global Leadership

In 2001, *Linkages* will have provided global leadership through technical meetings, information dissemination, and a small-scale operations research program. While technical meetings will have focused on USAID Missions, selected countries, and the key institutions mentioned above, the results of these conferences will have broadly diffused around the world through the information dissemination program. *Linkages* will also have carried out at least three important, globally-relevant research studies whose findings will be disseminated widely. The information dissemination program will also regularly report findings from model programs, field experience, the scientific literature as well as from various governmental institutions and multilateral bank reports. BCM issues will be much higher on the world agenda.

Year 2006

During the second five year period of this Cooperative Agreement, *Linkages* currently envisions that the focus of activities will shift from "mainstreaming" to "broad institutionalization," which *Linkages* defines to mean that most of the relevant institutions of a country, or subunits of international organizations, have incorporated BCM into their programs in such a way that most citizens affected by these institutions are aware of and practice up-to-date BCM behaviors. For example, *Linkages* expects that BCM will have been broadly institutionalized in at least ten joint programming countries and in up to five joint planning countries, subject to the availability of funds. *Linkages* expects that BCM will have been broadly institutionalized in the key institutions mentioned earlier and, for international donor institutions, *Linkages* expects that at least 15 major programs will have strong BCM components. Globally, *Linkages* expects to have completed at least three additional globally-relevant research programs whose findings will be made available through an extensive information dissemination program.

B. STRATEGY

Linkages will apply a behavior-change approach in all three results areas to improve attitudes and norms, the policy environment, and the access, availability, and quality of support services. The strategy for achieving these results is based on the lessons learned from two decades of experience in breastfeeding, LAM, nutrition, family planning, and health behavior change. The principal elements are described below:

Use the PVOs, NGOs, and commercial sector as engines of growth. We will adapt the strategy used successfully by AED's Nutrition Communication Project in Mali to initiate community-level activities with PVOs and NGOs and then expand these results by linking them to government and other PVOs and NGO programs. This strategy uses the PVOs and NGOs as a bridge between the community and government services. It recognizes that PVOs and NGOs are most familiar with local problems and the resources available to correct them. Under *Linkages*, this bridge will be extended to the commercial sector by training commercial salesmen and women to deliver BCM messages and sell selected BCM products. Training and educational materials, information, and other products developed by the private sector will be shared with government and other local PVOs and NGO programs in health, population, agriculture, education, and related sectors. The PVO and NGO years of in-country experience will promote the expansion and scaling-up of successful behavior change strategies in the public sector.

Work with cooperating agencies to provide technical support and also joint programming for country-specific activities. Mainstreaming BCM into existing health and family planning programs requires close relationships with the cooperating agencies working in these fields and providing support to USAID missions and country programs. *Linkages* will serve as a reservoir of technical expertise in these areas. We will advocate for routinely including breastfeeding and LAM materials (drawing on Georgetown's experience) in family planning communications and social marketing programs and provide technical assistance in areas such as IEC, training etc. to ensure that family planning programs offer LAM. We will work with BASICS to support its efforts to improve breastfeeding and complementary feeding practices, which are part of the minimum package of nutrition interventions for child survival. With the FOCUS Project we will advocate for efforts to improve the nutrition of young women by delaying first births and improving dietary practices during pregnancy and lactation, especially in Asia and Africa. These are illustrative examples only. Many opportunities exist to provide technical assistance and input, and *Linkages* will respond. For field-level collaboration, *Linkages* will participate in work plan development and joint programming with different projects and missions. We will use our core funds, as necessary, to leverage decisions and ensure that nutrition results are achieved.

Jump-start activities by beginning where other programs have left off. *Linkages* will extend previously supported USAID activities by using the materials, methods, and tools developed under the Wellstart Expanded Promotion of Breastfeeding and Lactation Management Education projects, the Georgetown University LAM Project, AED's Nutrition Communication Project, HEALTHCOM, and Support for Analysis and Research in Africa projects, and by La Leche League International, WHO, UNICEF, and other organizations that have proven materials. We will use the networks of professionals trained under previous programs, including Wellstart associates and La Leche League counselors, to provide local leadership in our efforts. Consultants from the Latin America region, where most breastfeeding training has taken place, may be used to assist programs in Africa and Asia, when appropriate. We will also jump-start activities by integrating BCM into the programs already being implemented by USAID counterparts, cooperating agencies, PVOs, and NGOs.

Promote cost-effectiveness in all program activities. *Linkages* will maximize the cost-effectiveness of its program activities by employing the following principles derived from program experience:

- **Targeting:** When the increase in social benefits and the savings in program costs exceed the costs of screening, cost-effectiveness is improved by targeting. In general, targeting is more cost-effective when prevalence is low, program costs are high, and a good, inexpensive screening tool is used.
- **Timing:** Periods exist in the life cycle when nutritional vulnerability and potential benefits are greatest. When appropriate nutrition inputs are provided at these times, cost-effectiveness will be increased. For example, maternal stunting is best addressed during periods of maximal growth, such as in early childhood and adolescence.
- **Community-Mobilization:** By mobilizing agents of change at the community level, a set of untapped resources can be harnessed and used for BCM improvement at little or no cost to the program, thereby increasing cost-effectiveness. Although community resources are an economic good that can also be counted as a cost, these resources often otherwise go either unused or misused. Further, because community mobilization is also a means toward ensuring sustainability and the success of other development efforts, the tapping of these resources can equally be perceived as a benefit in itself.
- **Synergism:** When two program components have effects that are greater than the sum of each in isolation, cost-effectiveness is increased. For example, increasing the availability of suitable complementary foods or nutrition knowledge alone may have little impact on the adequacy of complementary feeding, but when both are provided together, significant behavior change is more likely.
- **Integration:** By using existing systems and networks, integration of *Linkages'* project activities into government, PVOs, and private-sector services can have a high marginal impact at low additional cost.
- **Sustainability:** The cost-effectiveness of programs is generally measured over the life of the program, relating program costs to the net change in some relevant indicator over the same period. This method does not account for differences in the duration or sustainability of the program after completion. Other things being equal, programs with sustained impact are more cost-effective than those with transitory impact. If the means of achieving the increased duration of impact are inexpensive, such as community-level social mobilization (see above), then cost-effectiveness may be increased.
- **Scaling-up and Replication:** Often, the greatest cost of a program is in the start-up phase. After the program is functioning well, adaptation and replication may be relatively inexpensive. Total cost-effectiveness should, therefore, increase with greater expansion and economies of scale. Similarly, new programs that can use or build on previous work are likely to be more cost-effective than programs that start from scratch.

Explore multiple avenues to achieve sustainability. *Linkages* will address sustainability in three ways: institutional strengthening; changes in policies and norms that influence practices; and financial sustainability.

- Our work with host governments, PVOs and NGOs, and other organizations to build public, private- and commercial-sector linkages (partnerships and mechanisms for collaboration), and our technical assistance to integrate BCM into continuous programs are the bases for institutional strengthening. We are teaming with a number of private-sector organizations because of their expertise and reach at the community level and because of their long-term presence in more than 100 countries worldwide. These organizations currently reach more than 387 million people worldwide. Strengthening these institutions' nutrition and behavior-change capacity at the headquarters, regional, and local levels is likely to have benefits beyond individual countries where activities are being carried out, and beyond *Linkages'* ten-year life span.
- To ensure long-term sustainability, we will also identify efficient mechanisms to influence pre-service training in nutrition and reproductive health. We will adapt existing breastfeeding, LAM, and complementary feeding training materials for pre-service settings and work with networks and professional organizations that already have a mandate to improve pre-service curricula, such as the Network of African Public Health Institutions or the Reproductive Health and Nursing Programmes of the Health Secretariat for East, Central, and Southern Africa, to institutionalize their use. Appropriate new materials for maternal nutrition and dietary practices will also be developed.
- We will work with Wellstart Collaborating Centers and La Leche League International affiliates to move beyond the hospital setting to create and implement policies for mother- and baby-friendly workplaces, clinics, and communities. With Macro International, we will explore new ways to present and use DHS data to influence national family planning, health, and nutrition-related policies and programs.
- Throughout our communications work, we will actively involve women and others to identify small changes in practices that they can make to improve their breastfeeding and dietary practices. This approach ensures that recommendations are practical and behavior changes are sustainable at the household level. Communications messages will be targeted and strategically timed for optimum cost-effectiveness. This endeavor is in contrast to using a campaign approach, which is expensive and has repeatedly failed to produce sustained behavior change.
- For financial sustainability, we will harness the commercial sector and its expertise. We also will identify products that can be sold to generate revenues for training and continued communications activities ("cross-subsidization"). We will develop tools, such as an LAM guide, that can be sold in pharmacies together with appropriate contraceptives for when menses returns, and products, such as feeding bowls and spoons, high-calorie biscuits, or iron "tonics" that can be sold to generate income with outlets and sales forces also serving as delivery points for critical messages concerning their proper use. This commercial-sector approach will be emphasized in Asia and Latin America as well as in parts of Africa where urbanization and commercial economies are strongest.

Link costs and results. *Linkages* gives prominence to measurable results. One of the core staff positions is reserved for a senior Results Monitoring and Evaluation Adviser who will lead our efforts to measure and report program results. He and his support team of experts from AED's research and evaluation unit will be working directly with the core staff, counterparts, and collaborators to develop indicators and monitoring and evaluation plans for every activity and to establish data-collection and reporting systems. Cost measurement will be central to these activities. It will allow us to state confidently the most cost-effective strategies, approaches, and interventions that we will work to institutionalize.

C. IMPORTANT THEMES

Linkages will emphasize several principal themes throughout its activities:

Male involvement. Although engaging women as active participants is a priority, we also will seek new ways to involve males in behavior-change activities. Their involvement is critical to decision-making on family planning practices, and previous experience with the Nutrition Communication Project (NCP) also suggests that involving males may be central to changes in maternal nutrition norms and dietary practices.

Regional adaptation. Suboptimal breastfeeding, complementary feeding, and maternal dietary practices are common throughout the world. Yet, different regions are confronted with different nutrition practices and problems that must be recognized and highlighted. For example, in the LAC region, South Africa, and the ENI, formula and feeding bottles are commonly used and contribute to suboptimal feeding, early return of menses and pregnancy, preventable morbidity, and early termination of breastfeeding. In other parts of Africa and Asia, breastfeeding is well-established but other issues lead to suboptimal practices, such as food insecurity (Africa) and gender discrimination (parts of Asia). In Southern Africa, the HIV pandemic has already influenced breastfeeding practices and policies and has given the large formula industry in South Africa an open window of opportunity to undermine years of work dedicated to the support and protection of breastfeeding in the region. Thus, although the similarities between countries and regions are well-known, implementation strategies will differ from area to area. *Linkages* will begin its work by addressing the priority issues and problems in each region and will develop regional "packages" of information and materials that can be used in multiple countries. With this approach, *Linkages* will become truly integrated and will avoid the weaknesses of past programs, which emphasized technical excellence in only one problem area (e.g., breastfeeding, LAM, and weaning).

Urban opportunities. By the year 2001, nearly half of the world's population and almost 60 percent of the world's poor will be living in urban and peri-urban environments. Rapid urbanization contributes to shifts in dietary practices and often causes a breakdown in the social support for exclusive and optimal breastfeeding. Yet urbanization also presents new opportunities for reaching women, for involving the commercial and private sectors, and for disseminating messages. *Linkages* will explore new avenues for reaching women who live in urban areas, such as through shops and commercial outlets, to provide BCM products, information, and messages. Guidelines for urban BCM interventions are one expected contribution of the program.

Opportunities outside of the health system. Historically, breastfeeding promotion has emphasized changes within the health care system. This situation is the result of the negative impact of hospital policies and practices regarding breastfeeding. Further, the health profession has had a relatively small impact on complementary feeding and maternal dietary practices in the developing world. *Linkages*, therefore, takes seriously the challenge to move beyond the hospital setting and into the community and will actively find new ways to reach women who choose suboptimal feeding and contraceptive practices for reasons that are unrelated to the health care system. We also will identify new programs, such as early child development and school-based and informal education, that can benefit from our technical assistance and support.

Leverage cooperation and support. In these times of shrinking financial resources, it is important to recognize strengths and comparative advantages, and leverage the support of other organizations to fill the gaps. *Linkages* provides a comparative advantage for technical support in breastfeeding, LAM, nutrition, social marketing, and behavior change and access to communities through PVOs and the commercial sectors for BCM activities. The research that we conduct will be program-driven and operational. Therefore, we will work closely with universities and other institutions to develop research agendas that will answer key scientific questions of programmatic value. Likewise, we will not always be in a position to influence government services and systems support. In these cases, we will actively work to leverage the support of other USAID programs and the contributions of other bilateral and multilateral donors who are working in these areas.

In sum, USAID has been the major supporter of the use of social marketing and behavior-change methods to improve health and related practices in developing countries. The creation of a new USAID program that links breastfeeding, LAM, complementary feeding, and maternal nutrition technically and programmatically is exciting as well as challenging. Completing these linkages will require special attention to some areas that have been neglected in the past.

During the next decade, *Linkages* will give special attention to, and advance global knowledge in, three areas that are currently perceived to be weak links in our efforts to improve BCM policies, programs, and practices. These are community-based strategies for achieving change in BCM practices, commercial-sector involvement and partnerships, and cost analysis and cost-effectiveness studies, particularly for identifying strategies to improve maternal nutrition. Through *Linkages* we will break new ground in each of these areas and find solutions that will lead us into the 21st Century.

II. PERSONNEL

In this portion of the proposal, we introduce the team members and describe the expertise they bring to the *Linkages* Project. Later on, the Management Plan delineates how they will work as a cohesive team - all based at AED headquarters. The staffing plan is organized around the three Results packages to give special and constant focus to obtaining measurable results. A senior technical expert is being assigned to lead each of the Results Packages: Behavior Change, Policy, and Service Delivery. All staff will have multiple functions. Thus certain staff are also being designated to have Regional management responsibilities. They will liaise with Regional Bureaus at USAID and coordinate program inputs into country and regional activities.

Jean Baker, Director: The team will be led by Jean Baker, who will provide day-to-day direction of *Linkages*, supervise the performance of senior staff members, and work in close collaboration with the USAID/CTO. Ms. Baker will work closely with the Deputy and Administrative Manager; and also with the Monitoring and Evaluation Coordinator to track the impact of program activities and progress toward achievement of the Interim Results.

In an international career spanning 20 years, Ms. Baker has worked extensively in both nutrition and population. She brings experience in managing field and central activities from the home-office level as well as field-level experience in program design, implementation, and evaluation. For 14 years, she worked with MCH, nutrition, and family planning programs in Kenya, Nepal, Pakistan, and Thailand. She is highly skilled in program development and management and knowledgeable about all aspects of USAID project management. In addition to assignments with numerous USAID projects, she has also worked with other international organizations and local NGOs. This varied experience provides her with an excellent foundation for managing a new program that must develop solid working relationships with many different partners. Ms. Baker is currently the Director of the USAID Expanded Promotion of Breastfeeding (EPB) Program that is one of the predecessors to the *Linkages* Project, working for Wellstart on assignment from Nurture. In that role, she has managed all of the programmatic, technical, and financial aspects of the program and has supervised a staff of 20.

Ms. Baker's experience in nutrition began in Pakistan in 1976 when she worked for the Asia Foundation to develop a PHN program that included nutrition education and training for NGO community health workers and a community-based child weighing program in the Punjab. While in Pakistan, Ms. Baker co-authored, with Dr. Mushtaq Khan, a manual titled *Nutrition and Health Care for the Young Child*, funded by UNICEF, which was subsequently used throughout Pakistan. Working for the Regional Office of the Population Council in Thailand from 1979-1983, she served as the in-country coordinator for a four-country Infant Feeding Study. During that time, she also assisted with the publication of a report on *Breastfeeding and Supplementary Food* and wrote on *Determinants of Malnutrition in Thailand*.

From 1983-1987, Ms. Baker continued her work in nutrition on a Washington-based assignment with Management Sciences for Health (MSH). For the USAID Office of Nutrition, she evaluated a centrally-funded international nutrition communication project, designed a new five-year nutrition education and training project, and evaluated a worldwide USAID maternal/infant nutrition project, which included a review of hospital-based breastfeeding support activities in Thailand and Indonesia. She authored a policy paper for UNICEF on *Operations Research: A Tool in Program Strengthening and Expansion for Child Growth*, a review of infant and child survival in the developing world; and a paper on *Breastfeeding and Medical Education in Indonesia*. As the Technical Director of Nurture/Center to Prevent Childhood Malnutrition from 1995-1996, she wrote *Exclusive Breastfeeding: A Summary of Experience from the Field* and authored a strategy paper on *Women's Nutrition and its Consequences for Child Survival and Reproductive Health in Africa*, in collaboration with AED.

Ms. Baker also brings to the *Linkages* Project significant experience in family planning and reproductive health. During five years in Kenya, from 1987-1992, she was the MSH resident adviser for the USAID Family Planning Management Development Project. This project provided support to family planning service delivery organizations, including the Family Planning Association of Kenya, National Council on Population and Development, and an NGO umbrella organization. In Asia, she participated in a review of family planning programs in the region and a study of the epidemiology of pregnancy outcomes in Thailand. In Nepal she conducted an assessment of the quality of care

provided by the family planning program. And, early in her career Ms Baker was the Director of a Planned Parenthood clinic in New York.

Women's health is another of Ms. Baker's strong interests. She designed a Women's Health in Nepal Project while serving as the senior technical adviser for a USAID-funded Child Survival Project. That project integrated women's reproductive health services with a female literacy program and is currently being implemented with USAID/Nepal bilateral funds. She also worked as a policy and management specialist with Family Health International and the Ministry of Health, assisting in the design and implementation of programmatic and policy research on population and family planning, child survival, reproductive health care, and AIDS. Ms. Baker wrote papers on the status of HIV/AIDS in Nepal and the practices of commercial sex workers in Kathmandu.

Ms. Baker holds an M.P.H. degree in population and family planning from the University of Michigan. She speaks both Urdu and Thai.

Margaret Burns Parlato, Deputy Director and Results Package I Manager: Ms. Parlato will work closely with Ms. Baker on overall project management and technical direction, giving special attention to the leadership of Results Package I on Attitudes and Norms and to providing program-wide guidance in the area of behavior change. She will supervise the work of the Information Specialist and of the social marketing test activities.

Ms. Parlato, AED's Director of Nutrition and Population Programs, has 22 years of experience in behavior-change programs in nutrition and family planning. She has worked in 18 countries in all regions of the world, including providing long-term technical assistance in both Asia and Latin America. Recently, she completed a seven-year term as the director of the USAID Nutrition Communication Project (NCP). She oversaw technical assistance to more than 20 countries while taking a lead role in program development. She is well-versed in the management of large-scale USAID projects and in AED's financial, logistics, and administrative procedures. She has worked with many international organizations, including UNFPA, PAHO, UNDP, The World Bank, and CARE; national governments and NGOs; and commercial-sector firms.

Ms. Parlato began her international career helping to pioneer the application of social marketing to nutrition projects. With CARE in India from 1970-1972, she directed the field research for a multimedia program that reached an audience of more than 250,000 rural people. She also conducted a study on the use of commercial weaning foods and infant formula in low-income areas of New Delhi. For the last two decades, Ms. Parlato has continued to develop effective behavior-change strategies and programs and has been a principal contributor to AED's emergence as a leading institution in applied behavior change.

Ms. Parlato has specialized skills in developing broad program strategies at the regional and national levels. While working for INCAP in Central America, she designed a nutrition education strategy for the entire region as well as a comprehensive nutrition communication campaign for Costa Rica and Panama. She worked with the Federation of African Radio and Television Organizations to develop and distribute family planning radio and television broadcasts in Africa. At the national level, she assisted government agencies and NGOs to strengthen their behavior change programs. For the World Bank, she conducted the feasibility studies leading to the development of Senegal's Integrated Food and Nutrition Project. She is a member of the BASICS Nutrition Working group and provides technical direction to activities in West Africa.

Ms. Parlato has extensive experience in family planning, managing AED's work in the area for the last ten years. She was a resident advisor in Bolivia and Ecuador to the national family planning programs in the early 1970s. For three years, she served as the Francophone country coordinator for the Population Communication Services Project with The Johns Hopkins University. Later for PCS she guided development of national family planning IEC strategies for Senegal and Zaire. Presently she provides assistance to the West Africa Family Health and Aids Prevention Project and to PCS-IV. Her experience includes LAM. She has guided the development of LAM components to breastfeeding materials under a range of circumstances and assisted the MOH in Honduras harmonize its breastfeeding, LAM, and family planning behavior change strategies. In all of her work, she has been involved in designing innovative programs. In India, she worked with the Protein Foods Association of India and food processors to strengthen the nutrition messages in commercial advertising. In Ecuador, she designed a special

family planning program for new Army recruits. Ms. Parlato holds an A.B. degree in economics from Vassar College. She speaks and writes French and Spanish.

Dr. Roy Miller, Monitoring and Evaluation Coordinator: Dr. Miller will work closely with the Project Director, USAID/CTO, and project staff in preparing a monitoring and evaluation plan and system for tracking the progress of the program toward achieving its Interim Results. This activity will involve developing M&E systems at the country (i.e., field project) level that will be sustainable with local resources, while having the rigor to provide quality data into a program wide data-gathering system. He will assist country staff in establishing an M&E system, in monitoring their progress, and then in collating the results from the various sources and for various activities to create a project-wide picture for USAID and Linkages staff. He also will work with Macro International and other sources of data and data analysis to derive findings that will support policy and advocacy efforts and provide data that can be used in the program's cost studies.

Dr. Miller brings an unusual, if not unique, perspective to the monitoring and evaluation of nutrition programs. Holding a master's degree in mathematical statistics and a Ph.D. degree in urban and regional planning, Dr. Miller combines a strong analytic capability with a deep understanding of complex social systems. His knowledge of nutrition has accrued over almost 20 years of work in the area, with most of that experience being in the area of monitoring and evaluation. Dr. Miller's entry into the field came with his position as the statistical analyst, data manager for a USAID-funded project, the Analysis of Community-Level Nutrition Interventions. Drawing heavily on the knowledge and experience of nutrition experts, Dr. Miller developed the skills not only to manipulate data but also to interpret and understand it. Today, one of the conclusions of that study - that the proper use of data to strengthen program management is, in itself, an element contributing to the success of the program - is often cited as an objective for M&E systems in the public health arena.

The transition from nutrition data analyst to evaluation expert began when USAID, recognizing that the analysis skills required to perform the previously mentioned study were needed by project evaluation staff, began inviting Dr. Miller to join teams evaluating projects in the nutrition arena ranging from school-feeding projects, to growth-monitoring projects, to early warning information systems.

In 1983, UNICEF and WHO received funding from the Italian government to run a global nutrition intervention known as the Joint WHO/UNICEF Nutrition Support Program (JNSP). Following a short-term assignment for JNSP to design a baseline study for the Sudan country program, Dr. Miller was invited to join the central management team as evaluation officer. This permanent position required not only that sound recommendations be made about a project but also that the follow-up be organized to oversee the implementation of those recommendations. The addition of Dr. Miller to the JNSP team made that program a model for incorporating evaluation into the routine management of country project activities.

More recently, Dr. Miller has been the director and technical director of USAID's Center for International Health Information (CIHI). Although not a nutrition center, CIHI, largely through Dr. Miller, remained in close contact with USAID's nutrition community through its role as the architect of USAID's Reports to Congress on Child Survival. Since the introduction of PRISM to the Agency, the precursor of USAID's current model for performance monitoring, Dr. Miller has been a pivotal member of almost every USAID task force developing guidelines and standards for performance monitoring in the health and nutrition sector, often advising on indicators to make performance monitoring operational. In sum, Dr. Miller is an accomplished data analyst and a veteran at conducting on-site evaluations. He is also one of the few individuals who has been solely responsible for monitoring and evaluating a long-term integrated community nutrition program and is intimately familiar with USAID's movement toward performance monitoring.

Dr. Sandra Huffman, Coordinator for Global and Operations Research (50%): Dr. Huffman, who has joined AED as part of Nurture's merging with AED, will oversee global and operations research, drawing on the resources of AED's research department as well as external consultants and collaborating institutions.

Dr. Sandra Huffman's long-standing interest in nutrition and family planning was sparked by her work as a Peace Corps Volunteer in Colombia, working with a MOH nutrition program. There, the high demand for but lack of availability of

contraceptives led her to start a CBD program. Following her work in Colombia she pursued graduate work in the Department of Population Dynamics at Johns Hopkins University, School of Public Health with a focus on Human Nutrition. Since there was no Department of Nutrition at Johns Hopkins at that time, she designed her own graduate program that linked the two areas of human nutrition and family planning.

Dr. Huffman's career in nutrition has spanned more than two decades, during which time she has made numerous contributions regarding infant feeding, breastfeeding, and lactational amenorrhea. She has spearheaded a range of policy and research initiatives. In Bangladesh, as a Guest Investigator at the International Centre for Diarrheal Diseases Research, she conducted epidemiologic research on maternal and child nutrition and its relationship to breastfeeding and lactational amenorrhea. Later at Johns Hopkins University, where she was an Assistant Professor in the Department of Population Dynamics from 1978-1979, she completed a number of research papers on nutritional amenorrhea and breastfeeding. Later, at the USDA Food and Nutrition Service she conducted policy research on the U.S. Child Feeding Programs, including WIC.

She returned to Johns Hopkins University in 1987 where she held a joint faculty appointment in the Department of International Health and the Department of Population Dynamics. In this capacity she served as principal investigator on the research program "Determinants of Natural Fertility" funded through a grant from the Population Council (a USAID-funded program); and led research funded by the Centers for Disease Control to assess the nutritional status of children entering kindergarten in the District of Columbia. During this period Dr. Huffman also oversaw numerous doctoral-level research projects including utilization of health services in Bangladesh, adolescent nutritional status and age at menarche, maternal nutritional status, and anthropometry among others. Her research on lactational amenorrhea led to an invitation to serve on the National Academy of Sciences (NAS), Committee on International Nutrition Programs, and to Chair the NAS sub-committee on Nutrition and Fertility. Dr. Huffman remains an Adjunct Associate Professor at Hopkins.

Dr. Huffman has continued working on lactational amenorrhea and contraceptive use among breastfeeding women through the policy arena. She served as a consultant to the Population Council on postpartum contraception and Georgetown IRH program on LAM and co-authored papers with Miriam Labbok on LAM entitled "Breastfeeding in family planning programs: a help or a hindrance?" *International Journal of Gynecology & Obstetrics Supplement*. S23-S32, 1994. She has emphasized the need to assess the lack of protection by breastfeeding women by either LAM or contraceptive use in the breastfeeding assessments conducted by EPB and has worked on births averted by breastfeeding for the policy piece "Breastfeeding and Family Planning: Saving Resources, Enhancing Care" produced by EPB.

Other major research efforts include serving as co-investigator of the USAID-funded research on Dietary Management of Diarrhea for which she was responsible for the large-scale survey of child feeding and health related practices in the Central Peruvian Highlands. In this research on child feeding practices related to diarrhea, she worked closely with AED on interventions to improve child feeding. She was also a research advisor to AED on the Peru Breastfeeding Promotion Project, which the Population Council funded and for which AED designed the behavior change component.

In 1986 Dr. Huffman founded the Center to Prevent Childhood Malnutrition (Nurture) in order to develop programs linking community based activities with research as a way to demonstrate the importance of a community-based approach to preventing childhood malnutrition. The field office in Peru (CEPREN, now CEPRED) conducted program research on preventing maternal malnutrition through community kitchens. This was followed by research, funded by the Thrasher Research Fund, to assess the impact of community-based interventions to prevent the malnutrition of young children.

Dr. Huffman's has also carried out a range of policy-related research efforts to illustrate the importance of improving maternal and child nutritional status to prevent morbidity and mortality. Some of the original research used in David Pelletier's recent analyses were based on her work in Bangladesh. She has continued to use her research and analytic skills to develop needed arguments to convince policy makers of the importance of improving nutrition and the linkages between family planning and nutritional status. She has also conducted numerous cost-studies and evaluations of breastfeeding promotion programs. Additionally, her recent work with the Wellstart EPB program has been in the development of indicators to assess breastfeeding practices.

Dr. Huffman has published extensively on breastfeeding and infant feeding. She holds a degree in nutrition from Cornell University and a Sc.D. in nutrition and population from the Johns Hopkins University. She speaks Spanish.

Barbara Jones, Manager for Results III, Service Delivery: Ms. Jones, who is a family planning services delivery specialist, will lead project activities to integrate breastfeeding and LAM into health and family planning programs; and increase access and quality of services. She will work in close coordination with the Training/Community Specialist and the MCH specialist. She will help coordinate the input of Wellstart and LLLI into the program, particularly in the clinical training and community areas. She will coordinate activities in the Near East Region.

Ms. Jones is currently AVSC's Director for the North Africa/Middle East Region. In this position she manages reproductive health programs in Jordan, Morocco, Oman, and Yemen and is responsible for developing country strategies; negotiating project agreements with collaborating institutions and donor agencies; and evaluating programs. She manages a staff of five and oversees the work of numerous consultants. Ms. Jones has more than 15 years experience in family planning and health program management, ten of them living overseas. This includes four years as JSI's regional representative in Togo for the Enterprise Project to develop family planning services in West and North Africa; and three years in Mali as the USAID coordinator for the Sahel Regional Demographic Research Project.

Ms. Jones understands first-hand the family planning service delivery environment. She is well positioned to work directly with the family planning service delivery community to promote LAM and appropriate contraceptive use in the postpartum period. Ms. Jones also has considerable experience in primary health care and child survival programs. She worked with the project staff of the Urban Health Delivery Project in Cairo to develop services for immunization, nutrition, prenatal care, and family planning. Ms. Jones assisted local non-governmental organizations in Haiti to design a project which provided services for child survival and family planning interventions and developed appropriate referral mechanisms. As a Peace Corps volunteer, she began a nutrition education project in a rural village which included breastfeeding and growth monitoring promotion. Ms. Jones has experience with both public and private sector institutions in developing family planning services. She has developed introduction strategies for Norplant in several countries and participated in a feasibility assessment of postpartum family planning services in the Ivory Coast.

Rounding out the support she can provide, Ms. Jones's experience includes conducting needs assessments, evaluating programs, organizing training workshops, and initiating and managing research activities. Ms. Jones earned a M.P.H. at the School of Public Health, Boston University and a M.A. at the School of International Service, American University. She speaks French and some Bambara.

Nomajoni Patricia Ntombela, MCH Specialist: As a member of the Results III Service Delivery team, Ms. Ntombela will have lead responsibility for working with MCH, child survival, and related sectoral programs. She will also coordinate development of activities in Africa. Ms. Ntombela is being assigned full-time to *Linkages* by Wellstart.

Ms. Ntombela brings almost 30 years of experience working in Africa and internationally in the field of breastfeeding, complementary feeding, maternal nutrition and LAM. She has extensive experience and expertise in the following areas: clinical lactation management; HIV/AIDS/STD and population issues; national, regional and global policy development; training; community-based programming; NGO development and coordination; and advocacy. She has been in the forefront for the post-Cairo integrated approach to providing services and a leader in integrating breastfeeding and LAM into health programs.

Since 1992, Ms. Ntombela has been the regional coordinator of the International Baby Food Action Network (IBFAN) in Africa. IBFAN Africa, part of a 150 country network, is an NGO which coordinates breastfeeding and complementary feeding activities in English- and Portuguese-speaking countries in sub-Saharan Africa. At present, Ms. Nomajoni is chairperson of the IBFAN Coordinating Council and was a founding member and long-time president of the NGO, SINAN, the Swaziland Infant Nutrition Action Network. While at SINAN, she was instrumental in its inclusion in USAID's ten-year plan on family planning and in assuring coordination of breastfeeding and family planning programs.

A nurse-midwife (King Edward Hospital, South Africa) and an Advanced Fellow in Lactation Management (Wellstart International, 1991), Ms. Ntombela has been a Wellstart Associate since 1987. She is a Master Trainer and Master Assessor for the UNICEF/WHO Baby Friendly Hospital Initiative (BFHI) and was involved in developing the BFHI Global Assessment Criteria. She has conducted numerous training courses on LAM for health and policy-level staff at all levels. Aside from promoting lactation management/BFHI training at the regional and national levels throughout Africa, she is active in advising governments on a variety of policy issues, including the BFHI. Her role as an advocate for breastfeeding has made her a familiar figure both throughout Africa and at World Health Assemblies and international conferences. She has served on several national and international advisory and steering committees related to nutrition and infant feeding and was instrumental in developing Swaziland's national breastfeeding policy. At present, she is Vice-Chairperson of the Population, Health, and Social Welfare Committee, which advises the Swaziland Government on policy and strategies. Ms. Ntombela has been actively involved in the Schools' HIV/AIDS and Population Education (SHAPE) Project in Swaziland since 1990.

Maryanne Stone-Jiménez, Training/Community Specialist: Ms. Stone-Jiménez will be part of the Results Package III service delivery team. She will give special attention to coordinating training and developing community support activities and networks that will aid in the expansion and sustainability of BCM practices at the grassroots level. She will also work closely with Wellstart on development and delivery of training at the clinic and hospital level. Another of her responsibilities will be to serve as the coordinator of LAC activities. Ms. Stone-Jiménez is being assigned full-time to *Linkages* by LLLI.

Ms. Stone-Jiménez is a public health specialist with extensive field experience in Latin America working in the areas of breastfeeding, LAM, complementary feeding, nutrition education, maternal health, and community support groups. She is presently executive director of La Leche League in Guatemala and principal investigator for a LAM project. For the last 14 years, she has served as an accredited La Leche League (LLLI) Leader counseling mothers and promoting the creation of mother support groups. During the last nine years, she has worked in Guatemala, Honduras, Nicaragua, Guyana, and Antigua to promote better infant feeding practices, the use of LAM, and child survival interventions. For four years, she has directed the USAID/Guatemala Child Survival Project, assuming responsibility for overall project design, supervision, and finances. As the Executive Director of La Leche League/Guatemala, she manages programs in peri-urban areas using breastfeeding counselors and community-based mother-to-mother groups.

At the same time, she has been serving as principal investigator for the Institute for Reproductive Health of Georgetown University on the Guatemalan Breastfeeding and Child Spacing Project, which emphasizes LAM training for health providers and community members. In this capacity, Ms. Stone-Jiménez has conducted three conferences on LAM for: 1) policy makers, 2) health personnel, and 3) professionals responsible for the Medical and Nursing Schools curriculum content. She has trained staff from numerous NGOs (including Project Concern, World Vision, MotherCare, and local NGOs) on LAM and has refined a LAM training curriculum in Spanish. She also worked with the MOH of Guatemala on LAM training for 13 regions through USAID Mission funding. She has provided LAM services directly to women from 13 communities in urban Guatemala through Mother-to-Mother Support which included support groups and individual counseling. Cloth posters and a simplified version of the algorithm were developed for use at the community level.

Ms. Stone-Jiménez has shown special interest in the area of human capacity- building at the community and clinic level, working with LLLI, international and national PVOs, USAID, Wellstart, Georgetown University, and ministries of health. The main topics of her training efforts have been breastfeeding, infant feeding, group facilitation and counseling skills, and community support groups. Since 1987, she has been organizing workshops to accredit LLLI Leaders. For Save the Children/Nicaragua, she conducted a needs assessment on infant feeding practices in rural areas and then developed a training curriculum for supervisors and health promoters. She has designed and run workshops on community support groups for mothers in Nicaragua and Guatemala as well as a training-of-trainers' workshop for the Guyana MOH and UNICEF. Her general training methodology is participatory and based on popular education techniques. Throughout her work in training, she has been active in developing job aids for health educators, clinic staff, and volunteers, including cloth posters, manuals for community breastfeeding counselors, pamphlets, and curriculum for classes and courses.

Ms. Stone-Jiménez has had first-hand experience with PVOs and ministries in integrating BCM into training programs. Her training assessment for Save the Children/Nicaragua led to a recommendation for an integrated approach to training that included breastfeeding in child survival interventions and vice-versa. On the basis of this recommendation, she was asked to develop a training course on infant feeding, which incorporated a competency-based curricula using adult education precepts and the latest scientific findings. This curriculum, Optimal Infant Feeding in the First Two Years, included exclusive breastfeeding and the timely and adequate introduction of available, low-cost weaning foods. The approach of treating infant feeding as a total package, including breastfeeding and weaning foods, proved to have a great appeal to health professionals, ministries, and NGOs.

Ms. Stone-Jiménez has also been active in research activities seeking to understand breastfeeding behavior and health staff support, particularly in urban and peri-urban areas where breastfeeding often faces greater obstacles. She was principal investigator for a KAP survey of breastfeeding practices in Guatemala for LLLI, a study of the growth and sustainability of LLLI programs for the BASICS Project, an organizational case study of community efforts to promote breastfeeding for Wellstart, and a survey of breastfeeding at the marginal urban level for INCAP. This research experience, combined with her extensive hands-on work in training, has given her an in-depth understanding of how breastfeeding and infant feeding can be best promoted and instilled in institutions, communities, and individuals. Ms. Stone-Jiménez holds both a bachelor's degree and an M.S. degree in biology from St. Louis University. She is fluent in Spanish.

Dr. Jay Ross, Manager for Results Package II, Policy and Advocacy: Dr. Ross will develop a strategy for policy change and coordinate all policy-related activities at the international, country, and institutional level. To assure a leadership role for Linkages in international fora he will draw on talents of spokespersons such as Drs. Huffman and Naylor and others. Another task will be to establish a system for tracking policy developments internationally and in focus countries. He will also advise core staff and those of cooperating organizations on policy issues.

Dr. Ross has been working in the field of international nutrition for 13 years. He studied nutritional epidemiology and economics at Cornell University and has extensive research and field experience. He has particular experience in maternal nutrition. For the last two years, he has coordinated nutrition advocacy activities at AED, using PROFILES nutrition policy analysis software and other analytical and communications tools to engage policy-makers and technical staff in policy reform efforts. Dr. Ross began this work under the Nutrition Communication Project and has since served a variety of agencies, including the World Bank, the Asian Development Bank, the Micronutrient Initiative, UNICEF, BASICS, and SARA. Dr Ross' familiarity with PROFILES and his experience using it for policy reform in the Philippines, Uganda, and Senegal will provide Linkages with a rapid start in its policy reform efforts. His doctoral-level training in epidemiology and economics have proved invaluable in this work which often relies on arguments that link the causes of malnutrition through to their economic and human consequences. He has directed a number of cost studies for the multilateral banks and advised them on developing brochures for policy-makers.

Dr. Ross also has intensive country-level policy reform experience. Following a period of field research on the causes of child malnutrition in an impoverished rural area of Papua New Guinea, where he lived for eight months in 1983, he spent four years as regional nutritionist for the Save the Children Fund (UK), where he was responsible for overseeing nutrition research, service delivery and training in four PNG provinces. As part of this work, he was active in developing multisectoral provincial nutrition policies in several provinces and in helping to coordinate their implementation. He also contributed to national nutrition policy, helping with the analysis and dissemination of information from PNG's first national nutrition survey and focusing nutrition priorities on appropriate complementary feeding for infants and away from a longstanding emphasis on dietary variety for older children.

Dr. Ross has also conducted field surveys and analytical studies on nutrition-related topics in PNG, the Philippines, and Malawi. His research interests include the effects of lactation on maternal nutrition (the subject of his doctoral research in Malawi), the intrahousehold distribution of malnutrition, the causes and consequences of maternal and child malnutrition, nutrition monitoring and surveillance systems, the effects of household economic and other behavior on food security and nutrition, and food and nutrition policy. He is skilled in a variety of research methods, including

epidemiology, statistics, research design, survey design, instrument development, validation, and rapid appraisal techniques. He has extensive computer expertise in data management, statistics, and presentation graphics. Dr. Ross received an M.Sc. degree in nutrition from the University of Guelph, Canada, and a Ph.D. degree in nutrition from Cornell University. He is proficient in French.

James T. Gregory, Administration and Finance Manager: Mr. Gregory has 20 years experience in management, with expertise in finance, administration, human resources and facilities management. He currently serves as Deputy Director for Finance and Administration for Wellstart International's Expanded Promotion of Breastfeeding (EPB) Program. He has been responsible for budgets in excess of \$15 million, developed and managed country and activity budgets, and ensured contract compliance. He has developed the systems used to manage project finances and to analyze the costs of individual functions. Previous to his promotion as deputy director of EPB, Mr. Gregory held the positions of Administrative Officer for EPB (1992-1994) and Finance and Contracts Officer (1994-1995). Prior experience includes fifteen years with the Institute of International Education, of which three years were in the Washington, D.C. office where he implemented a new administrative division as Manager of Administration, and twelve years in IIE's Southeast Regional Office in Atlanta, where he served in a variety of positions ranging from Program Assistant to Assistant Director. A graduate of Vanderbilt University, Mr. Gregory has done postgraduate work in both translation and interpretation and pedagogical methods.

Information Specialist (TBN): During the first quarter AED will work with USAID to design an information plan. Recruitment will be based on the job description established.

Regional Experience: The team has in-depth experience (both resident and short-term) in the joint programming countries as well as other countries emphasized by USAID in Asia, ANE, and Africa. (Please refer to chart in the Appendices for a list of countries.) Individually, most team members have working experience in more than one region. And, several team members have managed large regional activities with multi-country activities: (Baker, Parlato, Ntombela, Jones, and Ross). There is also a good mix of language capability.

For the ENI region, the team will draw on specialists at AED and subrecipients who have experience in the countries receiving USAID support. For example, LLLI is doing work in this region as has Wellstart and have local technical experts to draw on.

Staff Numbers and Expansion: AED feels that the proposed staffing pattern is sufficient for Year I. As the project develops, the AED Director and USAID/CTO will assess the need for an expansion of the staff.

Key Consultants and Advisers: Given the small core staff, the project will draw on a wide range of talent from within AED and partner organizations as well as from other sources - on an as-needed basis. Soon after project startup, there will be immediate needs for consultants to assist with assessment visits and the development of training interventions and other activities. An illustrative list of Key Consultants is provided in the attached table.

In addition to these Key Consultants, the project staff may feel a need to consult with a leading expert for help in solving a specific problem; reviewing technical material; helping design a program or program element; or for advice about specialized technical questions. The Linkages Team, therefore, has also assembled a group of leading experts on specific technical areas who are willing to provide advice and limited technical assistance as required over the life of the project. This could mean attending a small advisory panel called to discuss a specific issue; reviewing materials and responding by fax or E-mail; or conducting a briefing in Washington, D.C. A list of these potential advisers can be found in the Appendices.

Illustrative List of Key Consultants

Specialty	Names	Organization
Breastfeeding/ LAM	Audrey Naylor, M.D., Ph.D. Beth Styer, IBCLC Ruth Wester, R.N., CPNP Barbara Heiser, R.N., B.S.N., Nanette Jolly, M.B., B.Ch. Janine Schooley, M.P.H. Susan Welsby, M.P.H., DTM&H	Wellstart International La Leche League Wellstart International La Leche League La Leche League Wellstart International Ministry of Health, Barbados
Complementary Feeding	Ellen Piwoz, D.Sc. Sandra Huffman, Ph.D. Hilary Creed-Kanashiro, M.P.H. Kathryn Dewey, Ph.D.	Academy for Educational Development AED/ Nurture Instituto de Investigación Nutricional, Peru University of California, Davis
MCH/ Nutrition	Ellen Piwoz, D.Sc. Kristy Hendricks, D.Sc. Laura Altobelli, D.P.H.	Academy for Educational Development Simmons College Cayetano Heredia University, Peru
IEC/ Behavior Change	Peter Gottert, M.A. Renata Seidel, M.A. Julia Rosenbaum, M.Sc.	Academy for Educational Development Academy for Educational Development Academy for Educational Development
Research	Carol Baume, Ph.D. Lonna Shafritz, B.A. Claudia Fishman Parvanta, Ph.D.	Academy for Educational Development Academy for Educational Development Emory University
Monitoring / Evaluation	Orlando Hernandez, Ph.D. Elizabeth Sommerfelt, M.D., M.S. Leslie Snyder, Ph.D. Stanley Yoder, Ph.D.	Academy for Educational Development Macro International University of Connecticut Independent Consultant
Cost Evaluation	Margaret Phillips, M.Sc. Susan Horton, Ph.D. William Bender, Ph.D.	Independent Consultant University of Toronto Online Development Corporation

Training	Valerie Uccellani, M.S. Mildred Morton, Ph.D. Lauren Blum, Ph.D. Michel Andrien, M.S.	Academy for Educational Development Independent Consultant Independent Consultant University of Liège, Belgium
Quality Assurance	Berengère DeNegri, Ed.D., R.N. Norma Wilson, D.P.H. Wayne Stinson, Ph.D.	Academy for Educational Development University Research Corporation University Research Corporation
Gender	Chloe O'Gara, Ed.D.	University of Michigan
Private Sector	Judith Timyan, Ph.D. Kim Winnard, M.A. Steven Chapman, Ph.D. candidate	Population Services International Population Services International Population Services International
Policy	Bob Porter, Ph.D.	Academy for Educational Development

Staffing Qualifications	Education and Field Experience				Essential Technical Areas				Other Key Technical Areas				Cross-Cutting Areas					
	Highest Degree	LDC Experience	Languages	USAID Experience	Breastfeeding and Nutrition	Family Planning/Services	Evaluation/Research	Behavior Change Communication	LAM	Policy/Advocacy	PVO Experience	Program Design	Research			Training	Gender	Private Sector
													Behavioral/Formative	Applied/Operations	Cost			
Jean Baker	M.P.H.	Asia Africa	U, T	13	✓	✓	•	•		•	✓	✓		•		•		
Margaret B. Parlato	B.A.	Africa LAC Asia	F, S	18	✓	✓	•	✓	•	•	✓	✓	✓			•	•	
Roy Miller	Ph.D.	Asia Africa	F	8	✓		✓			✓				✓	•			
Nomajoni Ntombela	R.N. M.W.	Africa LAC	P		✓	•		•	•	✓	✓	✓				✓		
Maryanne Stone-Jimenez	M.S.	LAC	S, F	6	✓	•	•	•	✓	•	✓	✓	•	•		✓	•	
Barbara Jones	M.P.H. M.A.	Africa N.E.	F, B	13	•	✓	✓		•		•	✓		✓		✓	✓	
Jay Ross	Ph.D.	Asia Africa	F, M	2	✓		✓			✓	✓	✓		✓	✓	•	•	
Sandra Huffman (50%)	Ph.D.	LAC	S, BA	10	✓	•	✓		✓	✓	✓	✓		✓	•	•	•	
James Gregory	B.A.	LAC	S	5														

✓ Primary Expertise
• Secondary Expertise

Languages
B = Bambara S = Spanish F = French M = Melanesian Pidgin
U = Urdu T = Thai P = Portuguese BA = Bangla

III. TECHNICAL SECTION

Achieving USAID's strategic objective of Improving BCM Practices - and the specific results set forth in Results Packages 1 through 3 - will require working at a country, institutional, and global level. The challenges of working at multiple levels and with numerous institutions to achieve change are considerable, particularly when this approach entails forging new alliances and relationships. Establishing close working relationships with the USAID COTR and others within the PHN Center and Missions will help to ensure that project activities contribute to achieving USAID's strategic objectives.

Following is an operational plan for core-funded activities, which is presented by level of activity.

A. OPERATIONAL PLAN

1. Country Level

Several streams of activities are planned: 1) replication, adaptation, and institutionalization of successful interventions; 2) operations research to develop, test, and implement sustainable and cost-effective, community-based, public and private sector services; and, 3) policy reform and information dissemination activities to enhance impact. *Linkages* expects to carry out programs in ten joint programming countries during the first five years of operation and to cover the remaining five by year ten. The intensity of our involvement will vary depending on country context and the field support received.

Countries will be selected based on Mission interest as well as on the opportunities presented by USAID funded cooperating agencies, PVOs and their NGO counterparts, and government institutions.

In addition to the 15 joint programming countries, we expect to work in three joint planning or special circumstance countries over the ten-year period, through the continuing programs of collaborating institutions or Mission field support transfers. As such, we will develop 13 country programs during the first five years and 8 new country programs during the second five years. We expect different levels of intensity in different countries, with a range of small and large efforts. This would depend on Mission and CA interest, existing BCM conditions, and local capacity. This will be better understood once we have input from USAID and have completed the first round of assessment visits. We propose, therefore, that we jointly review the targets with USAID at this time and adjust them as appropriate.

At this stage, however, the feasibility of these estimations can be gauged by comparing the expected numbers with the experience of HEALTHCOM II and the Wellstart Expanded Promotion of Breastfeeding Program (EPB). HEALTHCOM I and II worked in 60 countries during a ten-year period with 15 national programs. EPB worked in approximately 10 national programs during its five years. *Linkages* will reach additional countries through its plans to implement BCM activities with PVO, CAs, etc.

One of the problems EPB experienced was obtaining Mission support for country activities in support of national programs. The largest funding allocation received through Mission field support was under \$150,000 annually, with a total of only \$300,000 during a three-year period. Most often however, there was a complete lack of field support funds or up to only \$50,000 for one to two years. The low level of Mission support reflects declining resources during recent years and lower Mission

priority for nutrition programs in contrast to the wider range of child health programs aided by HEALTHCOM.

Thus, our approach to country programs is to use core funding to "jump-start" activities through PVOs (*Linkages* PVO partners and others), indigenous NGOs, and the private sector that already have defined and funded operations in each country. We will then provide technical assistance and some financial support to improve continuous country efforts and test new strategies. Our vision for country programs is to use these "jump-start" activities strategically, to gradually involve the public sector, and lead CAs/contractors working in the PHN arena. Our experience under the Nutrition Communication Project (NCP) is that Mission field support for nutrition more easily follows when there are successful national models, as well as interested government partners already on board. Expansion would thus occur during years five and ten. Exhibit III-1, on the following page, lists affiliate field offices in USAID countries which have already expressed an interest in collaboration.

The anticipated steps in this process are as follows:

1. Meet with USAID CTO bureaus, staff of CAs, and PHN contractors working in joint programming countries to learn of USAID-supported activities in each country, to refine priorities, and to locate background material and studies. Three "types" of countries will be selected - countries where there are opportunities for 1) private-commercial partnerships, 2) private-public partnerships, and 3) countries where there are opportunities for wide coverage and rapid implementation (building on existing successful programs). Country selection decisions will be based on regional diversification (focusing on Africa and Asia) and estimates of feasibility, replicability, likely sustainability, and potential for expanding planned activities. Activities with the greatest likelihood of achieving project results at lowest cost will be given priority.
2. Conduct country mini-assessments (no more than two weeks) during which teams with two to three members meet with local organizations, the USAID Mission, local MOH, and other ministry staff and meet with CA staff working in country to assess interest and identify potential collaborating institutions. Local associates of partner institutions will facilitate the assessment. *Linkages* will prepare a strategic investment plan in order to determine in which activities to invest core funds. This plan will seek to balance our objectives and expected results, with the objectives, results, and resources of other partners and organizations. It will enable management to avoid a piecemeal approach and insure that our activities are focused on achieving the expected results.

In all cases, *Linkages* will attempt to maximize available resources by developing consortiums of participating institutions. At the beginning of the project, each participating institution will identify its role (or comparative advantage) and potential resources (human and financial). Support from other donors will also be explored.

Core funds will be used to launch interventions in five joint programming countries during Year One and an additional five in Year Two. The magnitude of the activities in each country will vary. We estimate being able to work in two to three sites or regions per country, depending on our partners' activities. Core funds are also budgeted for technical assistance, training, and policy-related activities. It is important to note that core funds are also budgeted to work with additional NGOs, cooperating agencies, and the USAID implementation programs working in nearby areas to help them adapt BCM activities for their own areas.

III-1 PVO Affiliate Field Offices in USAID Countries

Joint Programming Countries and PVO Affiliate Field Offices					
Africa	PVO Field Office	Asia/Near East or Other	PVO Field Office	LAC	PVO Field Office
Ethiopia	PSI, CRS, CARE, WV	Bangladesh	PSI, WV*, CARE	Peru	CARE, Nurture, WSI**, WV
Ghana	WV, Nurture, CARE	Egypt	CARE, WSI, LLLI**		
Kenya	PSI, CRS, CARE, WSI**, WV	India	PSI, LLLI**, CARE, CRS, WSI**, WV		
Nigeria	PSI, WSI**	Indonesia	CARE, WSI**, WV		
South Africa	PSI, WV*, LLLI**	Morocco	PSI		
Tanzania	PSI, CARE, WV	Nepal	CARE		
Uganda	WV*, CARE, WSI**	Philippines	PSI, WSI**, LLLI**, CARE, WV		
Joint Planning Countries with PVO Affiliate Field Offices					
Benin	PSI	Jordan		Bolivia	CARE, WSI**, LLLI**, PSI, WV
Eritrea	WV*, LLLI*	Yemen		Dominican Republic	LLLI, WSI**, WV
Guinea	PSI			Ecuador	WSI**, LLLI**, CARE, WV
Guinea-Bissau		Ukraine	WSI**	El Salvador	WSI**, CARE, WV
Madagascar	Nurture**, CARE	Romania	WV	Guatemala	CARE, LLLI, WV
Malawi	PSI, WV*, CARE			Honduras	LLLI, WSI, CARE, WV
Mali	WV*	West Africa		Jamaica	LLLI**
Mozambique	PSI, CARE, WV	Southern Africa	LLLI**	Nicaragua	WV*, WSI**, LLLI**, CARE
Niger	CARE, WV	Greater Horn of Africa		Paraguay	LLLI**
Senegal	WV*				
Zambia	PSI, LLLI**, CARE, WV				
Zimbabwe					
Special Circumstance Countries					
Rwanda/Burundi	PSI, CARE	Cambodia	PSI, CARE, WV	Brazil	PSI, LLLI**, WV
		Pakistan	PSI	Colombia	LLLI**, WV
		West Bank/Gaza	CARE, WV	Mexico	LLLI**, WV
		Russia	WSI**	Haiti	PSI, CARE, WV
		Turkey			

KEY: PSI - Population Services International, CRS - Catholic Relief Services, WV - World Vision, WSI - Wellstart International, LLLI - La Leche League International
 * - USAID Child Survival Projects ** - Affiliated personnel, but no field office

3. Facilitate a workshop to develop the country action plan. This strategy will maximize the impact of the commercial, PVO, government efforts, and local indigenous NGOs on improving BCM. Plans will target specific strategic areas for *Linkages* to support in policy, behavior change, and support service access and quality. Some countries may focus on only one area, others on more. Still other countries might have only "jump-start" activities with one NGO or may focus on helping one CA institutionalize BCM in its country program.
4. Provide funding and technical assistance to strengthen continuing activities and to test new strategies (e.g., with the private sector or with community networks). Operations research is implemented to help enhance program effectiveness.
5. A monitoring and evaluation system is developed in conjunction with existing information systems that governments and PVOS have instituted so that the evaluation process is started at the beginning of project, and ensures that project results are measurable.

Specific planning activities for Results Packages 1 through 3 are presented in Sections C, D, and E below.

2. Institutional Level

Integrating BF/LAM into existing programs is a major thrust. *Linkages* will work with organizations at the headquarters and regional level to: 1) effect policies and technical directives, 2) design programs, 3) develop training and educational materials, and 4) foster a commitment to BF/LAM through other activities.

Given the broad range of potential institutions that could benefit from *Linkages* assistance, we propose to focus in the following way:

- Designate staff to coordinate. Each core staff will be assigned primary responsibility for integrating and collaborating with one or two cooperating agencies, NGOs, multilateral organizations, and other donors. *Linkages* and its staff already have ties with the BASICS, FOCUS, PCS, Quality Assurance, SARA, and SANA projects at AED. Organizations active in family planning communications (e.g., Population Communication Services) and involved in PVO and NGO training (e.g., the PVO Child Survival Support Project at The Johns Hopkins University) will be a high priority.
- Place part-time staff and consultants within CAs. During the second year, we anticipate opportunities to place part-time technical advisers within other organizations and projects, as needed.

Linkages' staff will use the following process to identify targets of institutional opportunity and to develop institutional strengthening plans for CAs, PVOs and other institutions:

Cooperating Agencies

USAID CAs have potential as channels for integrating BCM into their continuous activities and the activities of their partners in the field. *Linkages*, however, has to keep in mind that the CAs are already fully engaged in pursuing their own project goals and priorities. *Linkages* will use a behavior-change approach to devise a strategy to enlist the support of the CAs, just as it does with mothers or health providers. Staff first become familiar with their situations, then carefully weigh the perceived benefits and obstacles that the CAs will encounter in becoming involved in the *Linkages* agenda. We will devise "actionable" strategies and support systems for collaboration that will make it easier for these institutions to adopt or integrate BCM components. Fortunately, AED and its partners already have links to many of these CAs and will be able to build on the existing relationships.

The following sequencing of activities will be conducted:

1. Assessment and Prioritization with USAID: *Linkages* will meet with staff from the PHN Center and all of the regional Bureaus, as well as the Bureau for Humanitarian Response, to identify opportunities for BCM technical inputs from *Linkages*. This activity will include cooperating agencies, PVOs, and multilateral and bilateral organizations. Given our emphasis on reaching out to communities, we will work

actively with the Food for Peace and Office of Private Voluntary Cooperation to identify opportunities and priorities for supporting the PVOs who are implementing child survival programs and those who are shifting their emphasis from food distribution to maternal/child health and family planning activities. Criteria will be developed for selecting institutions to work with.

2. BCM Workshop for CAs: Within three months of project start-up, *Linkages* will host a one-day workshop for key CAs and their USAID COTRs to: 1) explain the goals of the project, 2) present the case for the importance of BCM and why they should be involved, and 3) solicit their input on how *Linkages* can best work with their program. The emphasis is on how *Linkages* can help them rather than vice-versa. *Linkages* will present a range of "products" (e.g., technical assistance, joint planning teams, BCM briefings, and training materials) that it can offer. Products of the workshop will include: 1) a list of specific actions *Linkages* can take to help all CAs integrate BCM; 2) an initial plan by each CA on how BCM can be integrated in their current work; 3) a determination of how *Linkages* can specifically help them and 4) solicit research ideas.
3. CA Investment Plan: *Linkages* and the USAID COTR will review the results of the workshop, divide CAs into "high impact" and "low impact" for investment of *Linkages* resources; have follow-up meetings with most promising CAs; and decide on its overall strategy and principal partners for the next one to two years.
4. Planning Meetings: *Linkages* will hold a planning meeting with each priority PHN cooperating agency to explore options for integrating BCM. Following this meeting, a series of sessions will be held with the coordinators for regions and specific technical areas (such as policy, training, behavior change, integrated management of childhood illness, and women's health). Plans for project collaboration will be defined with each CA. If necessary, memoranda of understanding will be drawn up to specify the areas of joint concern and *Linkages*' responsibilities (e.g., technical assistance for program assessments, co-sponsoring workshops, producing manuals, and field-testing materials). The same process will be used for our work with the PVOs, multilateral banks, and key donors, such as the Japanese International Cooperation Agency (JICA).
5. Joint Action Plan and Memorandum of Understanding: Information obtained during the planning meetings will be used to develop an overall plan for institutional strengthening over the next one to two years. Core funds will be used, as necessary to leverage support for high priority BCM activities. The plan will be updated annually.

Multilaterals and Bilaterals

Linkages will follow a similar process for identifying priority agencies to work with and for forging plans for strengthening their capacity in BCM.

PVOs

Linkages will work with PVO headquarters and regional offices to determine how to have a broad influence on their global operations. Integrating new technical areas and incorporating behavior change approaches at the field level will be easier if headquarters explicitly sanctions these actions.

1. *Linkages*' core staff will meet with either central or regional PVO staff to plan how to best integrate BCM into their respective network of programs. Activities may include conducting a technical review of their guidelines, training, and educational materials on BCM; adapting/creating a package of simple indicators for BCM attitudes, norms, and behaviors; holding training workshops on specific topics; and planning regional field activities.
2. A two-day meeting will be organized during the first months of the project to establish relationships among priority PVOs; to give technical presentations on BCM and what each PVO is already doing in these areas; and to develop a two-year action plan. These action plans may include technical assistance provided by one PVO organization to another.

Strategies for Institutional Strengthening in BF/LAM. Principal ways of interacting with institutions include:

- **Training and technical assistance.** Presentations and short courses will be developed for pivotal headquarters and regional staff. Linkages will seek ways to work with groups of institutions when this is feasible, through umbrella organizations, and regional and professional networks.
- **Symposia and workshops.** *Linkages* will take advantage of annual conferences at APHA, NCIH, and InterAction (The American Council for Voluntary International Action) to sponsor full-day workshops on BCM issues to help increase the knowledge of staff from the many international agencies attending these meetings. As members of InterAction, an umbrella agency of more than 125 organizations, AED and its team will be able to work with member organizations to enhance their technical knowledge and programmatic skills in BCM.
- **Agency meetings.** *Linkages* will take advantage of annual meetings of USAID PHN officers to present project results and BCM advances. Prearranged debriefings and electronic announcements of important *Linkages'* events and findings will also be established.
- **Information dissemination.** *Linkages* will reach institutions through a variety of means. Field tools, training curricula, and educational materials will be produced and shared at meetings, workshops, and via post. Other project results and products will be disseminated electronically (e.g., electronic mail and Internet).

3. Global Level

On the global level, *Linkages* will work to enhance political and financial support for BCM by USAID Missions, donor and technical agencies, such as the World Bank, Inter-American Development Bank, Asian Development Bank, African Development Bank, Rockefeller Foundation, WHO, UNICEF, and PAHO. This activity will be carried out through policy initiatives, advocacy, information dissemination, and participation in international technical working and advisory groups.

Linkages will also lend support to global and regional policy initiatives that further USAID's strategic objectives in BCM. This type of assistance might include helping to establish coalitions (not to run them), contributing to international symposia, commissioning and preparing state-of-the-art papers, and participating in conferences on BCM technical and policy issues. Whenever possible, participants from country programs and collaborating institutions will be given opportunities to participate in global-level activities. The principal ways of working globally are similar to those described above.

One of *Linkages'* major, global technical contributions will be the dissemination of existing tools to operationalize BCM program activities, skills, advocacy to encourage international organizations to use these materials, and training to promote their use. *Linkages* expects to produce at least three additional field tools for: 1) nutrition policy analyses, 2) development of public-, private-, and commercial-sector linkages for BCM, 3) policy and strategy guidelines for maternal nutrition. Additional topics related to integrating and mainstreaming BCM will be determined after consultation with USAID and other organizations. Specific global activities are discussed in the sections on policy, information dissemination, and research.

Country Program Illustration: India

Nearly half of all severely malnourished children in the world live in India... AID strategic objectives in India include reducing fertility and mortality, improving reproductive health and child survival in six northern states, including Madhya Pradesh where both CRS and CARE are active. CARE distributes Title II foods through ICDS (Integrated Child Development Scheme) aganwadi child care centers and CRS in non-ICDS areas. PSI is the largest condom distributor in India, marketing them through shops, CBD workers, pharmacies. We will coordinate with the many other CAs working in these areas including BASICS.

Major issues in India which *Linkages* could help address:

- Community involvement with the aganwadis is limited.
- Upgrading of technical and counseling skills is a priority.
- Key indicators are need for monitoring by the community, field offices, and government staff counterparts.
- Nutrition communications needs to be strengthened.

We would work with the new integrated family planning, child survival and reproductive health project in Madhya Pradesh that AID is planning.

What are the BCM problems in Madhya Pradesh?

MP ranks third in India for the highest rates of malnutrition with 57% of children 0-3 with weight-for-age less than 2 S.D. BCM problems are multiple: while the median duration of breastfeeding is 25 months, nearly 75% of mothers delay start until after 24 hours; late introduction of foods in addition to breastmilk is common with less than one-third of infants receiving complementary foods by 6-9 months of age; complementary feeding is generally inadequate in calories, micro-nutrients; frequency of feeding is low and foods often contaminated due to reheating or lack of handwashing and food hygiene.

What will we do?

Social marketing to develop messages and tools, training of aganwadi workers in the use of counseling cards, multiple media sources to disseminate messages. Training and supervision to address constraints health workers face, primarily limited counseling skills.

Private sector marketing of products to increase availability of appropriate foods and utensils. Title II foods will be used to develop weaning foods (as in the Tamil Nadu project prepared by community women). BCM messages will be disseminated by PSI's commercial and CBD networks. Media links will be activated. Community based support will address constraints mothers face in breastfeeding using community volunteers.

Policy. Linkages will join with UNICEF to revise ICDS policies to focus on children 0-3 years instead of the present 0-6. Results from our interventions will help make the case for stricter targeting.

Monitoring and evaluation systems will be designed to fit into MIS; to document results and costs. Broudscale information dissemination will site visits of government and other staff to encourage cross-fertilization of successful approaches. Linkages will provide assistance for replication.

B. TECHNICAL FOCUS AND OVERALL APPROACH TO BREASTFEEDING AND LAM

AED understands that the main focus of the project is on breastfeeding and LAM. The balance of activities between breastfeeding/LAM and the related areas of complementary feeding and maternal nutrition will need fine tuning at each step of the way. Clearly there are many needs. A major challenge will be to determine what is "manageable" for this project to address; how best to integrate strategies to improve complementary feeding and maternal nutrition; and, to understand better the circumstances that favor successful integration. AED will work closely with USAID to determine allocation of resources among the different technical areas in different program contexts.

The following sets forth our strategy for 1) mainstreaming breastfeeding/LAM into family planning service delivery programs; 2) integrating BF/LAM into Maternal Child Health service delivery programs; and what we view as 3) opportunities and priorities for complementary feeding and maternal nutrition for this project to address.

LAM and Family Planning

Our broad approach for scaling up with LAM within Family Planning is to build on the excellent work that Georgetown has done. The LAM aspects of breastfeeding will also be mainstreamed into MCH, AIDS prevention and other programs. Although the family planning community is not the only one concerned with LAM, they are an important audience requiring a unique strategy. Specifically, for those programs, CAs and interventions concentrating on family planning, we will focus on:

1. Continued advocacy to include LAM as an essential component of family planning programs (including CBD and social marketing). We feel that developing better cost data than we have now will be critical to success. One of the lessons from IRH is that family planning programs are not convinced that LAM is a cost-effective method. We need to document costs of different approaches and establish the benefit of using LAM as an introductory method, and one that can help women transition to other family planning methods. We also need case-control studies to show impact relative to non-users.
 2. Training of medical personnel. A key component of past LAM efforts has been training of medical personnel at all levels. We propose that this be handled by a core team of regular consultants, using many of the same consultants used by IRH (who are often Wellstart associates) to work on training and policy changes. Several key Wellstart technical consultants who have worked previously with IRS - Veronica Valdes, Mary Kroeger, Andres Bartos, Ricardo Gonzalez, and Andrey Naylor - will help strengthen this component. Other specialists will be identified in collaboration with IRH once the cooperative agreement is in place. Mary Ann Stone-Jiménez will coordinate this work. In all regions there is a pool of local resource persons including Wellstart Associates who are capable of filling the gap.
 3. Reposition LAM as a mainstream family planning method. Another major lesson learned from the IRH evaluation is the need to address the perception that LAM is aligned with natural family planning. De-linking the two is pointed out as essential. AED, which has been a partner in SOMARC, PCS and other family planning and AIDS-prevention projects, is well positioned to help LAM gain wider acceptance. We will look at ways of using communication strategies to modify the "image", based on audience research. Recent studies about the perceptions of the health and family planning community regarding LAM can be used as a starting point.
 4. Continue to explore ways to use LAM as a social marketing tool to improve breastfeeding practices. This will be especially important for the behavior change Results Package 1.
 5. Take a behavior change approach to improving transition from LAM to other methods. We will give more focus to understanding the critical behaviors that must be promoted for women to successfully "transition" from LAM to other methods. There is still much to be learned. Some of the LAM educational materials now in use (developed without technical support from LAM experts), do not provide women with concrete advice on this issue. These efforts will be carefully monitored for cost-implications. IRH's efforts at integrating LAM into family planning programs has resulted in successful transitioning of women from LAM to other methods.
 6. Provide technical assistance on systems and policy change. The IRH program showed the need for a systems approach and policy changes to support incorporation of LAM into family planning service delivery programs. Thus we might develop activities to revise policies and norms governing the management of postpartum breastfeeding women; protocols for selecting appropriate oral contraceptive formulations; guidelines for administration of anaesthesiology to BF women undergoing surgical sterilization).
- IRH found it helpful to conduct research on views of practitioners about LAM. We believe additional systems research is needed to follow up with staff of family planning agencies to learn about their constraints to implementing LAM in order to develop appropriate actions to address the roadblocks that they have.
7. Actively disseminate existing materials and information. We will make maximum use of information that IRH has developed and will work with them to develop an information dissemination program.

8. Incorporate LAM into the curricula of regional and national FP training centers. In order to increase sustainability, we will work to include LAM as part of the family planning training strategies in regional family planning training centers, such as the Center for African Family Studies (CAFS) in Nairobi and IPPF country training centers.
9. Invite Georgetown's IRH to conduct an orientation course on LAM for Linkages staff and carry out an initial series of joint technical assistance visits during Year One to facilitate transfer of experience.

Experience of the team in working in family planning service delivery programs and LAM. A staff member with extensive experience in family planning, Barbara Jones, is being assigned to head up Results Package III and will have oversight of these activities. As documented in the Personnel Section, a number of other team members, including Jean Baker, Peggy Parlato, Nomajoni Ntombela, and Sandra Huffman also have extensive experience in this sector (as well as in MCH, AIDS and other related areas). Three teams members (Stone-Jiménez, Huffman and Ntombela) have strong LAM backgrounds. The proposed orientation plus review of IRH materials and reports on sub-projects will further strengthen these skills.

Breastfeeding/LAM and Maternal Child Services

Effort to date has been concentrated on strengthening of hospitals and training of health personnel in lactation management. Linkages will seek to:

1. Consolidate and maintain the support for breastfeeding at the hospital level. This will bear careful monitoring since UNICEF - a main supporter of the Baby Friendly Hospital Initiative (BFHI) - is scaling back its support.
2. Improve counseling and other support services for breastfeeding/LAM within the MCH system. Focus on missed opportunities for providing counseling and referral.
3. Apply lessons learned from NCP and HEALTHCOM on promoting optimal breastfeeding practices and instituting new community norms. Continue to refine strategies for achieving exclusive breastfeeding and linking messages with family planning, reproductive health and other topics.
4. Expand on proven models and further test systems to reach into the communities to provide information and services. This will include a range of strategies including mother-to-mother support groups, private sector linkages and use of non-health institutions with a strong community base.
5. Expand the scope of the Baby Friendly Hospital Initiative to the community level.
6. Focus on improving pre-service training, rather than on in-service training.

Experience of the team in MCH service delivery. Nomajoni Ntombela, a public health nurse and breastfeeding expert, with more than 20 years experience in assisting MOHs, will lead *Linkages'* effort in working with MCH programs. She is a pivotal member of Results III Package focused on services. Other team members also have strong track records in working with MCH service delivery programs. This experience is highlighted in their biosketches in the previous section. Subrecipients Wellstart International and La Leche League International bring further institutional depth to this area.

Priority Intervention Areas for Complementary Feeding and Maternal Nutrition

While breastfeeding is clearly the main focus of the project, it is important to emphasize the interrelatedness of breastfeeding to optimal infant feeding practices, and to maternal nutrition. Programs to improve complementary feeding must consider both breastfeeding and complementary feeding practices because, at the individual level, these decisions are inter-related. There are many lessons learned from programs to improve sub-optimal breastfeeding and complementary feeding practices. For example, a successful strategy for increasing rates of exclusive breastfeeding is to encourage a delay in the introduction of non-breastmilk liquids. Other strategies that have been successful for promoting, supporting, and protecting breastfeeding, such as peer support groups, mother to mother counseling, and enhancing confidence and self-efficacy, may also be useful for complementary feeding.

In hospitals, health facilities, and communities, emphasis should be given to motivating delays in the introduction of non-breastmilk foods and liquids. Likewise, mothers and others who are reached by breastfeeding promotion and support activities should also be counseled about appropriate complementary feeding practices, with emphasis given initially to appropriate nutrient density and food quality while frequent, on demand breastfeeding is maintained. As the infant gets older, messages and strategies should emphasize increasing the variety and quantity of foods offered, the frequency of feeding, and continued breastfeeding through at least 24 months.

There are many opportunities to promote complementary feeding. These include *sick-child counseling* and follow-up or *convalescent counseling* to reverse the detrimental effects of illness. *Community strategies* that reach mothers and other influential caretakers and decision-makers can affect complementary feeding practices. Reaching women and others on a daily basis requires the use of *multiple channels*, such as mass media, peer counselors, drama, messages targeted to men, etc. In addition, using *commercial channels* (markets, groceries, food stalls/vendors) to reach women and others is important to reach people when they are making food purchase decisions, on a regular basis, and to reach those that may not utilize health facilities. Linkages will explore opportunities for use of the private sector to market and make complementary feeding products more widely accessible to mothers and others, particularly in urban areas.

The priority interventions proposed in complementary feeding are:

- use of the Applied Behavior Change (ABC) approach to improve complementary feeding practices (e.g., all six steps from formative research through monitoring and evaluation), emphasizing developing appropriate behavior change messages, improving the quality of counseling interactions, and reaching women and other decision makers in the community environment;
- identifying new outlets and promising products that can be used to improve complementary feeding;
- advocacy to create awareness and support for complementary feeding;
- complementary program components that will magnify program impacts (e.g., support services, women's care);
- additional data collection, as needed.

Linkages has identified four priority areas for research on complementary feeding: 1) evaluations of the cost-effectiveness and sustainability of programs to improve complementary feeding practices (including identification of key elements of program delivery that are necessary for expansion, replication and sustainability); 2) studies on behavioral strategies for maintaining breastmilk intake by young children during the early complementary feeding period; 3) research to develop new tools that can be used in field settings (by programs) to assess the adequacy of complementary foods and appropriate strategies for improving complementary feeding (which take into account issues such as nutrient density, bioavailability, economic and cultural feasibility, etc.); and 4) research on potential private-public sector partnerships to improve complementary feeding.

Maternal malnutrition is a cumulative process, the result of poor diet, health and inadequate care throughout the life cycle. Therefore taking a life cycle approach to understanding maternal malnutrition is important. However, financial and resource constraints will require limiting activities to a few key entry points and interventions. For many women these entry points are adolescence, pregnancy, and the early postpartum period. Linkages will focus on adolescence as a point of opportunity, especially postponing the first pregnancy. Pregnancy is a period of increased nutritional need and women who enter pregnancy malnourished are at great disadvantage, particularly with respect to iron status, because of the high iron requirements to support blood volume expansion, fetal growth, etc. However, because it is difficult if not impossible to correct a pre-existing iron deficiency during pregnancy in developing country settings, preventing iron deficiency before conception through fortification, supplementation, and dietary change is preferred.

A key issue in the improvement of maternal nutrition is the constraint imposed by poverty. Unlike the improvement of infant nutrition, which can be achieved through inexpensive adjustments in breastfeeding and complementary feeding, improved maternal

nutrition may involve more considerable investment. Linkages will identify cost-effective means of overcoming such constraints, recommending more equitable and efficient allocation of existing household resources and linking, where possible, with income generation activities.

Greater access by adolescent girls and pregnant women to health services is imperative. Strategies to improve women's nutrition must create awareness and demand for services, not only by the girls and women themselves, but by the community at large. For many programs, involving men will also be critical. This is especially true for family planning and child spacing activities but is also necessary for all actions that involve behavior change, such as improved feeding, reduced work load, and health care. The benefits of health interventions will be maximized through interventions in other sectors.

Illustrative examples of the types of activities that Linkages might undertake are summarized in Table 1. Linkages could support some of the interventions listed, or others such as working with PSI to develop a social marketing strategy for promotion of iron tablets, tonics, etc. targeted to adolescent girls. This might be undertaken as part of an integrated strategy that includes a behavior change component as well, recognizing that iron supplementation programs that include appropriate counseling about need for compliance with dosage and how to prevent and minimize side effects are more successful.

Experience from previous projects shows that improvements in women's nutrition requires involvement of additional family members (particularly men), and that behavior change requires a shift in norms about women's needs, their roles, and even their perceived status. Linkages may work, in some locations, with community-based education efforts to raise awareness of women's nutritional needs. Other opportunities to improve women's nutritional status occur in many different sectors and within different types of programs. Linkages will identify the most cost effective approaches, such as through Child Survival programs to emphasize a focus on the girl child and her special needs (nutrition, health). Similarly, Child Survival programs can include a more focused emphasis on maternal nutrition, recognizing the critical role of the mother in improvements in child health and nutrition. Similarly, income generating programs that train girls, provide skills, and access to information (literacy programs) are avenues to reach girls to improve their nutrition.

Table 1. Health Sector Intervention to Improve the Nutrition of Adolescent Girls and Pregnant Women

Objectives	Interventions
<p>Improve the health and nutrition of adolescent girls by:</p> <ol style="list-style-type: none"> 1) Postponing the first pregnancy 2) Improving knowledge and practices related to reproductive health, especially HIV/AIDS and high risk sexual activity 3) Improving nutritional behaviors 4) Preventing and treating infections and deficiencies that undermine health and nutritional status 	<ul style="list-style-type: none"> ▪ Access to family planning and reproductive health services ▪ Education through schools, religious organizations, and markets/workplaces; use of social marketing techniques ▪ Research to identify cultural and institutional constraints and detrimental attitudes and practices; education, communication, and social marketing programs based on the research findings ▪ Prevention and treatment of sexually transmitted diseases (STDs), hookworm, and micronutrient deficiencies
<p>Improve the health and nutrition of pregnant women by:</p> <ol style="list-style-type: none"> 1) Increasing the number of women receiving quality prenatal and postpartum services 2) Improving knowledge and practices related to reproductive health and the dietary requirements of pregnant and lactating women 3) Improving nutritional behaviors 	<p style="text-align: center;">Service Delivery</p> <ul style="list-style-type: none"> ▪ Iron-folate supplementation during pregnancy ▪ Monitoring of pregnancy weight ▪ Tetanus shots for pregnant women ▪ Assessment of need for antimalarials, hookworm medication, vitamin A tablets, and iodine supplementation ▪ Vitamin A, in endemic deficient areas, in a single dose within 4-6 weeks postpartum to lactating women ▪ Prompt diagnosis and treatment of illness <p style="text-align: center;">IEC</p> <ul style="list-style-type: none"> ▪ Nutrition, breastfeeding, and family planning counseling ▪ Information on practices to reduce the risk of HIV infection ▪ Education on preventive measures e.g. mosquito nets ▪ Involvement of men and other family members to increase demand for health services for pregnant women <p style="text-align: center;">Research</p> <ul style="list-style-type: none"> ▪ Reinforcement of cultural practice of rest period for postpartum mothers ▪ Research to identify cultural and institutional constraints and detrimental attitudes and practices; education, communication, and social marketing programs based on the research findings

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A limited number of intervention-oriented research efforts related to maternal nutrition may be undertaken through Linkages. This may include testing strategies for reaching adolescent girls and boys, the effects of these efforts on nutrition and reproductive health/outcomes, and their costs. For example, Linkages may have opportunities to evaluate ongoing programs that reach adolescents, operated by PVOS, with an expected behavior change outcome.

(For a more thorough discussion of programmatic approaches to improvement of women's nutrition, see, *The Time to Act - Women's Nutrition and its Consequences for child Survival and Reproductive Health in Africa* by Baker, Martin, and Piwoz, Academy for Educational Development, July 1996).

C. RESULTS PACKAGES

The RFA articulates clearly the Strategic Objective of the program and three results necessary to reach the stated objective. *Linkages* will organize its work around these same results. Before describing, in detail, our approach to each of these results, a brief statement about monitoring of progress toward these results and the Strategic Objective is presented as background for what follows.

As described later in the Evaluation section of this document, *Linkages* is committed to the quantitative measurement of progress toward desired results. To do this, indicators and methods of collection of data will be developed and tested in parallel and applied throughout the life of the program. Within the newly reengineered environment of USAID, the process of selecting indicators for program performance monitoring and evaluation is changing. In order to hold down data collection costs and to insure that the indicators used for any single program are consistent with and supportive of indicators used by the missions, central bureaus and related program areas within the Center for Population, Health and Nutrition, it is necessary to coordinate indicator selection within the Cooperative Agency community and with the relevant Operating Units within USAID.

To facilitate this coordination process, USAID is in the process of designing a new activity called MEASURE. In the interim until MEASURE is operational, a number of other groups and projects are working on indicator development; for example, the ad hoc Child Survival Indicators Working Group. Before finalizing the selection of indicators for the BCM program, *Linkages* intends to check with all such groups to promote the consistency of indicator selection among related programs and at different levels of USAID. Therefore, the following comments on indicators for monitoring progress toward the program Strategic Objective and the concept for selecting indicators associated with each of the three results should be viewed as ideas to bring to the larger indicator development process within USAID rather than as decisions already made.

1. Higher Level Indicators: The Request for Application identifies nine indicators "to measure program impact." To make the list manageable and to focus data collection resources, *Linkages* proposes to focus on a smaller set. Given the emphasis of the program on breastfeeding and LAM, *Linkages* proposes to focus on one key indicator in each of these areas.

For breastfeeding, the indicator of choice is the proportion of infants exclusively breastfed, month by month, for the first six months of life. As the sample needed to generate statistically significant estimates for each month are rather large, *Linkages* proposes to explore the use of a variant of this indicator, the median duration of exclusive breastfeeding. The data required to determine a value for the two indicators is identical - the age and the current feeding practice of the infant. By using a technique known as survival analysis a relatively small sample of this data can be used to estimate median duration of exclusive breastfeeding and, if the program is successful, these estimates should demonstrate positive change. Where samples are big enough to support month by month estimates; for example, in a large demographic and health survey, both indicators will be reported.

For LAM, the indicator of choice is the proportion of women using LAM as defined in Attachment 3 of the RFA. It is important to note that this indicator does not measure the proportion of women who are amenorrheic because they are breastfeeding. Rather, it identified women who are consciously fully breastfeeding their children as a contraceptive method as well as a healthful practice for the child.

In the other areas making up the BCM program, the limited experience to-date makes indicator selection more speculative. For complementary feeding, *Linkages* would explore the indicator, "the proportion of children 6-9 months of age receiving complementary foods in a timely way." An area for research is the possibility of defining complementary foods in a more detailed way than the "mushy foods" reported in DHS surveys. Finally, regarding maternal nutrition, the indicator, "the proportion of women who practice key nutritional behaviors" has potential but needs to be further specified as those behaviors are defined.

2. Indicator of Progress Toward Results: *Linkages* proposes to define country specific results packages for each of its different country programs. While these programs may well share many common characteristics, it is anticipated that each country will present a unique set of problems regarding feeding behavior as well as LAM and that country programs will be defined specifically to address those problems. The illustrative indicators in the sections of this proposal describing the three results packages constitute a starting point for identifying indicators for the different types of programs anticipated. These will be selected to be consistent with the country strategic and performance monitoring plans and the selection will be made in consultation with USAID staff at global level. We will limit the number of indicators to be collected in each country.

In general, *Linkages* will seek to identify and focus on indicators at the highest level of program attention within the manageable interest of the program in a five year period. Level, here, refers to the place in a causal chain of events occupied by an activity. At the highest level, *Linkages* seeks correct application of a desired behavior by as many people as possible. However, a series of intermediate results must be attained to reach this highest level; specifically, people must first know about and understand the behavior. People must then adopt the proper attitude toward its use. And, finally, barriers or obstacles to its application must be overcome. In different countries, the focus will be at different levels depending on the maturity of the program and the nature of the problem. Indicators will be selected accordingly.

RESULTS PACKAGE 1: IMPROVED ATTITUDES AND NORMS

1. Issues and Challenges

Improvements in attitudes and norms about breastfeeding, and LAM, and related complementary feeding, and maternal nutrition (BCM) are critical to our goal of improving BCM-related practices. The scope of possible activities to be implemented by *Linkages* is broad, given the large number of factors shaping social and personal attitudes and norms about BCM practices. In addition, nutritional considerations must also be taken into account because the ultimate goal of these efforts is not only changes in beliefs and behaviors but also measurable improvements in nutritional well-being and fertility management. The strategies and resources required to improve maternal nutrition are very different from what is needed to improve and sustain optimal breastfeeding and changes in complementary feeding practices. The challenge for *Linkages*, therefore, is to be able to respond to these varied situations, using a common set of methods in a large number of program areas, and to make a difference for the people reached by these efforts.

Decisions about the activities to be undertaken by *Linkages* will be made in consultation with the COTR, USAID Missions, country-level counterparts, and other technical experts. A number of priorities have already been identified.

Use state-of-the-art, behavior-change methods to promote sustainable changes in BCM attitudes, norms, and practices. Unlike many health problems, improvements in feeding and diet require changes in practices that occur every day and thus changes occur incrementally. Food choices and feeding patterns are deeply rooted in history and culture; they reflect norms about flavor, consistency, and the suitability of a variety of foods for different groups of individuals (e.g., infants and pregnant women), and they are constrained by work patterns and the availability of water, fuel, and ingredients. *Linkages'* activities to improve BCM-related practices will include careful formative research to identify specific action-oriented behaviors and to suggest steps to overcome barriers to change.

Work with the private sector to find new, sustainable channels for BCM messages and products. Because BCM behaviors are practiced every day, it is essential that information, messages, and other program products, such as new recipes, reach target

audiences regularly. Many past IEC efforts to improve BCM practices have been costly and not sustainable. Although these problems are well known, the challenge still remains for *Linkages* to explore new opportunities for reaching people with advice, products, and BCM services and to develop strategies for making these services and products self-sustaining. Work to be done by PSI will provide new insights into how the commercial sector can be harnessed to improve BCM and related practices.

Mainstream BCM objectives into existing child survival, family planning, maternal and child health, reproductive health, and emergency relief programs. Previous projects have identified the important target audiences and age-groupings for specific BCM interventions. We have detailed information on the types of practices that are most feasible to change within each of these audience segments. We still lack guidelines on the appropriate times to provide advice and motivation for different behaviors and for how long a period of time these messages are needed to create sustainable changes in norms and practices. Practical ways of incorporating BCM objectives and activities into various programs have also not been well-documented. For example, we need to know the five most important BCM behaviors for dissemination by family planning workers and when they should be delivered. We know that anemia causes 20 percent of maternal deaths worldwide, but we do not know how to motivate reproductive health programs to take action in this area. *Linkages* will use knowledge of appropriate practices for different audiences in its work to mainstream BCM objectives and messages into different program areas. Questions of timing, intensity, and duration of these efforts will be carefully examined.

Build a capacity for behavior change within counterpart institutions. USAID projects have been working with host-country counterparts to implement health behavior-change programs for many years. Typical programs have involved intensive technical assistance to a few individuals. Although training-by-doing is extremely valuable, this model is not being used to change behavior in other systems, such as finance and planning. Further, the capacity is lost when the small number of individuals trained move to new positions where their skills cannot be used. *Linkages* will explore new and practical ways to build capacity in BCM behavior change within PVO, NGO, and government counterpart institutions. Available tools will be adapted and used to meet this challenge. Additional information on the types of inputs best to direct to central, regional, and field-level personnel will also be required and documented.

Identify cost-effective strategies for improving maternal nutrition and dietary practices. Although many projects have included components to improve maternal nutrition and dietary practices, the strategies used and their impact have not been evaluated or widely disseminated. The challenges are considerable. Firmly-held gender traditions regarding intrahousehold food distribution and women's limited control over family resource allocation restrict their ability to change their usual dietary practices. Some approaches targeted at men have been successful at improving the quality of foods consumed by women and children in Mali. *Linkages* must replicate and expand these approaches, create new ways to address social norms and attitudes, and identify activities that can have an immediate impact on women's nutrition and dietary practices.

2. Lessons Learned

The following lessons learned will be used to guide the selection of program strategies and activities.

The rewards of BCM behaviors are not immediate and, therefore, behavior change efforts must link them with concrete and tangible outcomes. Experience shows that mothers are more likely to adopt new feeding and family planning practices when they perceive positive benefits for themselves and their children. Programs must articulate these benefits in terms that are meaningful to the population. Frequent reminders and adequate support must also be provided to enable women to follow the desired practices.

Recommended BCM practices must be nutritionally beneficial, carefully balanced, and targeted. Recommendations for improved feeding practices must balance nutrient requirements with message clarity to ensure that they result in improvements (rather than declines) in dietary intake. For example, recommendations to give one-year-old children solid foods five times a day may result in reduced breast milk consumption and lower protein intake when the solid foods given are inferior to breast milk. Careful formative research and nutritional assessments are required to identify the specific

practices, new food combinations and recipes, and behavior changes that will make a difference.

BCM programs must define their audiences, design the action-oriented messages that each will receive, and communicate these messages with appropriate timing and frequency. To achieve an actual change in attitudes and norms, information about new BCM behaviors and practices must reach a wide audience through a combination of channels over a considerable period of time. Messages and information must be disseminated strategically - at key "teachable moments" when mothers, fathers, and families are active participants in a communication process and they are prepared to receive, assimilate, and act on the information received. Such moments are often different for different behaviors. Pregnant women attending pre-natal clinics may be eager to implement dietary advice if they also recognize its benefits and are not inhibited by fears of a difficult delivery. Others attending clinics with sick children are often less "teachable" because their primary concern is for their children's immediate well-being. This latter example underscores a major lesson learned during the last ten years: although there are many (often missed) opportunities for providing BCM messages within the health care system, most "teachable moments" for nutrition do not occur within health facilities. To influence attitudes, norms, and daily practices, BCM messages must be delivered in the communities, shops, and homes where people are living.

When time and resources are severely limited, it is best to begin BCM programs simply. Planning and implementing behavior-change programs requires time. During the months between formative research and the behavior-change intervention, staff frequently change jobs or become occupied with other activities. Therefore, it is best to begin by planning a limited number of activities that are feasible to implement and manage. The top priority is to promote a few key messages (e.g., on optimal breastfeeding and LAM) and, as momentum and experience build, expand to include new media, additional behaviors (e.g., complementary feeding), and larger geographic areas.

Effective print materials, counseling cards, videos, and training modules are readily adapted for use in new geographic areas. Experiences in HEALTHCOM, NCP, and EPB have shown that, with limited modifications, educational materials developed in one country can successfully be adapted for use in neighboring countries. The savings in time, cost, and technical inputs are considerable. For example, breastfeeding promotion guidelines for nonhealth workers were first developed by NCP in Peru and are now used (with slight modifications) in more than five countries. A storybook and counseling materials developed in Burkina Faso is now also used in Mali and Niger.

3. The Applied Behavior Change Approach

We have moved well beyond the early "knowledge-attitudes-practices" model to a more sophisticated one which draws on behavioral theory. Changing attitudes and social norms, deriving motivational strategies from perceived positive and negative consequences, as well as enhancing self-efficacy and skills, are known to be critical to changing people's behavior. Traditional IEC tends to emphasize knowledge, and therefore often falls short of achieving behavior change.

Linkages' efforts to improve BCM-related attitudes, norms, and practices will have its foundation in AED's *Applied Behavior Change (ABC)* approach. This approach combines behavioral theory with a grassroots, participatory orientation. It has been used successfully for nearly two decades to change health, nutrition, family planning, substance abuse, AIDS, agricultural, and environment-related practices. Results are documented in numerous publications (see appendices).

The ABC methodology is based on a five-step process (assess, plan, pretest, deliver, and monitor and evaluate). It contains six essential elements: 1) consumer-centered planning; 2) research-guided decisions; 3) specific behavioral goals; 4) multichannel communication; 5) integrated program components; and 6) balance of supply and demand. This methodology relies on a participatory planning process that uses formative research to give stakeholders (e.g. program beneficiaries, providers, and management) an active voice in decision-making.

Insights from experience using the applied behavior change approach to improve BCM-related attitudes, norms, and practices are summarized below.

- A variety of factors influence behavior. Important internal factors are knowledge, attitudes, norms, self-efficacy, skills, and perceived consequences of different behaviors. Important external factors are cost and access to necessary resources.
- Decision-making occurs in a family context. It is important to understand that context in order to develop messages that will resonate with relevant family members, especially men.
- Factors that contribute to poor performance by BCM counselors include poor communication skills; lack of concrete and practical advice to offer to women; lack of training on problem identification and analysis, which would enable them to devise practical solutions to unanticipated problems; and limited training and constructive feedback on their work.
- Once new practices are adopted, there is a "maintenance period" that lasts several weeks to several years (depending on the practice) when behaviors need to be reinforced and fully integrated into the daily routine. Maintenance programs must use sustainable community structures rather than outside financial resources. Sustainable behavior change takes place, and can be measured only when all outside financial sources of support are discontinued.
- By changing norms, an extraordinary amount of behavior change can take place with very little of it due to people having direct contact with a specific intervention component. What is important is the amount of public attention ("noise") around a particular issue.

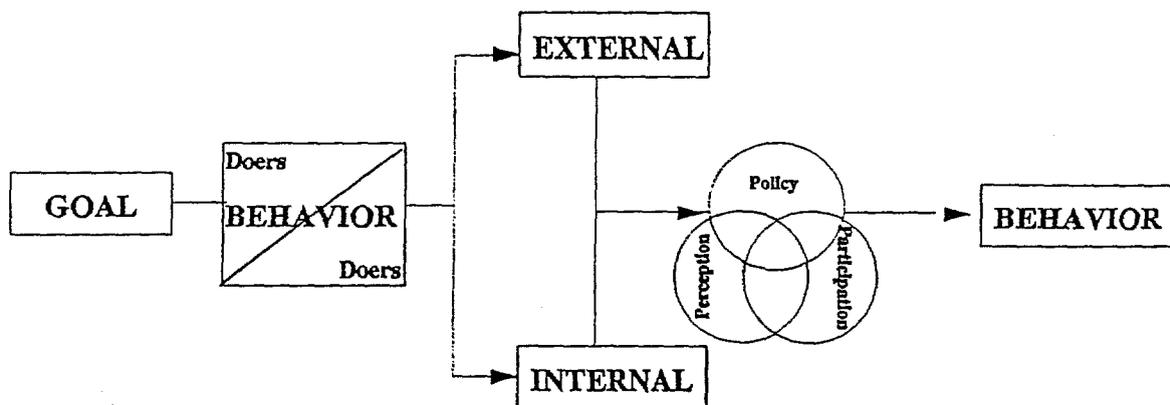
The ABC methodology is well-documented in *Communication for Health and Behavior Change* (Jossey-Bass, 1993) and operationalized in *A Tool Box for Building Health Communication Capacity* (1995), written by AED staff under the HEALTHCOM Project. Linkages will continue to refine its application for BCM behavior-change activities.

4. Social Marketing Approach to Increase Access to Information and Services

One of the major challenges faced by nutrition programs is in finding ways to reach out into the community. Health facilities have not proved an ideal setting for counseling. The overriding reason we see for using the private sector is to provide ACCESS to target populations, and tap into the highly motivated sales forces used for social products. Commercial marketing networks offer a way to increase Access and also to reach the population in a less intimidating way where they shop, relax and interact close to home.

Nutrition programs have not - so far - made use of the private sector the way

Applied Behavior Change Approach



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There are five principal ways we believe the private sector could help:

1. Link BCM messages to existing social marketing product lines. We feel there is potential especially for those products such as oral contraceptives, ORS, safe motherhood kits and depo-provera, that are used by women, during the key reproductive stage of their life that is of interest to our program. Pharmacists, private health providers and CBD workers are presently trained in counseling and product knowledge. They are already accustomed to counseling women. Promotion of breastfeeding/LAM could be a natural extension of these product lines.
2. Market products which can serve as symbols and tangible reminders of optimal feeding practices that have been difficult to convey and need to gain everyday prominence in order to become social norms. We would like to experiment with marketing a cheap plastic bowl as a way of focusing mothers on the need to monitor portions and as a way to encourage supervised feeding. These are key behaviors to improving the nutritional status of 6-18 month olds. The strategy would take advantage of a key marketing principle: it is easier to sell an idea if you have a product to link it to.
3. Market existing nutritional products that can make compliance with optimal practices easier. We propose to aggressively market iron tablets, tonics and other formulations to address anemia. (This is an area OMNI has been able to address in only a limited fashion. There is scope, therefore, for coordination.) Iron is one of the few nutrition products that already exist for maternal nutrition. Nutrition programs have not had the benefit of a product of interest to the commercial sector. We propose looking at ways of adding iron tablets to the product line of CBD, pharmacists and others who are selling contraceptives, ORS etc. in order to make it worthwhile.

We want to find ways to harness the PROFIT motive of the private sector, so there is interest in talking to mothers about iron. We believe that iron tablets will be of interest to those distributing oral contraceptives to women. Iron formulations could be a new product for use in the first six months after delivery; and then could continue to be a relevant product for women once they start on the contraceptives.

4. Help bring new, nutritionally beneficial products to consumers. Among the nutrition community there is renewed interest in promoting infant food mixes and maternal supplements. There are also some products ready for marketing (such as the many variants of maternal biscuits and food mixes developed by local industry.) These products are not likely to be available or distributed in public health settings.
5. Use specialized communication channels to reach into communities with nutrition information and affect behavior. PSI presently funds a number of channels to reach hard to reach groups. We could add to the reach of important messages by using these innovative and consumer-driven communications. Using PSI's existing community information channels to get out information about breastfeeding, LAM, complementary feeding and maternal nutrition, offers a cost-effective way of increasing the reach of messages. This includes tapping into: (a) mobile video units, used to reach rural villages that do not normally have access to mass media or public health information; (b) traditional healer associations, and, (c) peer educators who perform street drama in poor urban areas.

What skills/programs would PSI bring to the project? AED has skills in behavior change. PSI would complement this with strong capacity in product distribution, pricing and marketing. In addition they bring:

A large network of distribution systems. PSI's presence in 35 countries offers marketing networks and country offices for quick start-up of programs. In Bangladesh, for example, PSI products (including ORS and oral contraceptives) are distributed in 30,000 pharmacies, 40,000 general stores and 30,000 market stalls as well as by CBD workers.

Diversified donor base. Approximately 63% of PSI projects receive funding from multiple donors. This access to additional funding resources will permit the project to leverage initial USAID investments to secure other funds.

Interested USAID missions. PSI currently receives direct funding from 15 local Missions and pass-through funding from six others. These relationships will help the project to stimulate Mission consideration of project strategies.

Cross-subsidy experience. This is the principle of using high-profit items such as razorblades to subsidize a social product, such as condoms, to keep the price affordable for audience segments who could otherwise not afford the product.

How would the social marketing component be implemented to achieve the goals of the project? The following implementation strategy is planned:

- Linkages staff would identify country sites for commercial activities as part of assessment visits.
- Work with PSI core professional marketing staff to design the interventions and their evaluation.
- Conduct a Training of Trainers for PSI country staff to develop expertise in the BCM content area. They in turn will train local sales forces; design promotional and support materials.
- Local PSI person will manage on-site activities, with oversight from Linkages.

5. *Expected Results* By the Year 2001

- Improved BCM attitudes, behaviors, and community norms in all geographic areas covered by ten *Linkages* projects.
- Increased capacity to plan and manage behavior change strategies for BCM in three PVOs, three CAs, and three international organizations.
- Documented, successful models for cooperation among agencies in activities to mainstream and integrate BCM into ongoing programs.
- Commercial sector participation in marketing BCM products and messages in five countries.
- Field-tested tools to train community members, selected commercial salesmen and women, and health providers to be effective communicators and counselors.
- New indicators for measuring BCM behaviors and change over time to use in monitoring USAID results and progress toward reaching its strategic objectives.

By the year 2006

- Key practices and conditions necessary to support and sustain optimal BCM practices in different environments identified, and information widely disseminated within USAID, to other donors, and worldwide.

6. *Activities*

Country Level

The following is an illustrative sequencing of behavior change activities at the country level:

1. As part of the broad *Linkages* mini-assessment described earlier, the team will identify existing information about BCM problems and practices and determine which organizations have programs to change BCM attitudes, norms, and practices as well as the type of assistance needed. Plans will be drawn up to provide assistance to key institutions. These plans will include priorities, resources needs, and mechanisms for collaboration.

2. *Linkages* will train collaborators to adapt and use existing tools, methodologies, and protocols. These tools include *Communication for Child Survival*, *A Tool Box for Building Health Communication Capacity*, and *A Learner's Kit for Focus Group Research* (developed by HEALTHCOM); the manual on *Qualitative Research to Plan Improvements in Breastfeeding Practices* (developed by Wellstart EPB); *Designing by Dialogue: Consultative Research to Improve Young Child Feeding* (developed by the SARA Project); *Guidelines for Breastfeeding, Family Planning, and the Lactational Amenorrhea Method* (Georgetown University); and the *Manual de Lactancia Materna and Communautés en Bonne*

Santé, Vol. I-III (Nutrition Communication Project). Additional tools will be developed as necessary (see appendices for ready-to-use tools).

3. Formative research and behavioral trials will then be conducted, and if possible, across country sites during the same time period. This approach will permit joint training of researchers across several activities and it also has the advantage of beginning to establish a multi-institutional team for BCM. In this spirit, relevant government officers (e.g, from the Ministry of Health) will be invited to participate in training and formative research activities.

4. Behavior-change programs will be developed in each site using assessment, planning, pretesting, implementation, and evaluation for all activities. Materials will be developed with the assistance of a wide range of collaborators.

5. Market studies to identify opportunities for working with the private sector to disseminate BCM messages will be conducted in countries with promising private-commercial linkages. Salesforces, CBD workers, pharmacists, etc. will be trained to provide information on BCM. *Linkages* will explore the credibility of these agents as sources of information on BCM, and the messages and products they are best able to promote.

6. NGOs and commercial-sector organizations will receive assistance to establish compatible systems to monitor progress in changing behaviors, and to evaluate activities. Programs in half of the countries will have comprehensive evaluations funded by *Linkages*. The other half of projects will have more focused evaluations of one component or activity. In all of the countries we will conduct operations research to remove bottlenecks to implementation. These evaluations also provide a way for organizations to build their technical capacity.

7. Results will be disseminated to facilitate replication and establish a replication plan. Periodic working meetings will be held with partners to share experiences and determine ways to transfer experience. Midway through the project, when results are becoming available, *Linkages* will work with partners to establish a plan to transfer the experience to other sites in country and elsewhere.

Institutional and Global Level

Linkages will produce and disseminate tools that will benefit CAs, PVOs, and others institutions working in child survival, maternal health, family planning, and emergency relief programs. Examples of tools for behavior change that may be produced under the project are as follows:

- Guidelines for integrating BCM into other programs
- A module on formative research (including behavioral trials) for maternal nutrition that can be incorporated into or used with existing formative research manuals
- Guidelines on using behavior change theory to identify the ways in which programs can more effectively focus their resources and efforts in BCM
- Guidelines on strategies to enlist the support of men to improve BCM practices
- Guidelines on how to institute work site interventions to support breastfeeding, with examples of successful programs
- A manual on using the commercial sector to promote BCM behaviors
- Participatory Rural Appraisal module on empowering local women to identify nutrition problems and local solutions for them
- A package of BCM behavior change indicators, with guidelines on data sources (MIS, etc.) and frequency of data collection, etc.

Example: Linking with the commercial sector in South Africa

In South Africa, *Linkages* will use an extensive distribution network developed by PSI to reach mothers, fathers, pharmacists, and others with information and products related to BCM. The network includes wholesalers and retailers who dispense products to pharmacies and clinics and a sales force that supplies nontraditional outlets, such as bars, hotels, and market stalls.

We will bring together commercial marketers, behavioral scientists, and nutrition specialists to test new nutrition products (currently being researched by PSI) such as supplements for pregnant women and nutritious foods that are self-targeting and appealing and can be distributed by this network. Aside from products, we will place displays and other forms of information about BCM in thousands of outlets within a short period of time and test ways of joining products and messages in order to increase motivation to improve BCM practices.

PSI also collaborates with local women's organization and NGOs, including the Planned Parenthood Association (an IPPF affiliate) and the Progressive Primary Health Care Network (PPHCN), to integrate social marketing and communication activities in community-based systems. These organizations are already successful promoters of condom use. We will bring La Leche League experience to these organizations to incorporate infant feeding as well as maternal nutrition elements into the scope of their activities. These settings are ideal for teaching skills and developing self-efficacy, the confidence to perform new behaviors.

An "Avon Lady" approach is now being used by PSI to reach a target niche market of young women who may use the female condom. This personal approach may be an excellent way to reach young women to furnish guidelines for their own nutrition and to establish sound infant feeding practices. We anticipate developing materials and counseling approaches specifically geared to young women.

Collectively, these venues are an excellent means of changing knowledge, attitudes, and norms by reaching a wide range of audiences, many of whom are otherwise difficult to reach: pregnant and lactating women, fathers, pharmacists, clinic staff, traditional birth attendants, traditional healers, and community leaders.

Linkages will design, for sales purposes, innovative and attractive materials that carry information on BCM practices. The cost-recovery from the sale of these items will be applied to the Project. PSI has already done this successfully by promoting condom use. That project produced radio spots; a radio call-in show; print materials, including a booklet on reproductive health for youth; an award-winning television series; and billboards. The response to these materials was so successful that the project currently sells these communications materials to government clinics, other NGOs, and corporations, thereby generating a revenue stream that helps subsidize program operations. More than 250,000 brochures, booklets, posters, t-shirts, and videos have been distributed.

7. Illustrative Indicators

Results Package 1: IMPROVED ATTITUDES AND NORMS	
Interim Results	Illustrative Indicators
<i>Target audiences: Mothers/Fathers/Community Providers/Community Leaders</i>	
Increased exposure to information/materials about BCM	Proportion who saw/heard flyer/radio spot/counseling, etc. targeted to them Proportion who recall content of flyer/radio spot/counseling, etc. targeted to them

Results Package 1: IMPROVED ATTITUDES AND NORMS	
Improvements in behavioral determinants: knowledge, attitudes, perceived norms, self-efficacy and skills, motivation (increased perception of positive consequences; reduction in perception of negative consequences)	<p>Knowledge: Proportion who have basic knowledge about BCM behavior</p> <p>Attitudes: Proportion who have positive attitudes about BCM behavior</p> <p>Norms: Proportion who perceive that important others support BCM and related behaviors</p> <p>Norms: Proportion who believe that others are performing BCM and related behaviors.</p> <p>Skills & Self-Efficacy: Proportion who are confident they can perform BCM and related behaviors.</p> <p>Motivation: Proportion who perceive positive/negative consequences of BCM behavior.</p>
Improvements in BCM and related behaviors	Proportion who have done target behavior (the exact behavior will differ from program to program and by targeted population)
<i>Commercial Sector</i>	
Increased number of outlets for distributing nutrition products or information	<p>Proportion of mothers/fathers/providers who received information/product from a commercial outlet or sales agent</p> <p>Proportion of mothers/fathers/providers who received information/product from a community-based source</p>
Increased number of products that relate to complementary feeding	Increased sales/consumption of products that relate to complementary feeding
Increased number of products that relate to maternal nutrition	Increased sales/consumption of products that are targeted to pregnant and lactating women

RESULTS PACKAGE 2: IMPROVED POLICY ENVIRONMENT

1. Issues, Themes, and Problems

Decades of successful advocacy for breastfeeding and for the health and welfare of mothers and children have helped put policies conducive to the objectives of this project in place at many levels. The full benefits of exclusive breastfeeding to six months, appropriate complementary feeding thereafter, and adequate maternal nutrition, however, remain grossly unappreciated by community leaders, decision-makers, and politicians at every level. This situation exists in spite of recent empirical evidence strongly linking nutrition with morbidity, mortality, human development, and economic productivity. Linkages will use this new evidence, together with our growing experience and understanding of the policy process in this sector and new developments in communications technology, to involve decision-makers in a process of policy analysis and learning that will increase investment and support for nutrition in general and for *Linkages* activities in particular.

Our view of the policy-making environment encompasses not just explicit policies to promote BCM but a full range of policies (good, bad, or absent) across many sectors, such as policies on food subsidies, health services, workplace conditions, agricultural development, and women's political participation, all of which may exert a powerful influence on *Linkages'* objectives. The scope of policy reform efforts should also extend beyond policy-making to full implementation.

Decisions regarding priority policy issues will be made in consultation with the USAID Missions, country-level counterparts, and other technical experts. A number of priorities have, however, been identified:

Fully integrate breastfeeding into family planning programs. Although the promotion of breastfeeding is already an important component of most child survival activities, most family planning projects still do not actively promote LAM, thereby resulting in enormous lost opportunities to lower fertility and delay the need for more expensive contraceptive methods. Some programs may even encourage early weaning or use of formula by offering expensive hormonal methods that are (erroneously) claimed to be contraindicated during breastfeeding.

Expand and extend the baby-friendly hospital initiative (BFHI). The success of this UNICEF-led effort may be attributed to brilliant packaging – the linking of a major health problem to a simple cost-effective institutional solution with clear measurable indicators of success. The BFHI has its own momentum to which *Linkages* will contribute. The BFHI, however, also serves as a model that can be broadened to include "mother-friendliness" and extended to include other types of health service facilities (such as village clinics); non-health institutions; and even entire communities. BFHI also presents an opportunity to add LAM and improve linkages to hospital family planning programs.

Develop consensus on unresolved technical issues. Controversial issues requiring resolution to permit the formulation of policy recommendations include: appropriate practices and policies regarding breastfeeding by mothers with HIV, specific guidelines to define appropriate complementary feeding, the role of ORS for exclusively breastfed children with nondehydrating diarrhea, and appropriate strategies for the protection of maternal nutrition from the demands of reproduction.

Promote policies to improve the nutrition and reproductive health of women. It is now time to redress the balance in maternal and child health toward the health of women, for the sake of both mother and child. Relevant policies include improving the nutrition of the girl child, targeting adolescent girls in school for nutritional support, emphasizing reproductive rights, improving the quality of and access to, gynecological and obstetric services, and introducing energy-saving technologies.

Protect and promote breastfeeding, appropriate complementary feeding, and maternal nutrition in emergency and relief situations. UNHR estimates that there are approximately 23 million refugees and an additional 26 million internally displaced people in the world, three quarters of whom are women and dependent children. Crises are times of particular risk for the health of women and infants for a variety of reasons. Donor and government responses often further increase this risk by offering breast milk substitutes and failing to provide suitable ingredients for complementary foods or instructions on how to use unfamiliar ingredients.

Strengthen the links among research, policy, and training. Much research in the area of maternal and child nutrition either lacks policy relevance or takes years to influence policies and programs. Working closely with the nutrition research community, *Linkages* will suggest and promote policy-relevant research and will streamline the process for using new information in policy-making, programs, and training.

2. Lessons Learned and Policy Challenges

Lessons Learned

The following lessons learned will be used to guide the selection of policy reform strategies and activities in *Linkages*.

Information is a powerful tool for policy reform. Given a) the high priority already placed on the welfare of children and families; b) the strength of the scientific consensus on the impact of malnutrition on health, performance, and survival and the role of breastfeeding in reducing fertility; and c) the existence of simple cost-effective feasible solutions, information, and technical assistance can themselves be powerful forces for policy reform.

Institutional capacity for policy analysis should exist at the same level where decisions are made. When policy is formulated solely on the advice of outside experts

without any internal capacity for policy analysis and policy learning, the chances of actual implementation are slim. PROFILES and Wellstart experience reveal that involving either policy-makers or their technical advisers directly in policy analysis is more effective.

It is crucial to understand counterforces that restrict choices. Inappropriate (or absent) policies are due to political counterforces that restrict the policy options of decision-makers, that compete for their attention or for resources at their disposal. In such cases, "political mapping" of the policy-making environment can be used to analyze and address such constraints.

The benefits of policies should be "framed" differently for different audiences. A useful outcome of political mapping is an understanding of how to frame policy choices in ways that appeal to different stakeholders, emphasizing, for example, the many economic benefits of appropriate infant feeding practices when appealing to financial planners.

Policy "windows" open unpredictably, thereby requiring surveillance and readiness to act. A recent review by the SARA Project concluded that successful policy reform requires the convergence of three activities: defining problems, creating solutions, and forging political consensus. Sometimes this convergence can be engineered with a deliberate policy reform strategy, and it is important that advocates be prepared with policies and implementation plans.

Policy reform is a long-term, incremental activity. Although policy "events" may occur suddenly and may appear to be the result of a short spurt of intense advocacy, most sustainable policy reform comes after long years of policy learning and dialogue. Intense, short-term advocacy may be needed to forge this policy learning into a policy but cannot substitute for the effort needed to reach this point of readiness.

Policies must be linked directly with programs and resources. It is important to ensure that policies include an implementation plan and adequate funding.

Policy Challenges and Advantages

Linkages must address some unique policy challenges:

- The ultimate beneficiaries of the policies promoted (women and children) have little or no political power.
- However serious and deadly, maternal and child malnutrition are hidden problems that do not cry for decision-makers' attention.
- The hidden nature of malnutrition makes improvement difficult to measure. Appropriate monitoring methods are, therefore, required to provide the feedback needed to reinforce and perpetuate policy reform.
- Even many health workers consider breastfeeding to be "universally the norm" when, in truth, practices deviate far from the ideal.
- In many countries, the infant formula industry is still a resourceful opponent of the promotion of exclusive breastfeeding.

BCM policy reform also benefits from some important advantages:

- Most interested groups, from parents to politicians, care deeply about the health and welfare of children.
- There is broad scientific consensus and solid epidemiological evidence that the human and economic benefits of appropriate infant feeding and adequate maternal nutrition are enormous.
- Feasible solutions exist that can be shown to pay for themselves many times over.
- Many important policy advances in recent years provide momentum and models for future efforts (e.g., The Innocenti Declaration, The World Summit for Children, The International Code on the Marketing of Breast Milk Substitutes, and the BFHI).
- An extensive network of institutional support for reform exists (e.g., Wellstart, LLLI, UNICEF).

3. Key Strategies

Key strategies are outlined below.

Contribute to global advocacy efforts. Using expertise of both its core staff and advisers, and through knowledge of policy gaps gained from project implementation,

Linkages staff will be well-placed to contribute to global advocacy, from problem definition through devising appropriate policies to providing resources and opportunities for implementation. Drs. Audrey Naylor (Wellstart) and Sandra Huffman are internationally renowned policy experts who will represent and advise the project in these fora.

Situation analysis and planning. Techniques for rapid political mapping of the policy environment will be developed, adapting analytical tools from the Data for Decision-Making Project (Harvard) and the Education Reform Support Project (AED). Appropriate policy strategies will be devised that take account of the particular goals of policy reform; the influence and interests of different stakeholders; the capacity and resources for implementation; other competing, enabling, or enhancing policies on the political agenda; and the timing needed for strategic efforts to either galvanize opinion or evoke action. This plan will be flexible and will be re-evaluated and reformulated regularly. To ensure sustainability, attention will be paid to developing an institutional capacity to carry out independent policy analysis, planning, and advocacy.

Provide information for decision-makers. *Linkages* will maintain the flow of relevant information to principal decision-makers and to their technical aides. A variety of analytical tools and communications methods will be used, including the PROFILES computer model, developed by AED under NCP.

Framing the benefits for different audiences. *Linkages* will develop information dissemination and advocacy material strategically tailored for different audiences.

Emphasize economic benefits and cost-effectiveness. *Linkages* will conduct and compile information on the costs and benefits of different interventions and will use this information to create advocacy material that is strategically tailored for different audiences.

Policy surveillance and readiness. *Linkages* will monitor the policy environment at different levels (global, institutional, country) to identify opportunities to bring problems and feasible solutions to the attention of stakeholders.

Support local champions. In its country-level work, *Linkages* will identify local individuals and groups who can act as watchdogs (for policy surveillance) and as champions (to open and take advantage of windows of opportunity) and will support them with information, training, and technical assistance, as necessary. Advocacy training materials developed by the SARA Project will be used for this purpose.

Build coalitions and alliances. Although single champions can lead policy efforts, support for reforms typically requires a broader base. This project will, therefore, develop wider strategic support for the proposed reforms by involving all potential stakeholders in policy reform efforts.

4. *Expected Results*

Year 2001:

- Increased political and financial support for the promotion of breastfeeding, LAM, complementary feeding, and maternal nutrition at every level
- Institutional change so that health facilities, other relevant institutions, communities and governments at all levels are more supportive of positive BCM practices
- International consensus on definitions of appropriate breastfeeding, complementary feeding, and maternal dietary practices.

Year 2006:

- Global recognition of the value and importance of BCM practices for improving the health, performance and survival of women and children;
- "Broad institutionalization" of BCM policies and practices in project countries.

5. *Activities*

Country

At the country level, *Linkages* will focus on developing an institutional capacity to analyze BCM policy and to pursue appropriate policy initiatives. The first step, to be undertaken during the first few months of the project, will be the development of a tool kit to analyze country-level BCM policies and practices and to identify policy gaps and reform needs. A breastfeeding and LAM section will be adapted from *Guide for Country Assessment of Breastfeeding Practices and Promotion*, and *Guidelines: Breastfeeding, Family Planning and the Lactational Amenorrhea Method*; a child feeding section from *Designing by Dialogue*; guide for assessment of child feeding; and a maternal nutrition section from the *MotherCare*, *OMNI*, and *BASICS* country assessment guidelines. A final section will be designed to engage policy-makers, the technical nutrition community, and other stakeholders in the process of policy analysis and reform. It will illustrate how to use the policy data collected in previous sections to assign priority to policy issues and to develop action plans.

During the first year of the project, the following activities will be undertaken in five joint programming countries, selected according to the procedures outlined at the beginning of the technical section. Starting with our partner organizations and collaborating agencies within the country, *Linkages* will expand this work to include government agencies, NGOs, and international organizations, depending on the priority policy issues identified.

Specific Activities:

- 1) **Conduct rapid assessments:** One member of each assessment team will be responsible for collecting the information needed for the policy sections of the policy assessment tool kit.
- 2) **Develop a policy reform strategy:** Using the policy analysis tool kit, a policy reform strategy will be formulated, with *Linkages* providing technical assistance and facilitating among local partners (government technical agencies, donors, local and international NGOs and *Linkages* partners).
- 3) **Convene policy workshops:** Workshops to identify policy needs and constraints will be held to engage decision-makers and "local champions" in action-oriented policy analysis, to formulate policies and to devise strategic plans for policy reform.
- 4) **Support policy actions:** Funding mechanisms and technical assistance will be used to: forge new coalitions by emphasizing mutual benefits for different stakeholders and providing opportunities for networking and joint action; identify and support local champions with credibility and commitment; and identify and publicize the needs of specific disadvantaged populations that may be underserved relative to needs.
- 5) **Support policy-related research:** When research is needed to influence policy-makers, in-country research will be supported by *Linkages*, and results will be fed into relevant policy reform efforts (using tools such as *PROFILES*). Cost studies of selected interventions are particularly relevant as they provide a credible basis for promotion of cost-effective activities.
- 6) **Disseminate data on policy issues:** Information on BCM will be compiled, produced in a usable format and disseminated to audiences that influence policy. Electronic communications and desktop publishing will be used to respond rapidly to specific information needs. Existing databases, such as *DHS* and *ChildInfo* (for India and Nepal), will be used for this purpose.
- 7) **Monitor effects of policy activities:** Using the policy-related indicators (discussed later), *Linkages* will monitor the impact of these activities.

Institutional Level

Linkages will work at headquarters and regional levels, starting with our partner NGOs and collaborating agencies, then extending to other international institutions to review institutional policies and promote desirable reforms.

Specific Activities (in each institution):

- 1) Convene a planning meeting with partner PVOs and USAID collaborating agencies . headquarters and regional offices to identify all relevant institutional policies . should be scrutinized.
- 2) Convene a working group comprised of institutional decision-makers and technical experts to propose reforms and examine their technical, financial, and institutional implications.
- 4) Conduct actions needed to change and implement policies with technical guidance provided by *Linkages* policy staff and consultants, including technical assistance to regional training and research institutes, regional meetings, regional training activities, and by providing help in accessing electronic networks.
- 5) Monitor effects of revised policies.

Example: Use of ORS to Treat Diarrhea During Exclusive Breastfeeding

Staff at BASICS have raised the issue of the WHO policy promoting ORS among exclusively breastfed infants and the concern that it has negatively affected breastfeeding practices within the health program in Pakistan. Women who previously were exclusively breastfeeding were instructed by health personnel to provide ORS to infants brought to the health center with nondehydrating diarrhea. To address this policy concern, the following activities are proposed:

- 1) *Linkages* will hold a planning meeting with BASICS to discuss BCM-related policies and raise this issue as a possible policy to be addressed.
- 2) A working group will be set up, including relevant BASICS and *Linkages* staff, and appropriate "local champions".
- 3) *Linkages* will support a study in Pakistan through BASICS to assess a) the prevalence of dehydrating diarrhea and other diarrhea among exclusively breastfed infants < 6 months of age; b) the impact of the current policy on breastfeeding practices; and c) the constraints that Pakistani health professionals in health centers and BASICS staff would face in changing the policy.
- 4) A revised policy will be developed and approved by BASICS.
- 5) This policy will be disseminated both in Pakistan and at BASICS headquarters, and to international agencies, CAs and other health program staff. BASICS or *Linkages* will provide technical assistance on its implementation in Pakistan.
- 6) BASICS and Pakistani staff involved will work with WHO, international agencies, and other CAs to revise similar policies in other countries. One goal of this step would be a clear policy statement from WHO on this issue.
- 7) BASICS and *Linkages* will collaborate on evaluation of the impact of the new policy on breastfeeding rates and on hospital admissions for severe diarrhea.

Global/Regional Level

At the global and regional levels, *Linkages* will work with relevant UN agencies, multilateral banks, international organizations, bilateral donors, and universities to:

- Integrate BCM objectives into global policies in other sectors.
- Forge alliances among international organizations, bilateral donors, multilateral agencies and other stakeholders.
- Help develop and update consensus on the definition of appropriate BCM policies and practices.
- Stimulate research that is relevant to BCM policy.
- Streamline the application of new knowledge in policies, programs and training.

Specific Activities:

- 1) Convene meetings of technical experts and implementing agencies to identify global policy needs.
- 2) Set up an electronic Internet site for policy-relevant information. This site will link with relevant data housed at other sites and will include:
 - Texts of global and national policy statements,
 - Policy-relevant research findings in the form of short abstracts,
 - Updates on *Linkages'* own policy reform efforts and priorities.
- 3) Participate in international conferences. In all relevant multilateral fora, *Linkages* will contribute technical guidance on policy issues. Upcoming events include: the World Food Summit (November, 1996), the WABA Global Forum (December, 1996), the International Congress of Nutrition (July, 1997), UNICEF annual meetings for NGOs and WHO/PAHO technical meetings.
- 4) Disseminate policy tools. The policy tools developed through *Linkages* such as new PROFILES models and the policy analysis tool kit will be disseminated to international and regional organizations, together with technical assistance on their use, as required.

Example: International Policy Forum on Maternal Malnutrition

A priority area of policy reform is maternal malnutrition, for which proven cost-effective intervention strategies are lacking. Exhortations to "improve dietary practices" provide little useful guidance for programs and ignore fundamental constraints faced by women living in poverty. Solutions will require careful consideration of these constraints, the underlying causes of maternal malnutrition, and programmatic experience to date.

Linkages will prepare for an expert meeting on maternal malnutrition by commissioning or conducting reviews on selected policy-relevant topics to be presented at a forum

held in Asia in 1997. This forum will bring together researchers, decision-makers, and implementing agencies to define the research, policy, and program agenda for the next five years. Other multilateral and bilateral donors will be asked to contribute both technical and financial support for this forum. The expected results of this meeting will be as follows:

- 1) Agreement on
 - cost-effective programs requiring further commitment of resources
 - program solutions that require further testing
 - policies needed to improve maternal nutrition
 - research needed to formulate policies and design programs.
- 2) An international network of scholars, policy-makers, and program professionals committed to the improvement of maternal nutrition
- 3) Mobilization of resources needed for appropriate levels of investment in maternal nutrition, through the direct effects on participating donors and by initiating a global policy reform process that will mobilize further resources.

6. Interim Results and Illustrative Indicators

Policy change is a long and incremental process involving many steps in building a consensus and working toward a relevant policy and its implementation. Performance indicators should be designed to measure these gradual steps. Indicators that focus solely on the ultimate policy decision event ignore much important "policy learning" that goes on along the way. Further, although the signing of a declaration or the passing of legislation may be a significant step toward improved policies, the true test and, therefore, the best indicator of results is in the implementation. Indicators should, therefore, measure progress from the initial assessment of the policy environment through to implementation and impact of the proposed policy. For each country, for each level of decision-making and for each issue the indicators must be specified as part of the initial policy assessment, since they will be highly specific to the policy reform strategy emerging from this analysis. Unlike indicators of other results packages, for which objective, quantified, standardized indicators can be specified, those presented here are therefore general, qualitative, and illustrative.

Results Package 2: IMPROVED POLICY ENVIRONMENT	
Interim Results	Illustrative Indicators
<i>Community Level</i>	
Support for exclusive breastfeeding, mother and baby friendly workplaces, women's participation in decision-making	<p>Increased community support of BCM: e.g., provision of communal site-based infant care for mothers working in the community, endorsement of a mothers' support group</p> <p>Increased community resource allocation for support of BCM (e.g., payment in kind for a community volunteer counselor)</p> <p>Percent women members of community decision-making bodies (e.g., health committee or village co-op board)</p>
<i>Facility Level</i>	
Mother-Baby friendly policy implemented by health care facilities (village health post to urban hospital)	Percent of mothers in each institution who confirm MBF criteria (to be developed along the lines of BFHI "Ten Steps")
Clinics' policies to include providers discussing LAM	Percent of postpartum mothers informed about LAM
CDD policies revised to promote feeding	Percent of children with diarrhea receiving foods while admitted to CDD unit
Family planning services offered on same days as child health services	Percent of mothers < 36 months postpartum using family planning
<i>National Level</i>	
Investment in BF promotion, legislation against substitutes, mother-baby friendly policies in all sectors	<p>Resources spent on promotion of BF</p> <p>Passage and enforcement of appropriate legislation</p> <p>Percent of facilities that meet MBF criteria</p> <p>Percent of facilities that meet BFHI criteria on the basis of exit interviews with clients</p> <p>Percent of official policies (in all sectors) revised to address BCM issues</p>
Educational curricula with consistent BCM (from early education to preservice training)	Percent of medical, nursing and nutrition schools with appropriate curricula
Legislation for girls education	Percent of adolescent girls attending school
Women's participation in decision-making	Measurable increases in women's political participation
<i>Institutional Level</i>	

Results Package 2: IMPROVED POLICY ENVIRONMENT	
Among PVOs, CAs, regional organizations (research institutes, training institutes and universities): policies and plans conducive to project outcomes	Policies with specific provisions for training, research, and information dissemination activities to improve BCM.
<i>Global Level</i>	
International organizations, international fora, multilateral banks, etc. have policies that promote BCM	Number of specific policy instruments or implementation plans that are conducive to BCM objectives Percent observance of international code (industry producers and countries)

RESULTS PACKAGE 3: IMPROVED ACCESS, AVAILABILITY, AND QUALITY OF SUPPORT SERVICES

1. Issues and Challenges

Over the past decade, considerable progress has been made in strengthening hospitals to promote initiation of breastfeeding and teach mothers the necessary techniques. The challenge is now to provide a continuum of services so that nutrition information and support reach the mother throughout the cycle of pregnancy, lactation, perinatal care, breastfeeding, and return to fertility. This means moving beyond the institution to ensure that optimal practices are supported in the home and the community.

The challenges are great. Counseling and other support services for maternal and child nutrition generally are either weak or nonexistent in government health systems. PVO programs typically do not have technical capacity to implement state-of-the-art behavior-change approaches. Health care workers, charged with providing information often are themselves poorly informed regarding the practical and culturally appropriate behaviors to promote; lack quality teaching aides; and are handicapped by having little time in which to interact with mothers. Facility-based services are typically organized vertically thereby resulting in many missed opportunities to provide BCM support. Few countries have systems in place to reach into the communities and undertake activities to change nutritional behaviors.

2. Lessons Learned

Lessons learned internationally and domestically have revealed the following about access and quality of services:

- Important gains in access to health services can be made by developing a more "consumer-oriented" health services system that tries to ensure that desired services are available when the consumer wants and needs them rather than when the professionals want to provide them.
- Major gains in access can be made by establishing additional nonhealth community networks for support services.
- Access to services and support systems is necessary but insufficient; improved quality is critical.
- An important yet weak element in quality of services is the health provider-client interaction. This presents an opportunity for collaboration with MAQ (Maximising Access and Quality Initiative).
- The best measure of quality is customer satisfaction; the second best measures of quality are outcome-based indicators; measures that look at the "process of care" are the least desirable measure of quality.
- Quality measurement requires adequate information systems.

Linkages will address all of the foregoing issues but will particularly emphasize the community and the client-provider relationship because that is where our knowledge is weakest.

3. Strategies and Activities

Improving Access and Availability

Develop a more consumer-oriented health system: *Linkages* will emphasize improving the access of women to BCM services. It will develop and test new health services models that modify days and hours of operation, minutes of time per patient, and offer consumer-friendly facility environments. In addition, *Linkages* will test the extension of BCM elements into community-based health services such as traditional midwives, CBD, and other community-based health providers. These improvements will be based on qualitative research and "customers" will be segmented by gender, age, and location of their homes.

Expand nonhealth community-based networks: *Linkages* will expand information concerning BCM elements by doing cost-management studies of successful nonhealth support networks, such as religious, social, commercial, women's, and other development organizations. For example, in Brazil, a church-affiliated lay movement integrates breastfeeding support into its family home visiting program. In Venezuela, mothers' groups include breastfeeding messages in their group meetings. A chain of department stores in Guatemala offers classes on breastfeeding to interested employees. *Linkages* will bring together principal players to exchange experiences and to select the most promising approaches for discussion with the PVOs.

Adapt proven community-based models for new situations and developing new models, where needed. There is considerable experience to build on, both from PVO child survival projects, LLLI efforts, and public-sector experiments in using outreach mechanisms. A need still exists, however, to develop models that work well in rural societies in Africa where women need support in order to prepare adequate complementary foods. Strategies also need to be developed that meet the needs of women in low-income peri-urban areas who spend a great deal of time away from their children. The challenge will be to develop approaches that are cost-effective to start up and maintain.

Expand the scope of the Baby-Friendly Hospital Initiative (BFHI) to the community level: To test program models with varying degrees of ties to the formal health structure, *Linkages* will coordinate with UNICEF and WHO country offices, national BFHI authorities, and other groups involved in the Initiative at the country level. This effort will focus on BFHI's continuing work to convert and sustain baby friendly maternity services emphasizing Step 10 (community linkages) leading to new efforts to expand the scope of the Initiative. Many countries have already experimented with strategies that include an emphasis on both the baby and the mother and encourage mother-baby friendliness at the community level in various ways.

A primary strategy for ensuring an appropriate project contribution at the country level will be to include a BFHI component in country planning activities. Project staff and consultants will work with national BFHI authorities and responsible UNICEF and WHO personnel to determine how the project can best help to reinforce the continuing work of the Initiative as well as support new strategies for application and expansion of the successful aspects of the BFHI approach. As the resources available through the project expand, additional funds will be programmed to implement and expand innovative community-based mother-baby friendly strategies.

Improving Quality of Services

Improve customer satisfaction: *Linkages* will test models to improve customer satisfaction through initial qualitative research and use of participatory methods to pinpoint problems and identify solutions. Programs will then be implemented and tested - all linked by careful, periodic monitoring of customer satisfaction through adaptation of the plethora of customer satisfaction surveys currently available. (see Appendix: Observation and Quality Assurance Tools) Likely findings of this research include the access measures mentioned above and the quality of the provider-client interactions.

Improve client-health provider interactions: AED has considerable experience in improving interpersonal communications through the Nutrition Communication Project (NCP) and through our contributions to the Quality Assurance Project operated by URC and the redesign of the Texas WIC program. *Linkages* will use focus groups and other qualitative methods to determine the key issues and participatory training approaches to both

sensitize providers and provide them practical experiences in improved interpersonal communication and the ways in which to communicate information to clients effectively.

Improve outcome-based indicators for BCM services: *Linkages* will develop and test both health services-related indicators and nonhealth community-based network indicators for outcomes of BCM interventions. These indicators will emphasize individual behavior change and changes in social norms and attitudes in a variety of settings. *Linkages* will provide guidance to local partners on BCM outcome indicators and assist these partners in measuring, analyzing, reporting, and disseminating these findings. Most importantly, *Linkages* will monitor how these indicators are used for program modifications.

Improve information systems for monitoring and evaluating BCM changes: *Linkages* will assist local partners and CAs in developing these systems which are themselves crucial elements of program management to improve BCM services - in both the health system and the nonhealth community networks. Our monitoring and evaluation specialist will lead this effort, with strong support from MIS designers and financial analysts. Both URC and MACRO are prepared to assist *Linkages* in these efforts.

4. Activities

Country level activities

The assessment and planning process proposed by *Linkages* has been described earlier. The result of the country planning should be about 2-4 "sites" in each of 10 of the joint programming countries.

Linkages expects that most sites will test multiple strategies at the same time. For example, improving the health system and expanding the nonhealth community-based networks and expanding the Baby Friendly Hospital Initiative and improving quality. The role of *Linkages* is to assist local partners in the design of these programs, in establishing the monitoring and evaluation systems (including quality), in training of managers and technical staff, and, where research is included, to give particular attention to research design and measurement issues. The list below highlights some typical *Linkages* activities in a country site.

Assist local partners to:

- Design and implement qualitative research on patient flow processes to help develop a more consumer-oriented health system for BCM services;
- Train volunteers and primary care level workers in community support;
- Develop a strategy for reaching pregnant/breastfeeding women, and those with young children (e.g., through home visits and support groups);
- Use a participatory process to identify a suitable existing group to take on nonhealth community-based networks for BCM (when existing networks are to be used);
- Develop integrated service and support models, including BFHI, that have been proven to work in other countries/regions;
- Develop and implement customer satisfaction survey;
- Use participatory training approaches to improve provider-client interaction;
- Develop outcome-based indicators for monitoring quality;
- Develop information systems to measure quality in both health and nonhealth community-based systems;
- Develop or adapt educational materials from the many excellent products already developed by the members of the *Linkages* team;
- Improve community organizations through staff training following the EPB manual *Community-based Breastfeeding Counseling and Support: a Program Planner's Manual*, the Population Council's Individualized Diagnostic and Re-Training Instrument model, NCP's *Learning to Listen to Mothers* model, and EPB's *Community-based Breastfeeding Counseling and Support: Guide for Trainers and Supervisors*.

Linkages Special Emphasis Areas

Linkages will give special emphasis to:

Strengthening Nonhealth Community-based Networks to Promote LAM and Improve Infant Feeding: For example, in West Africa, a project has been suggested to train teachers to provide BCM counseling during the "hungry season" (also the peak malaria season) that coincides with the annual school break. Within *Linkages*, a priority will be conducting and evaluating approaches with varying degrees of ties to a formal facility.

To support these country activities, staff will assemble kits for country-level collaborators containing Lessons Learned on community networks, sample supervision and monitoring tools, etc. They will be added to as new material becomes available and shared through *Linkages'* Information Dissemination mechanisms. An example of this is shown in below.

Community Support Groups for Peri-Urban Areas

It is essential to gain experience in working with both the mother and the community in low income, urban communities. Obtaining solid evaluation and cost data is also of high priority. The proposed site Ata-Vitarte District in metropolitan Lima includes 50,000 women of reproductive age is served by 16 health centers/posts, and counts numerous community kitchens (Comedores Populares). It is estimated that no more than 17 percent of babies 0-4 are exclusively breastfed; the prevalence of diarrhea is high.

LLLI, in collaboration with the Centro de Promocion y Estudios en Nutricion (CEPREN), which was one of Nurture's field offices, and a local NGO, Nueva Era, will build on the experience of the "Community Kitchen" to establish a community plan of action to promote, protect, and support optimal BCM practices, including a strong and active MTMS component. LLLI leaders from the successful Mexican and Guatemalan programs will serve as consultants to transfer lessons from their experiences. *Linkages* will provide existing community level IEC materials from the region and assist in the design of the evaluation/cost study.

Improving Counseling Skills: Improving service providers' knowledge does not automatically translate into more informed clients. Training in communication is essential to improving skills in interacting with mothers, providing motivation, and a heightened understanding of how to conduct behavior change activities within the framework of different jobs. Core funding will be used to develop and test modules and help conduct TOT sessions for PHN organizations. Funding of training costs for a broader public sector audience would need to come from other sources. Many excellent training guides, manuals and videos have been developed under previous USAID-funded projects, which *Linkages* will help channel (e.g., *Learning to Listen to Mothers*, *Unlocking Healthworker Potential*) (see Appendix: Ready to Use Tools).

Inviting and attractive educational materials have been shown to improve quality of services, satisfaction, and knowledge gains of clients. *Linkages* will assemble sample materials for use by CAs and PVOs and national Information Dissemination Centers and will share new materials developed in country programs. When indicated, new materials will be developed for use in the "Jump-Start" country activities. Broader printing would require Mission field support funds.

Improving Quality through Better Supervision: There is strong evidence showing that good quality supervision can make a difference in service quality. Under NCP, QAP and HEALTHCOM, AED developed a series of methodologies and protocols for supervision. These include observation check lists, self-evaluations, peer and paired supervisor-provider evaluations. These will be adapted for BCM.

Improving Quality through Information Dissemination: *Linkages* will make information available to communities, service providers, management, and political authorities.

Draw on Pool of Local Expertise Built up over Past Decade: Preference will be given to use of local experts in all technical support to in-country activities. They will be involved in the assessment and subsequent phases and will assist with training (see below). In addition to resources from the Regional Centers, the Project will draw on several networks of expertise including the nearly 600 Wellstart Associates; key members of LLLI's network who bring experience with support groups and policy change; and IBFAN's Africa Network which can also be utilized in policy matters. Teaming these individuals with seasoned consultants will be used as an approach to building confidence and capacity.

Strengthen National and Regional Expertise in BCM: Long-term sustainability will be achieved by strengthening in-country expertise (through professional schools and research and training centers) and through regional training centers and resources with expertise in the content areas of BCM and LAM. In addition, the support of local national centers in key joint programming countries will be focused where they do not

exist, as they can play a critical role in providing a sustained source of in-country expertise in BCM. Enhanced local expertise can result in:

- Technical assistance and faculty development in support of initiatives to strengthen pre-service medical, nursing, nutrition, and public health school curricula in BCM as a part of an integrated strategy of reform for Integrated Management of Childhood Illnesses (IMCI).
- Orientation and training for NGOs, PVOs, and other community groups that will be involved in providing outreach, counseling and support for BCM and LAM at the community level.
- Training for "master trainers" who will reach service providers involved in a wide range of MCH and reproductive health interventions (perinatal care, CDD, ARI, immunization, family planning, etc.) to integrate appropriate BCM and LAM components into their work.
- Technical support to national BCM programs, NGO collaborators, and others in areas such as policy development, IEC, operations research, and development of appropriate supervisory and quality assurance strategies.
- Assistance in materials review and adaptation as well as development and testing of new materials as necessary.

This "investment" in institutionalizing capabilities at the national and regional levels is essential to the development of cost-effective, needs based, support systems for optimal feeding and maternal nutrition, involving both the community and health provider levels.

Strengthen selected national and regional training centers and cadre of health professionals that have been supported by Wellstart and the IRH: The regional training centers, and by extension the Wellstart Associates that are affiliated with these centers, offer another channel for support for BCM activities. The regional and national centers differ in size, scope, institutional affiliation, and "maturity". Some centers exist within well established institutions (i.e., Kenyatta Hospital in Nairobi, Catholic University in Santiago) while others are not formally connected to a hospital or medical center (Mexico, Bolivia). The regional and national centers described in the proposal are truly independent and not "owned" by either Wellstart or AED. They function autonomously and there is no "recipe" for what the centers should look like. At present, with assistance from Wellstart, these centers are in the process of developing organizational plans, with projections of activities and strategies for fundraising. Some are already partly self-sustaining. Proposed support from the Linkages Project to aid in the sustainability of the centers will vary, but may include technical assistance in the development of their own action plans, assistance in the integration of BCM training into related primary health care areas, such as training in child survival (ARI, CDD), or technical assistance to enable the centers to broaden the types of training offered. This technical assistance will be directed at strengthening the internal capabilities of the centers, and improving the "marketability" of the training and other services they offer. The Linkages Project may also assist in the development of affiliations between the centers and PVOs or NGOs with a community focus.

Role of the regional and national training centers and plans for sustaining them: The centers are set up with inter-disciplinary teams with a physician, nurse and nutritionist. In all of the centers, a main focus will be expansion beyond health-facility based breastfeeding support activities and training, to community-based activities, acknowledging that while policies and practices in health facilities affect breastfeeding, in many places only a minority of women deliver in hospitals instead they take their cues with respect to breastfeeding decisions from the communities in which they live. The scopes of work for the regional centers differ widely, depending on the priorities and needs in the country or region, although there are some common elements. The scope of work will focus primarily on training "master trainers" at the PHC level and community level. The Linkages project may assist with adaptation and use of curricula, planning manuals, and other materials already developed by the EPB Project and others, for use of the community level. Where feasible we also plan to incorporate training in quality assurance methods for supervision; and introduce relevant management and behavior change components.

Economic viability is clearly an issue for many of the centers. We would seek to assist those centers with the greatest promise of becoming self-sufficient. While the project cannot maintain the centers, we could provide limited assistance in institutional planning and orientation about how to seek funding.

It is assumed that Wellstart International, through these regional and national centers and the network of trained Wellstart Associates, will have an essential but tightly focused role in the provision of facility-based and community level training. For example, where preservice training of health professionals is a priority, Wellstart may provide technical assistance in the design and implementation of breastfeeding into a preservice curriculum. This may include assistance with materials development or review for quality assurance. Wellstart Associates, known for their expertise in breastfeeding, usually come from pediatric or obstetric specialities and therefore offer a good source of expertise in infant feeding and maternal nutrition and health issues. They represent a source of training and/or technical expertise in these areas over and above breastfeeding. Because they are highly placed within key institutions in their countries, they also represent a resource for policy initiatives and advocacy work. AED might provide support for certain elements such as counseling and supervisory skills.

Continue efforts to improve Pre-Service Education programs as part of a long term strategy for cost-effective interventions: Efforts to improve the provision of health services have focused almost exclusively on "in-service" training whereby providers in practice are provided with basic, often remedial, education in order to compensate for inadequacies in their preservice training. Because of the limited opportunity for hands-on practice, continuing education courses typically result in a rapid decay of new knowledge and skills. Substantial professional time and health resources are tied up each year in training and refresher courses. The *Linkages* project therefore will emphasize a more sustainable and far reaching approach by providing technical assistance and faculty development to strengthen BCM in pre-service health professional curricula.

Linkages will build upon the experiences of Wellstart International and the IRH in this area. A prototype series of activities for integrating BCM into preservice health professional curricula has been implemented based on plans developed by universities in East Africa.

These steps include (see Appendix Wellstart Consultant Network for a more detailed outline): regional or multi-university workshops to sensitize key faculty and administrators to the need, benefit, and process of strengthening preservice curricula with regard to BCM; university-wide workshops involving faculty from all relevant departments to design department level plans for the integration of the material; approval of the curriculum and action plans by university and MOH authorities; faculty development in the form of training; materials development and selection; preparation of course/lesson plans by individual faculty and actual integration of the material into teaching activities and monitoring and evaluation. During the first year of the project, we will assist the University of Nairobi, which has already advanced in this process, with faculty development. *Linkages* will provide technical assistance to assist the university design education activities in upgrading faculty knowledge and skills; financial and technical assistance will be provided for a training workshop; and to assist faculty as they develop their course plans. The preservice initiative will also be expanded to the Asia region during the first year of this project in the form of a multi-university workshop in the Philippines.

In the second year of the project, we will continue to assist with the monitoring and evaluation of activities at University of Nairobi; assist Muhimbili University (Tanzania) with the faculty development phase; and assist with a university-wide workshop at the University of the Philippines.

Institutional Capacity Building Activities

Improving Curricula: The box below gives an example of how this might be done.

JHU/PCS. Work at PCS headquarters (through AED) to integrate BCM content into the training courses offered to IEC managers of family planning programs. Additionally, *Linkages* can assist in developing modules to be incorporated into TOT and in-service courses on counseling for FP clinic and outreach workers. In Bangladesh, for example, where PCS is updating the counseling curriculum and IEC materials, *Linkages* might focus on a LAM module and identify ways to add LAM messages to the new materials. Similarly, technical input could be provided to integrate BCM themes into the weekly radio program

aimed at FP-MCH workers. The cost of new programing would also be funded (but not air time).

Holding Workshops: All too often, "one-shot" training has only limited impact because no follow-up is provided to help attendees implement what they have learned. A major emphasis of *Linkages* will be to hold workshops complemented by follow-up technical assistance as part of the training package. The box below gives an example of this.

Train PVOs on Breastfeeding and LAM in Refugee Settings

Many of the policies and programs established in refugee camps undermine traditional breastfeeding practices and contribute to increased fertility. The misperception that displaced and malnourished women are unable to adequately breastfeed their children is frequently encountered in these settings.

One way we will address this problem is to Collaborate with InterAction, the umbrella organization for PVOs, to develop training courses for Complex Emergencies. These courses are currently being designed, with funding from the Office of Foreign Disaster Assistance, as part of the State Department's new policy of certifying PVOs. Development of curricula dealing with health topics as well as educational techniques are in progress. Support could come from *Linkages* to develop the BCM components. *Linkages* will support a series of training seminars for all the major PVOs that provide health services and food to refugee camps. We will inform them about appropriate breastfeeding, LAM, and complementary feeding issues in these settings, provide training materials that they can use to orient their staff in the field, and identify policies and structures within their programs which need to be modified.

Assisting with formative research for nutrition counseling and communications: Technical assistance is not only needed on the technical contents of programs but also on the other program components such as counseling and supervision. The box below shows how we would develop support in West Africa.

Collaboration with BASICS in West Africa. BASICS provides assistance to a large number of bilateral programs in West Africa and recently assumed responsibility for implementing the child survival components of the Family Health and AIDS Prevention West Africa regional project. Nutrition is a key component of the BASICS child survival portfolio, and the BASICS regional nutrition advisor (Serigne Diene) is responsible for both bilateral and regional support in nutrition.

Linkages will support the BASICS West Africa regional program and its nutrition advisor in several ways. We will provide technical assistance for the breastfeeding components of the existing and new bilateral programs in Senegal, Mali, Niger, Benin, and Guinea, as suggested in the BASICS Work Plan.

KEY ILLUSTRATIVE INDICATORS

Result 3: IMPROVED ACCESS, AVAILABILITY AND QUALITY OF SUPPORT SERVICES IN THE COMMUNITY	
Interim Results	Illustrative Indicators
<i>Community Counseling Networks</i>	
Increased number of counseling networks	Percent of communities with an active community counselor (or supervisor) Percent of pregnant women and mothers of children less than 24 months receiving nutrition education, counseling, home visit
Improved counseling and promotion skills	Percent of breastfeeding women using appropriate family planning methods at month 7 Percent of women taking the pill who are on the progestin-only pill
Improved quality assurance and supervision systems within community networks	Use of supervisory and monitoring tools at project sites Number of sites using the project's key indicators for program monitoring and evaluation
Increased access of NGOs, community groups to program information and research results	Project and other resources adapted and used by NGO partners
<i>Training</i>	
Improved knowledge of providers to support clients in facilities (public and private sectors)	Percent of providers trained through <i>Linkages</i> activities associated with the project who know appropriate BCM-related knowledge for problem solving
Improved counseling and promotion skills	Percent of breastfeeding women receiving appropriate BCM-related information Percent of clients satisfied with counseling
Improved preservice and inservice training curricula	Improvement in BCM knowledge of graduates
Improved systems within facilities	Percent of facilities receiving assistance through the project that use supervisory and monitoring tools (protocols, service checklists, quality assurance procedures, etc.)
Increased access of managers to program information and research results	Number of project and related resources adapted and used
Increased training opportunities outside of traditional classroom instruction	Increased number of alternative work site training activities

Result 3: IMPROVED ACCESS, AVAILABILITY AND QUALITY OF SUPPORT SERVICES IN THE COMMUNITY	
Improved preservice and inservice curricula	Number of preservice curricula improved
<i>Information Dissemination</i>	
Improved access to program information and research results	Project partners and collaborators disseminate materials and lessons learned to field offices outside of the project's program countries Satisfaction of partners and collaborators with access, quality, usefulness, and timeliness of materials distributed
<i>Overall Integration</i>	
Increased integration of BCM by CAs and national organizations into their programs	Project activities serve as a model for new activities initiated in other areas by the project partners and other organizations Number of projects with evidence of integration of BCM changes in protocols, delivery systems, educational materials, training modules, etc.
<i>Regional Centers of Excellence</i>	
Increased number of national training resource centers for BCM	Upward trend in request for services from center
Improved skill and knowledge faculty (as measured by written exams/observations)	Amount and adequacy of content incorporated into classes/rotations

D. CROSS-CUTTING ISSUES

1. Training

Training will be a primary vehicle for extending BCM activities to new communities and institutions. Our approach to the project will be to give continual attention to transferring and building skills at each level. Workshops and in-service training programs will be results-oriented and will be assessed in terms of how they increase the quality and intensity of field activities rather than in terms of measuring knowledge gained. Linkages believes that this shift in orientation will enhance program impact and sustainability and will promote a rapid transfer of responsibility for all training activities to national teams.

Special emphasis will be placed on improving the quality of face-to-face communication between the health worker, midwife or community leader, and mothers and fathers through a fourfold approach:

- Emphasize short, specific, skill-based training grounded in the principles of adult learning and experiential education. Activities will focus on communicating useful information at appropriate moments using techniques such as modeling, role-playing, and true-to-life exercises.
- Develop interactive, family friendly counseling materials, designed for easy use by both providers and grassroots workers.
- Infuse an "each one teach one" theme into all training activities. Learners will be given some responsibility for carrying information to others. Experience has shown that this approach is critical to mobilizing community support.
- Encourage follow-up in the field as the principal means of measuring training effectiveness.

The design of strategy and planning workshops, media development workshops, and training-of-trainers' (TOT) programs will maintain the same learn-by-doing approach. These workshops will be evaluated in terms of the contribution they make to achieving the final goal: motivating individuals and families to understand, adopt, and maintain beneficial eating and feeding practices. Materials already in use will be evaluated for their effectiveness as front-line teaching tools. Regional adaptation of quality materials has been successfully explored by HEALTHCOM and NCP. The cost-saving implications are important.

At higher institutional levels, Wellstart's considerable training experience and international network will be brought to bear on project activities. *Linkages* will serve to accelerate Wellstart's efforts to ensure that BCM issues receive increased attention in pre-service programs and to develop national and regional training centers throughout the world.

2. Gender Considerations

Many of the problems that this project addresses have their roots in gender inequity, son preference, female infanticide, seclusion, domestic violence, lack of reproductive control, genital mutilation, female illiteracy, low access to education, and political underrepresentation as well as in gender inequities in workloads, wages, and working conditions. These all contribute to the poor health and nutritional status of women and their dependent children. The patterns of inequity vary across cultures and across levels of society and should, therefore, be addressed differently within each of these unique contexts. This project will, therefore, adopt three approaches to redress these imbalances, as follows:

■ Encourage the Participation of Women in Country Activities

Because women are primary caregivers in the household, providers of health services in the community, and the direct beneficiaries of project activities, their participation in all aspects of the activities undertaken by *Linkages* will be crucial to ensuring a successful outcome. *Linkages* will actively encourage participation by women as legitimate authorities and stakeholders whose contributions to the overall design and direction of programs will be valued. To accomplish this goal, *Linkages* will use participatory appraisal techniques and participatory evaluation involving women on management committees, obtaining the informal advice of women, and generally advocating for and rewarding greater women's representation at every level.

■ Redress Inequities Through Country Programs

Many of the proposed activities are directly related to the improvement of women's health and welfare: improving the nutrition of the girl child through improved infant feeding and of the mother through reduced fertility and better dietary practices. Because most of the behaviors this project will promote are undertaken by mothers, and because behavior change often has "costs" as well as benefits, *Linkages* will pay particular attention to these "costs". Important areas for consideration are the time and other resources needed to carry out new actions, the social costs, and risks of innovation. *Linkages* will also be sensitive to the need to disaggregate by sex in assessments, formative research, and monitoring and evaluation.

■ Establish Needed Policy Reforms

Women's health and nutrition is inextricably linked with their position and status in the family, community, and society. *Linkages* will promote the participation of women in health and reproductive decisions, their access to services, and their understanding of relevant behaviors. Policy reforms at higher levels, however, may have even greater impact on the long term welfare of women. For example, policies that encourage girls to attend school may be particularly effective at reducing fertility rates, increasing economic productivity, improving health and nutrition knowledge, and increasing their participation in society generally.

3. Research

Operations research will be used to improve program management, training, and implementation. In the first 18 months of the project a priority is to assess the feasibility of using PSI's network of commercial vendors to promote positive BCM practices, and possibly market new products, such as fortified biscuits, and

specialized feeding bowls and utensils. In subsequent years, operations research will be used to examine strategies for expanding and replicating our community-based support and counseling strategies, and for testing alternative approaches to achieve sustainability in our efforts. Priority research topics include (but are not limited to) examining the effectiveness of alternative strategies for retaining and supervising community peer-counselors and service providers, and reaching target groups on a regular basis to provide behavior change-oriented dietary advice. Program sustainability through cross-subsidization of products (e.g., using the proceeds from sales of feeding bowls or contraceptives to sustain the information and communications training and materials development) will also be explored.

Linkages will work closely with universities and other organizations in the U.S. and abroad that are conducting applied research to improve breastfeeding, LAM, complementary feeding, and maternal nutrition in order to develop a broader research agenda that will answer key questions of programmatic and policy value.

Collaboration will be achieved through various mechanisms, ranging from informal meetings to discuss research priorities, to joint participation in periodic technical advisory meetings, to memoranda of understanding or subagreements (with non-U.S. universities primarily) for collaboration on specific research activities. Following is an illustrative list of research priorities that we will either support directly or encourage other organizations to pursue in partnership with *Linkages*:

- Testing of alternative strategies for maintaining breast milk intake during the complementary feeding period to ensure that total consumption increases and that solid foods complement, rather than replace, breast milk consumption during 6- to 24- month age period
- Development of simplified tools and algorithms to use in the field to measure the adequacy of diets of women and young children and appropriate strategies to address major problems
- The interrelationships among maternal nutrition, and breastfeeding/LAM, and complementary feeding practices, including understanding the role that poor nutrition plays in limiting a woman's ability to participate in BCM practices
- The effectiveness of alternative strategies for reducing the risk of HIV transmission during the perinatal period among breastfeeding women (e.g., condom promotion to reduce HIV infection during breastfeeding).

In addition to formal arrangements for specific research products, *Linkages* will engage in a continuous dialogue with universities and international organizations (e.g., International Food Policy Research Institute) that receive funds from USAID for BCM-related research (e.g., in child survival, micronutrients, reproductive health, food security) to discuss research priorities and identify areas of mutual interest. For example, with The Johns Hopkins University, we will explore options for collaborating on specific research topics related to improving complementary feeding practices, which university staff are planning to study in three countries through their existing child survival Cooperative Agreement. With IFPRI, we will explore issues related to nutrition and food policy in urban environments.

4. Monitoring and Evaluation

Under *Linkages*, monitoring and evaluation will be given high priority and will be planned and integrated into major activities from the start. The focus will be on producing accessible and timely evaluations that answer primary questions about the effectiveness of programs and produce concrete recommendations for program improvements and future interventions. We have chosen our staff and collaborating institutions to reflect the priority we give to evaluation and to ensure that we will be able to respond to the challenges of the task. A full-time senior staff member with extensive experience in evaluation and measurement will be able to draw upon a cadre of 12 full-time professionals from AED's Research and Evaluation Unit (see appendices for list of AED research projects) as well as from our collaborating institutions, University Research Corporation and Macro International.

Evaluation Plan: Although evaluation is critical, it is resource-intensive and has to be planned judiciously. We plan to have three levels of evaluation: 1) comprehensive evaluations in five of the ten country programs, 2) focused evaluations in five of ten country programs, and 3) in-depth cross-site analysis of data.

Comprehensive evaluations will examine all major *Linkages* activities, while focused evaluations will examine specific components of interventions. Some of these will be cost-effectiveness studies. We will also use data gathered by implementing agencies to conduct cross-site analyses of particular issues to generate global lessons learned. The evaluations will be selected on the basis of USAID interest, geographical representation, and PVO type (e.g., child survival, reproductive health, or emergency relief). We wish to address several issues associated with such evaluations, as follows:

- Evaluations will focus on measuring progress in achieving Interim Results rather than on tracking program inputs. Nonetheless, it will be necessary to include at least a minimal measure of inputs so as to be able to link outcomes with levels and types of inputs. We will assist our partners in learning as much as possible about which aspects of the program are working, which are not, and why.
- Although each evaluation must be tailored to the specific program elements and objectives in each country, we will recommend that our partners use a core set of standardized indicators for the three content areas, so as to permit comparability across programs.
- In addition to behavioral results, our objectives include integration and other impacts on cooperating agencies and PVOs. Assessing the extent to which these objectives have been reached will require both qualitative and quantitative approaches and new sets of indicators.
- The RFA notes the need to balance large-scale surveys with routine administrative monitoring. Population-based surveys can provide high-quality data, but require high levels of expertise and large investments in time. Routine administrative data collection is lower in cost, builds in local participation and feedback, and is more likely to be used for local management and policy decisions than large-scale surveys; such data, however, may not in fact be collected routinely or with sufficient care to make the data reliable. A strategy for reducing the costs of monitoring and evaluation which has proven quite useful for nutrition surveillance activities in the past, is the designation of selected locations as "sentinel sites." A sample of locations participating in a program is selected and a special effort is made to generate representative data from each site on a periodic basis.

Our strategy, therefore, is threefold:

(1) We will collaborate with other data-collection efforts such as the Demographic and Health Surveys (DHS), PVO evaluation systems, other Cooperating Agencies such as BASICS, national health information systems, and the WHO Global Data Bank on Breastfeeding. We will use existing data that could serve our purposes and, where feasible, integrate with any upcoming surveys.

(2) Where we cannot draw on data-collection efforts of other agencies, we will conduct smaller, focused surveys with PVOs and governments that will be cost effective and engage the participation of local personnel.

(3) Develop local monitoring systems that will be implemented by our partners and provide periodic data which can feed into a larger evaluation.

Linkages will facilitate five smaller focused evaluations of components of interventions. We will concentrate our efforts on those activities which are innovative, those for which there has been little evaluation or operations research, and those about which we want cost-effectiveness information. Depending on their purpose, these evaluations can range in scope from small and rapid to more substantial and complex. Examples include:

- Evaluating projects that use products to encourage BCM behavior
- Assessing the impact on breastfeeding and contraceptive practices when LAM is added as a method into programs.
- Evaluating the impact of work site interventions on breastfeeding rates among employees
- Comparing the marginal costs and effectiveness of different strategies for improving maternal dietary practices.

To date, almost all cost-effectiveness studies of breastfeeding promotion are in Latin America and are institution-based. Little has been done anywhere on the effectiveness of complementary feeding or of maternal nutrition programs, or on the cost-effectiveness of community interventions. As a result, we will select our cost-effectiveness topics to address those gaps. We will also adapt the LAC/HNS study design to make it less costly.

Indicators: The RFA calls for the refining and testing of indicators to ascertain their feasibility of collection and the costs associated with their use. Indicators for breastfeeding behaviors are fairly well developed; those for complementary feeding and maternal nutrition are less well-defined. Indicators for other types of program outcomes, such as impact on other cooperating agencies or NGOs, need to be developed. We see an important contribution of this project being the identification of a package of indicators in all of these areas which are valid, feasible, and affordable. One of our first activities will be to set to work on this task.

As a first step, we will assemble the many BCM indicators that Wellstart EPB, the IRH, the Evaluation Project's working group on breastfeeding indicators, WHO and UNICEF and others have developed. A small working group drawn from our collaborating institutions, DHS and URC, as well as other will identify the most promising indicators, which will be field tested in the context of our country monitoring and evaluation. We will follow a similar process (with a separate working group) for developing indicators for less tangible outcomes such as participation and institutional capacity-building. We also see an important part of indicator development being dissemination and the provision of technical assistance in their use. We intend to collaborate with those working in government health information systems, PVO data collection, etc., to refine and add to their indicators where desirable.

Monitoring: Monitoring is an underused tool for understanding operational dynamics and obtaining feedback on what aspects of an intervention are or are not working. It can also be a means of involving and motivating local staff and communities and making leaders accountable and responsible for results. Full local participation in planning and implementing monitoring systems is essential. Monitoring methods are available that can be carried out by nonresearchers; systems should be doable and usable and be designed to keep staff in touch with their beneficiary populations. A successful monitoring system requires social marketing research to find out what data people will find meaningful and how to create understandable indicators for the people who will use them. Yet, it is not sufficient to put a system in place; part of the monitoring package must include follow-up to work with staff in how to use the information obtained.

Few "model" monitoring plans are available. One promising monitoring system at the hospital level (MADLAC) is being implemented in Honduras. Under this system, mothers are given brief exit interviews regarding information and support received on breastfeeding, and information on progress toward achieving the Ten Steps is fed back to administrators monthly. We will follow Honduras' experience with this system for potential replication or adaptation elsewhere.

Operational Plans: Linkages will start early and involve local participants in the evaluation process. To ensure that baseline studies are put in place, we will begin planning for evaluations at the needs assessment phase. During needs assessment, we will review existing data to determine its possible suitability to serve as baseline measures, explore potential collaboration with upcoming data-collection plans from other agencies; and find out about data collection capacity of MOH, PVOs, university, and local research firms. We will encourage our partners to contract with these entities.

Dissemination: Much of the time and effort spent on evaluation is wasted if results are not disseminated and used. For our larger country evaluations, we plan to hold dissemination workshops to spearhead further activities based on results. These could happen at baseline and/or after completion of the study. Policy-makers and others who need to be made aware of findings would be invited. To make results accessible to a wide audience, we plan to publish summaries of our larger evaluations and one-page summaries of our focused evaluations of interventions and to make them available both electronically and in printed copy.

5. Information Management and Dissemination

Information will be a critical component of all aspects of the project. We see information as key to supporting USAID's technical leadership in the BCM area; to supporting field programs; and to facilitating local capacity for exchange of information. Given the cross-cutting importance of this component, and given the major change in focus presently underway as USAID closes down the Clearinghouse on Infant Feeding and Maternal Nutrition, we propose that AED work closely with USAID to develop a strategy during the first six months that will meet the new information needs. Recent experience of BASICS and SARA, for example, showed that clear directives for their information strategies, could not be developed until the projects were underway and operational needs could be defined more concretely. Staffing needs also changed dramatically once the projects were underway.

The goal is to develop a comprehensive Information Plan. An internal AED team of information dissemination specialists will be brought together to assist in this task. This will include individuals from the National Demonstration Laboratory, CDIE, as well as specialists from SARA, BASICS, and other information centers at AED (including the National Information Center for Children and Youth with Disabilities). AED has a good track record in finding creative ways to package and disseminate information. More and more, AED is finding ways to establish a two-way flow of information. *Linkages* hopes to continue this tradition. The planning process for developing a forward-thinking information approach is outlined here:

- Analyze information needs of the project in close collaboration with USAID, CAs and other institutional targets, USAID missions and public/private sector organizations working in BCM to identify key audiences, needs and cost-effective channels.
- Review the experience of the APHA Clearinghouse, information centers run by BASICS, SARA, the resource center of the IRH, as well as the dissemination experience of OMNI, the World Bank (PHN Flash), AIDSCAP, and others. Cost-effective strategies for different audiences will be of prime concern.
- Assess the potential role of collaborating information centers. Based on the review, establish criteria for which ones to strengthen and develop a plan for doing so.
- Define the information management role of the Clearinghouse. As an initial operating principle we propose keeping the APHA Clearinghouse Collection as a coherent system. We believe the collection of materials and the organizational data base that the Clearinghouse has amassed over the past 14 years are unique resources and that it is important to keep them in a central place. We propose, therefore, that we integrate the collection with the existing Nutrition Communication Project (NCP) collection. And, that it be housed at AED. It's exact role will be defined as part of the information plan.
- Establish a job description for the Information Dissemination Manager based on the information plan. Recruit and present candidates to USAID.

AED's approach to information management has evolved over the 24 years of managing information resources. Key factors of this focus which will guide development of the information plan are to:

- use every channel as it develops and to use different approaches for different audiences.
- make increasing use of electronic communications, as a way to cut costs, reach more people and establish two-way communication. Projects such as SARA have found, for example, that more and more LDC institutions are hooked up electronically. This is apt to evolve quickly over the next couple of years.
- develop quality products and involve multiple organizations in their development and testing to assure widescale use and dissemination. UNICEF, for example, has funded mass reproduction of many print materials when they are associated early on.

IV. PROJECT MANAGEMENT AND FACILITIES PLAN

A. THE LINKAGES PARTNERSHIP

AED, as the prime contractor, has carefully assembled a select number of organizations in order to provide a rapid program startup and progress toward achieving the program's goals by building upon existing networks, country activities, and established relationships. In addition to AED, the partnership features two primary subrecipients: Wellstart International (WSI) and La Leche League International (LLLI), who will serve as technical resources for breastfeeding and LAM. Each of these organizations will contribute one staff person, who will function as an integral part of the core project team. All remaining core staff positions are held by AED employees. A third subrecipient, PSI, has a much smaller role focused on testing private sector dissemination approaches. (See Figure 1 for the Institutional Chart.) More specifically:

- Wellstart was selected as a subrecipient for their expertise in breastfeeding and LAM; clinical training; breastfeeding policy; and their global network of associates, whom the project will use to provide technical assistance in breastfeeding and LAM.
- LLLI will contribute expertise in breastfeeding and community support groups and its network of volunteer leaders and consultants, whom the project also intends to use as resources when needed.
- PSI brings private sector experience. We would like to test the use of commercial sector networks to deliver LAM and BCM services and information in a limited way during Year 1. Subsequent involvement will be determined in collaboration with USAID. They have unique commercial networks already operating in 35 countries which make rapid assessment of this strategy possible.

In addition to the core team, AED has contacted an array of institutions with special experience which we feel may be of use to USAID over the life of the project. We have made no financial commitments, but have had substantive discussions about their willingness to work with the Agency and AED. We look forward to working with USAID to determine how best to use any of their services.

Flexible financial commitments. AED fully understands the need for financial flexibility in this project, since much of what will be accomplished technically will be defined during performance. The LOEs and budgets for our three subcontractors reflect this uncertainty. No hard commitments have been made and all of our partners understand this.

AED will issue three master subordinate agreements (WSI, LLLI and PSI). An initial administrative task order will be issued at project start to cover assignment of any full-time core staff plus the level of short-term technical assistance needed to launch project activities. Subsequent task orders will be issued, based on field and CA assessments, the annual work plan, and the corresponding areas of technical expertise that each partner brings to the project. This will be carried out in collaboration with the CTO, the Global Bureau, USAID missions, Contracting Officer (CO) and others involved in establishing the technical and contractual parameters for the project.

Role of AED and subrecipients. As the prime contractor, AED will have responsibility for managing the project. The Director or Deputy Director are the official point of contact for USAID. AED will provide technical leadership; and assure that the project achieves the results promised. AED brings capacity in behavioral change for infant feeding and maternal nutrition, policy, information management, training, research and evaluation, and has a long track record in bringing different technical groups together to meet a challenge. The role of Wellstart and LLLI will be to provide technical depth in breastfeeding and LAM and clinical services; PSI will provide expertise in product social marketing. The three subrecipients have technical support roles, not management roles. These organizations bring long-standing commitment to optimal infant feeding practices and LAM.

Direction and supervision of subrecipients. All management and technical direction of subrecipients is the responsibility of AED acting through its project Director and

Deputy, and in collaboration with the CTO. Subrecipients are technical partner help define and implement substantive parts of the program. The two team members 1. Wellstart and LLLI, both of whom will be based at AED, will be supervised by the Director, not their parent organization. This arrangement, whereby AED manages a team of AED and subcontractor employees all housed in the same offices, has worked well for projects such as GreenCOM, AIDSCOM, SARA, and NCP. The Project Director and the CTO oversee decisions about the inputs that subs are asked to make to the project. Core staff members will be assigned to manage specific activities and will provide day-to-day supervision and regular guidance for this technical work.

All core staff - including the two staff from WSI and LLLI - will be located at AED. The entire project staff (core and support) will be located in adjacent offices in AED's Social Development Division at 1255 23rd Street, NW, Washington, D.C. This will ensure easy access to AED central services in finance, administration, contracts, human resource development, and computer technical support, as well as the Behavioral Research Unit, National Demonstration Laboratory for Interactive Information Technologies (NDL), and technical staff working on other PHN programs. Such access will place the staff of Linkages in a challenging environment where they are able to interact with, and draw upon, the technical resources of AED's 120-person Social Development Division. The staff will be placed in contiguous office space in order to promote optimal interaction. The office is only a ten-minute taxi ride to the USAID/Office of Population, Health, and Nutrition.

B. MANAGING FOR RESULTS

Project Organization: The management of a global program is a complex undertaking that requires a management system that attends to the overlapping requirements of technical and operational demands. Does one organize on the basis of regional and country concentration, management functions, technical skill areas, task groups, or outcomes? For *Linkages*, we are proposing an organizational structure based on outcomes and activity streams with the management of the results packages at the heart of the program. (See Figure 2 for the *Linkages* Organization Chart.)

Management Team: The management team is composed of the Project Director, Deputy Director and Financial/Administrative Manager. Jean Baker, as Director will have overall responsibility for project management and technical leadership, and will be the point of contact with USAID and subrecipients for management purposes. She will serve as final arbiter on all programmatic, financial and management issues. She will have lead responsibility for overseeing the cross-cutting function of mainstreaming BCM into CAs and other institutions. Peggy Parlato, as Deputy will assist with management and take over Directorship duties in Baker's absence from Washington. Parlato's main focus will be on technical issues. She will manage Results Package 1 dealing with Behavior Change and will be responsible for seeing that a behavior change approach - which we feel is critical to project success - is applied to all the Packages. Her management time should be approximately 20 percent. Some of this will be for technical direction to the other Results Packages and for oversight of Information Management and the social marketing test-activities.

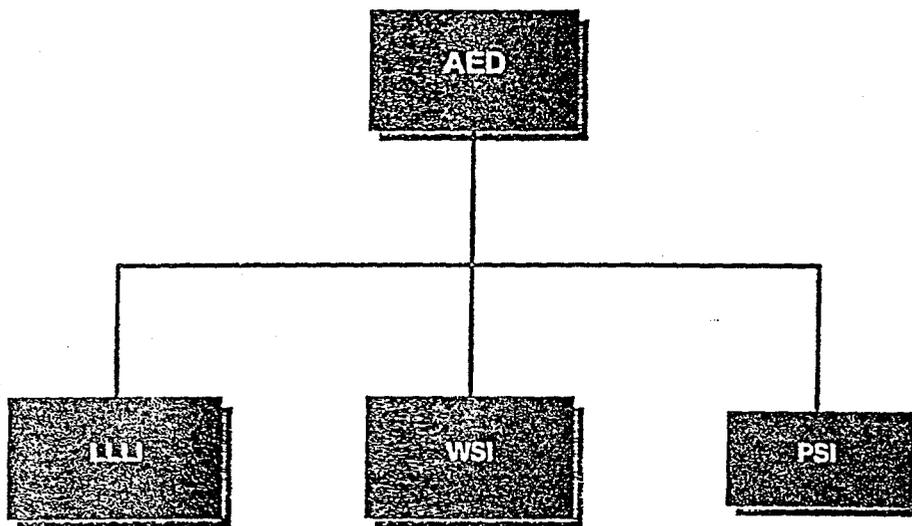
The Financial and Administrative Manager, Jim Gregory, will have oversight of the project budget, deliverables and subcontracts; be responsible for daily operations, including supervision of administrative staff under the Director, and working with core staff to develop and monitor country/activity budgets. The team will meet at least once per week but meetings between the Financial Manager and Project Director may be more frequent. He will be supported by AED's contracts, accounting and human resources departments which are provided at no cost to the project, as part of AED's overhead structure.

Monitoring and Evaluation: Dr. Roy Miller will be responsible for designing and managing Monitoring/Performance Evaluation systems; for developing and testing methodologies for the collection of data required to form proposed indicators; for coordinating data collection with other institutions; and for overseeing analysis. As a key member of the *Profiles* team he will keep the Director and team leaders sensitive to achieving results and to how well activities are doing. A key aspect of his job will be determining how that information can be fed back into the management stream and the work of the Results teams. Miller will lead the program's efforts to develop monitoring

systems for country and other field activities; coordinate with other institut
CAs collecting data; and will work with country partners to modify existing syst
furnish similar types of data. He will be able to call upon a pool of 12 full-tim

Figure 1. Institutional Relationships

LINKAGES INSTITUTIONAL RELATIONSHIPS



RESOURCE POOL

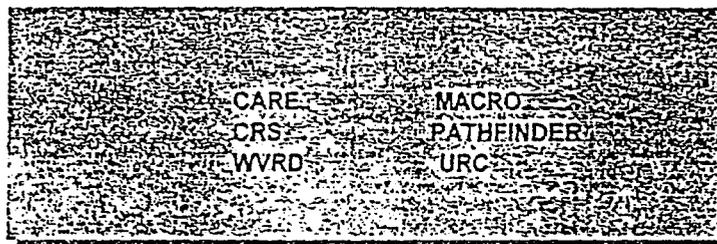
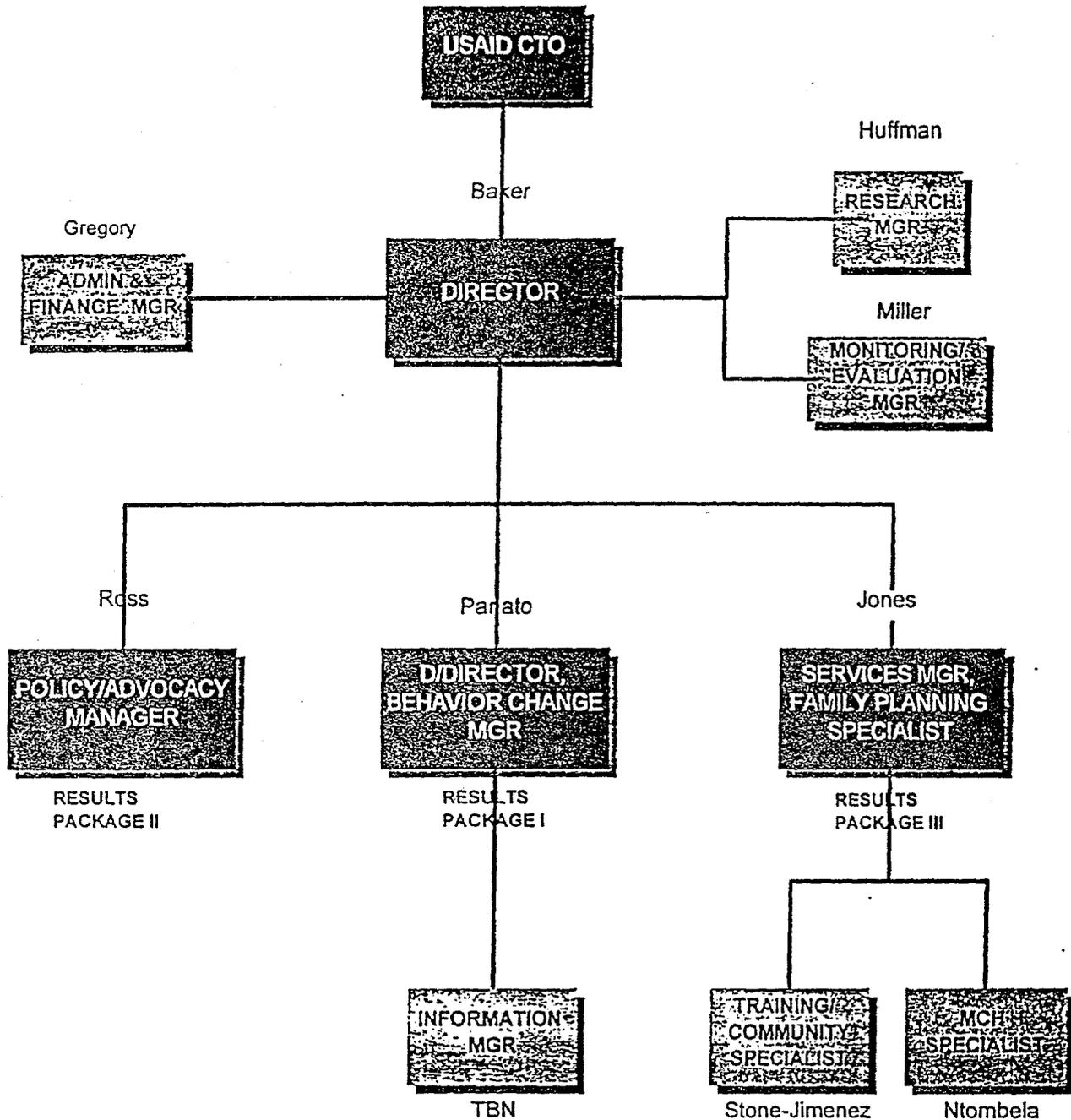


Figure 2. Linkages Organization Chart

LINKAGES ORGANIZATIONAL CHART YEAR 1



professionals from AED's Research Unit, as needed, including Drs. Carol Baume, Orlando Hernandez, Susan Blake, and Ms. Julia Rosebaum who have strong backgrounds in evaluation and monitoring of breastfeeding and other nutrition programs.

Research: Dr. Sandra Huffman (50%) will take the lead in managing the project's applied research agenda. She will also oversee operations research, calling on consultants specialized in this discipline. (Cost studies will be managed by Jay Ross; behavior research will be managed by Peggy Parlato). This is a very varied research portfolio for the project, including systems analysis to solve programmatic and service delivery problems; operations research, qualitative and quantitative research, data analysis and cost-effectiveness analyses. To carry out the work, Dr. Huffman will draw on specialists from AED's Research Unit including Dr. Paula Hollerbach, formerly of the Population Council and Ms. Rebecca Ledsky, who has worked on systems analysis of service delivery programs; and the pool of research consultants (including ones with operations research) which will be specially developed for the project. If needed, she will also have access to staff of University Research Corporation specialized in systems analysis, operations research and quality assurance. (See the Annex for an illustrative list of consultants and advisors.)

Results Teams: The project will not be considered a success unless it produces well-documented results in accordance with its work plan and Strategic Objectives. The team, therefore, is organized around Results Packages - modeling the Global Bureau. To meet the many other requirements of the project, all core staff will have multiple functions. Consequently, all core staff will also have country responsibilities and serve as technical leads for key project technical and functional domains. Each team will have a well-defined set of responsibilities and goals. Each core staff member will be called upon to contribute to other teams, as needed. Most teams will also draw upon the skills of consultants (from both within AED and partner organizations and from other sources) on an "as needed" periodic basis. The role of the team leaders will be to manage their components. They will be held accountable for the progress toward their goals. The role of the teams will be to develop innovative approaches for their project component; to identify, organize, and manage the work to be done; to monitor progress; and to make mid-course corrections in activities to increase impact. These are to be working groups not discussion groups.

Each of the three Results teams will work as a group, under direction from the team leader, to refine the approach and activities presented in our proposal and fine tune the measurable indicators we are working towards. This will include developing specific strategies for working with CAs whose objectives link with each Results Package, defining technical approaches, and research agendas and training needs. The Project Director will directly oversee the work of the Results Teams. Roy Miller, the Monitoring and Evaluation Specialist, will be charged with keeping activities focused on results and for providing feedback to the Project Director and Team Leaders on progress. The team leaders will work closely with him to design relevant indicators and monitoring systems; and track and adjust their strategies to achieve the desired results. Other support will be provided by the Information Specialist (TBN) who will assure that the information strategy is designed to support each team's specific objectives. The teams are constituted as follows:

■ **Results Package I Team: Improved Attitudes and Norms.** This team will be led by Deputy Director Margaret Parlato, a specialist in behavior change and former director of the Nutrition Communication Project, who has worked in every region of the world. She will be supported by Roy Miller, the Monitoring and Evaluation Specialist; Barbara Jones, the Service Delivery Specialist; Jay Ross, the Policy Specialist), and the Information Specialist (TBN). The team will meet regularly to look at behavior change issues and track progress in meeting behavior change goals, which cut across all the Results Packages. Parlato's role will be to integrate appropriate behavior change strategies in the service delivery training for LAM, for example, or to help bring a deeper understanding of audiences to priority policy initiatives. She will help identify needs for behavior change inputs in ALL country activities and across results packages; identify consultants to work in country; assist with designing their scopes of work; and review their contributions.

In addition to the regular team members, Ms. Parlato will be able to call upon assistance from a range of in-house expertise on a consultant basis. This might

include: Dr. Susan Middlestadt, Director of AED's Behavioral Research Unit and an internationally recognized authority on behavior change; Lonna Shafritz, AED social marketing and formative research specialist, who has worked throughout Africa and Asia; and Dr. Willard Shaw, former director of the HEALTHCOM Project and an AED development communication specialist with 25 years of field experience.

Results Package II Team: Improved Policy Environment: Dr. Jay Ross will lead this Results Team. He will have support from Dr. Sandra Huffman, formerly with Nurture, a specialist in MCH/nutrition and with practical experience in Policy research and policy formulation; Ms. Nomajoni Ntombela a veteran of many policy initiatives with IBFAN-Africa; and Barbara Jones, who as manager of the Services Results Package, will help identify policy issues at the country and program level. Dr. Roy Miller, monitoring and Evaluation Specialist; and Project Director, Jean Baker will also be a member of this team, bringing her global perspective to policy issues of concern to the project.

For specialized support and for key consultancies, the team will be able to call upon the assistance of Dr. Audrey Naylor, the CEO of Wellstart, who has worked on nutrition policy and advocacy for four decades; Ritu Sharma, an AED specialist on advocacy strategies; and Dr. Robert Porter, an AED advocacy and research specialist and author of *Knowledge Utilization and the Process of Policy Formation*.

Results Package III Team: Improved Access and Services: This Results Team will be led by Barbara Jones, who has more than 15 years field experience in service delivery, family planning and MCH programs. She will be assisted by core team member Maryanne Stone-Jiménez, a La Leche League trainer, who has worked extensively with training and mother support systems in the Latin America region. Nomajomi Ntombela, a public health nurse and midwife, with extensive field experience in Africa, will be the third core member. Monitoring and Evaluation Specialist Dr. Roy Miller and the Information Specialist will be regular members of the working group.

Resources the team can call on as consultants from time to time, but who will not be regular members of the Results Team include: Dr. Berengere de Negri, an AED specialist in interpersonal communication training and quality assurance, with extensive field experience in Africa and Latin America; Barbara Heiser, former member of the Board of Directors of LLLI, who is an R.N. and breastfeeding specialist, with years of experience in training providers in mother support; Valerie Uccellani, an AED training specialist who formerly worked with the Nutrition Communication Project; and Dr. Norma Wilson of URC, a specialist in quality assurance, who has worked in many African nations. Dr Willard Shaw, a distance education expert, and staff of AED's National Demonstration Laboratory may also help to explore the use of other learning technologies.

Staff will all have multiple functions: In addition to Results Package Teams we also anticipate having country teams. Staff will all have multiple functions: 1) managing/participating on Results Package Teams; 2) managing country activities; 3) liaison with Regional Bureaus; 4) serving as technical leads for project content areas (LAM, infant feeding, etc.); 5) liaison with designated CAs and other institutions; and, 6) training in areas of their lead specialty.

All core staff are expected to take the lead in managing training activities related to their results-package and skill-area. For example, Parlato will oversee training in behavior change, counseling skills etc. Miller will manage training on monitoring and evaluation. Given the small size of the staff, consultants will be used to conduct many of the events and work with CAs to incorporate LAM and BCM into existing courses and training materials.

Regional coordinators and country teams: Four of the core staff members will serve as point persons for the Regional Bureaus and will coordinate activities in the region. Initially, regional coordinators will meet with USAID regional bureaus, and technical divisions to assess interest and needs in BCM. Assessment teams will then be put together to visit the target countries, with team compositions determined by technical priorities of the country. However, once activities are defined by the Results Teams for a given country, a single individual will be designated as the Coordinator for activities in that country. That person will then be the focal point for communications with our partners in the field and will serve as the linkage to the staff of other

cooperating agencies and USAID on matters regarding that country. Regional coordinators will be the prime liaison with Regional Bureaus and will oversee the activities taking place in the country sites. They will organize field country assessment teams to develop country programs and then assign the management of a country to one of the core staff members. They will coordinate inputs from all core staff and consultants who will be working in a particular country.

Responsibilities are being assigned as follows:

- LAC and ENI: Mary Anne Stone-Jiménez
- Asia: Jay Ross
- Africa: Nomajoni Ntombela
- NE: Barbara Jones

Institutional Capacity-building Functions: Each core staff will be assigned to work with one or more CAs, PVOs, or multilateral agencies in order to develop BCM capacity and mainstream BCM into their programs. In terms of the large number of family planning CAs, we would assign one staff to each priority agency. For example, Peggy Parlato will work with SOMARC and PCS; Barbara Jones with IPPF-WH, SEATS, and QAP; Mary Ann Stone-Jiménez with CARE-FP, CRS, CEDPA, Child Survival PVOs, and the Johns Hopkins Child Survival project; Nomajoni Ntombela with AIDSCAP; Jay Ross with Futures on RAPID and OPTIONS; Roy Miller with Macro (DHS), Population Reference Bureau; and the information specialist with Population Information Program (Popline, Population Reports, CD-ROM, etc.), and Sandy Huffman with the Population Council and university CAs. The Project Director, Jean Baker, will oversee this cross-cutting function.

The Linkages team will work together in the following fashion. Weekly staff meetings and e-mail groups will be used to coordinate work flow and to share information. At project start, we propose holding a team orientation week, which would include briefings on LAM, breastfeeding, and other BCM topics, gender, management by indicators, and other priority issues.

Personnel Performance: Semiannual performance appraisals are conducted with each staff member, and annual performance reviews link performance with salary increases.

C. FACILITIES AND CENTRAL SERVICES

Accounting: AED's central accounting office tracks all direct project costs and sends a computerized printout of costs to the project within the first ten days of each month. Staff time is reported on an hourly basis against project or task. Accrued expenses not yet included in the prior monthly statement are tracked by the project's financial manager so that each project director has ready access to the current financial status of the project. Regular cost reporting and budget comparisons make it possible to avoid cost overruns and ensure swift reporting of budget variations. A flexible coding system makes it possible for projects to track expenses according to a particular category, such as country or task or theme (e.g., cost studies).

Facilities: All project computers will be connected to AED's Local Area Network which provides interoffice and worldwide E-mail, Internet access, and standard office software. Photocopy and fax machines and office supply rooms are located at convenient locations throughout the floor. A central mail room is available for interoffice and regular mail, and all major courier companies make daily pickups. Three kitchens are equipped with coffee machines, refrigerators, sinks, microwave ovens, and soda machines. Six meeting rooms seating from 10 to 100 people, and equipped with audiovisual equipment, are available on a sign-up basis. A voice mail system handles message-taking functions, while an AED receptionist assists visitors. An on-site facilities manager and a computer systems specialist ensure that all equipment is operable.

Project Oversight: An AED vice president is assigned to every AED project as the Officer-in-Charge to offer general oversight to the project and assist the Project Director on corporate issues related to the project partner organizations. This service is provided free of charge to USAID. The Officer-in-Charge for Linkages will be Jack LeSar, M.D., M.P.H., who also serves as the Director of AED's Health, Nutrition, Population and Environment Department. He will conduct quarterly reviews of the

progress of the project to ensure AED compliance with the goals of the Cooperative Agreement with USAID and provide general support to the Project Director, as needed.

V. INSTITUTIONAL CAPABILITIES

To provide USAID with technical and program management assistance of the highest caliber and to ensure a rapid program startup, AED has assembled a team of organizations with long and distinguished records of successful participation in international development. Further, each of these institutions is strongly committed to improving the health status of mothers and their children.

A. CORE TEAM MEMBERS

1. Academy for Educational Development (AED)

AED is a private, nonprofit service organization with 600 employees and 35 years of experience in development assistance. To date, it has completed 300 programs in more than 100 countries. AED's headquarters are in Washington, D.C., with project offices in 23 countries. Under contracts and grants, AED operates programs for state, national, and international agencies; multilateral banks; educational institutions; foundations; and corporations. Its international programs include social and behavioral research evaluation; public health behavior change; and policy dialogue in health, nutrition, and family planning as well as all levels of formal and nonformal education, training, and human resource development. At present, AED is conducting 49 long-term projects in 33 countries. Short-term technical assistance is also provided to approximately 60 countries each year.

Because of AED's extensive background in all of the principal areas addressed in the RFA, it is well-positioned to carry out this BCM program. During the last two decades, AED has supported child health and nutrition programs in more than 60 developing countries and has worked on national programs addressing virtually all major child survival interventions and specific nutrition programs on all continents. (A list of country programs is included in the appendices). At present, AED employs three full-time staff who hold doctoral degrees in human nutrition and one who holds an M.S. degree. All of these programs have been designed and implemented in close collaboration with local government and NGO officials and have been based on extensive consumer research and a participatory planning process that have enabled stakeholders to be partners in program design. AED's strong and multifaceted background provides it with the knowledge, skills, and support systems to help USAID reach its strategic objectives of lowering unintended pregnancies, maternal mortality, and infant and child mortality.

a. Experience in Attitudes, Norms, and Behavior Change

A principal theme permeating the RFA is that of attitudes, norms, and behavior change among mothers, families, communities, health providers, and policy-makers. During the past 18 years, AED has been a pioneer in developing a multi-disciplinary approach to behavior change that integrates elements from commercial marketing, behavioral analysis, anthropology, communication, and adult education. This approach has been successfully used in programs involving maternal and child nutrition, child survival, substance abuse, AIDS, agriculture, and the environment. Over time, this communication approach evolved into a comprehensive applied behavior-change strategy for involving child, parent, provider, and policy-maker in a coherent plan aimed at changing existing attitudes and fostering new behaviors. Independent evaluations of many of AED's country projects have documented their positive impact on desired behaviors and engendered international credibility for communication in general. This approach has been well documented through 50 journal articles and a book entitled *Communication for Health and Behavior Change* by Jossey-Bass as well as materials designed for developing country professionals, including *Motivating the Audience to Act*, an official document issued by the International Conference on Nutrition (1992); the *Tool Box for Developing Communication Capacity*; *Communication for Child Survival*; and *Starting with Behavior: A Participatory Process for Selecting Target Behaviors in Environmental Programs*.

AED's applied behavior change approach (ABC) has been applied to nutrition issues. Beginning with the Mass Media and Health Practices Project, AED designed breastfeeding messages within the rubric of diarrhea control interventions. Under the HEALTHCOM I and II projects, child survival interventions in Ecuador, Lesotho, Indonesia, Papua New Guinea, the Philippines, Mexico, and Nigeria consistently included messages about breastfeeding and feeding during diarrhea. A number of "umbrella" child survival

interventions (e.g., Ecuador and Guatemala) promoted breastfeeding as one of several essential ingredients of good health. Ecuador's PREMI Project created materials on this technology for physicians as well as for mothers. In Jordan, Paraguay, and Honduras, AED assisted MOH programs that saw breastfeeding as a complex skill, requiring messages and trained support by health workers.

In the Nutrition Communication Project, infant feeding increasingly became a technology in its own right. Specialized assessments were carried out for ministries of health as a basis for program design for behavior change in Bolivia, Burkina Faso, Haiti, Honduras, Mali, Morocco, Niger, and Thailand. In addition, special breastfeeding sector assessments were carried out in Bolivia and the Philippines. NCP produced a publication entitled *Breastfeeding Promotion in Central America: High Impact at Low Cost* as well as a guide to breastfeeding that is being produced by UNICEF for regional distribution in Latin America.

The primary goal of most AED health projects has been to achieve measurable behavioral impact among large segments of a given population. One of AED's principal roles in the Linkages Project will be to transfer its knowledge and skills on applied behavior change to its partner organizations and to maintain the focus on behavior change as the ultimate goal.

b. Management of Multipartner, Global USAID Projects

AED has successfully managed several dozen large-scale health and nutrition-related behavior change and communication projects for USAID, directing multiple field sites and contractors, and providing short-term technical assistance to more than 50 countries. Following are descriptions of selected projects:

- Mass Media and Health Practices Project (MMHP, 1978-1985)
- Communication for Child Survival Project (HEALTHCOM I, 1985-1990)
- Nutrition Communication Project (NCP, 1987-1995)
- AIDS Technical Support (AIDSCOM, 1987-1992)
- Communication and Marketing for Child Survival (HEALTHCOM II, 1989-1995)
- Communication for Technology Transfer in Agriculture (CTTA, 1985-1992)
- Environmental Education and Communication (GreenCOM, 1993-1998)
- Basic Support for Institutionalizing Child Survival (BASICS, 1993-1998).

MMHP (\$12 million), HEALTHCOM I (\$18 million), and HEALTHCOM II (\$32 million) were three ground-breaking global projects that helped establish the credibility of communication and applied behavior change as essential public health components. MMHP was the research and development phase which created and tested a systematic, multidisciplinary methodology to achieve large-scale changes in public health attitudes, norms, and behaviors. HEALTHCOM I refined this methodology by applying it to a greater range of child survival interventions and countries. HEALTHCOM II focused on institutionalizing the methodology within ministries of health, schools of public health, and regional and international agencies, such as WHO, INCAP, and PAHO. Activities were carried out in more than 40 countries, and successful behavior change was documented in projects promoting EPI, CDD, breastfeeding, vitamin A, etc.

Nutrition Communication Project. This \$9.5 million global project assisted USAID Missions, host-country institutions, and NGOs to implement, and evaluate efforts to promote better nutrition using communications. The project assessed maternal and child nutrition problems in developing countries; applied the ABC approach; and created, implemented, and evaluated communication programs that promoted good nutrition and transferred technical skills in social marketing, communications, and nutrition education to LDC personnel in organizations working in maternal and child health.

Basic Support for Institutionalizing Child Survival (BASICS). A partnership comprised of AED, JSI, and MSH, BASICS seeks to sustain reductions in morbidity and mortality among children through expanding access to and efficient use of child survival interventions. Although BASICS focuses mainly on EPI, CDD, malaria, and ARI, it has added nutrition as one of its priorities. In addition to its technical role, AED provides the project's management system.

Described below are examples of relevant country programs:

Nutrition Communication Project (NCP), Mali. The USAID-funded NCP in Mali was designed to address the poor nutritional status of rural women and children through collaboration with health programs and an integrated approach to message delivery. Rather than create a free-standing nutrition education program, NCP worked with the MOH and PVOs to build a nutrition emphasis into their related programs – such as different child survival components, safe motherhood, and so forth. NCP placed heavy emphasis on institutionalizing communication capacities within these PVOs and a central government organization. As a result of project activities, the prevalence of malnutrition (weight for age) was reduced from 38% to 28% (a 26% reduction) in trial villages, while it remained virtually unchanged (1% point increase) in comparison villages.

Nutrition Communication Project, Burkina Faso. This six-year project (1989-1995) was a comprehensive initiative designed to educate parents about the specific actions they could take to improve their children's nutrition, beginning with the mother's diet during pregnancy. A final KAP survey (630 men and women) conducted in four of the intervention provinces in late 1994, as a follow-up to a 1991 baseline survey (640 interviews) found that more than half of the population was reached with at least one source of information. Interventions occurring at health centers reached 55% of the women surveyed and 26% of the men.

The Texas Women, Infants, and Children (WIC) Project for Supplemental Feeding. This study, carried out in collaboration with Best Start, Inc., examined the barriers to access and utilization by eligible families to participation in WIC. The results of in-depth interview and focus group discussions with program participants resulted in a survey administered to more than 1,800 participants. Focus group discussions and clinic observations were developed into a survey administered to more than 1,300 staff in 70 WIC sites. Research findings are being used to affect federal and state policies, service delivery, community-based coalitions, public information and outreach, staff training, and customer education.

Breastfeeding Intervention, Jordan. With the Queen Noor al Hussein Foundation, AED promoted breastfeeding and child spacing. The project targeted policy-makers and the medical profession as well as the general public. As a result of project activities, mothers' knowledge about the appropriate timing of initiation and the importance of colostrum increased from 41% to 74%. Correct knowledge about the right time to supplement breast milk increased from 36% to 61%. Initiation of breastfeeding within six hours after birth increased from 43% to 69% among mothers who delivered in public hospitals and from 42% to 67% among those who delivered at home.

Breastfeeding Project/Peru. This project proved that a well-designed training intervention coupled with a highly focused strategy to change maternal/infant feeding behavior can have a dramatic impact. The project in three of Lima's largest maternities showed that mothers who delivered a child in one of the hospitals where training and mother-education took place were significantly more likely to be exclusively breastfeeding when the child was two and four weeks of age than mothers who delivered in the control hospital.

Vitamin A Foods Promotion/Niger. The consumption of vitamin A-rich foods was increased by promoting seasonally available local products. Taking into account availability, household cash flow and consumer preferences, project planners identified foods to promote and targeted men, women, commercial gardeners, and health and extension agents to shift cultural norms regarding roles and nutrition. Improvements in maternal dietary practices were registered.

Vitamin A Capsule Promotion/Indonesia. AED worked with Helen Keller International, the 500,000 member Family Welfare Movement, the community health volunteer network, and an Islamic women's organization to develop a pilot project in Central Java and then a nationwide program. The pilot for 150,000 children increased capsule consumption from 24% to 41% in participating districts. The nationwide program reached another six million children during a two-year period.

c. Policy Formulation and Promotion (International, National, and Local)

Support for Analysis and Research in Africa (1992-1998). SARA presents Africa-relevant research findings to policy-makers to assist them in making optimal strategy, policy,

or program choices. The project analyses how information is used for policy formulation and then helps to strengthen the link between research data and policy design and implementation. Dissemination activities include developing a training module and visual materials for public advocacy; issuing reports on research findings; collecting and repackaging information relevant to African health issues; and helping to strengthen African dissemination partners. The SARA Project has worked extensively in the area of nutrition advocacy among donors, CAs, and African institutions and governments.

Sustainable Approaches to Nutrition in Africa (SANA) Project (1995-1998). SANA provides support to African institutions and networks to integrate nutrition into existing pre-service and in-service training programs in public health and medicine. SANA is training African researchers in formative research and analysis and in the use of these data for designing nutrition communication programs. These researchers then become potential consultants to work on nutrition behavior-change programs in Africa. SANA is also developing modules for in-service training in community nutrition and defining protocols for measuring the elements of successful large-scale nutrition programs.

Africa Infant Feeding Initiatives. In collaboration with the Africa Bureau, PRITECH, and Wellstart, NCP launched an intensive program to focus the attention of policy-makers on critical infant feeding problems, notably breastfeeding for child survival, appropriate weaning, and diarrhea control. The program included recommendations on ways for ministries to integrate child-feeding promotion with primary health care, family planning, and CDD programs.

Social Sector Policy Analysis Project. AED collaborated with Nurture to create a package of materials on the economic value of breastfeeding that included a literature review, a briefing book for policy-makers distributed at the World Summit on Children, and a policy workbook that provided a guide for assessing the cost-effectiveness of breastfeeding. Studies examined costs and savings related to breastfeeding from national, public, governmental, hospital, and household perspectives. A study on maternal nutrition was conducted in Bangladesh with BRAC.

d. Access to and Quality of Services

Through its participation in the Quality Assurance Project during the last five years, AED has concentrated its efforts on worldwide assistance in institutionalizing quality assurance. Its primary role has been to establish interpersonal communication skills and train health care providers and managers to improve their relationship with patients and patient compliance. The effort began with a meta-analysis to evaluate what had been learned to date in the field of client-provider communications in both developed and developing countries and to determine what questions or issues were most important to address in developing countries where the QAP wanted to concentrate its efforts. AED has developed interpersonal guidelines for health care providers and trained teams in Egypt, Honduras, and Trinidad by using quality assurance methods.

As an integral part of AED's social marketing approach, considerable attention is given in all of its programs to the availability and quality of services. Formative research is always conducted to identify the barriers to a new behavior, whether it be limited access to facilities, poorly trained staff, lack of specific inputs, or some other obstacle. Among the specific activities carried out by AED recently in improving service provision are the following:

- Developing customer satisfaction and marketing programs for six Egyptian hospitals moving from a free service policy to a fee structure
- Conducting an evaluation of the distribution system for vitamin A capsules in Indonesia, proceeding from arrival at the port to district distribution
- Research in Kenya, Niger, and Burkina Faso for the USAID Measles Initiative on the KAP of mothers and health workers on EPI services, with the research findings leading to the redesign of interventions
- Research in U.S.-managed care facilities on the utilization of emergency room services and on the treatment of asthma among Medicaid patients.

e. Clearinghouse/Information Dissemination

Major dissemination efforts are currently being carried out by:

USAID Research & Reference Services (R&RS), (1990-1997). More than 40 AED staff provide USAID with information services related to development policies through database searches, bibliographies, tailored information packages, referrals, a current awareness up-date service, and several regular publications. *Federal Resource Center (FRC) for Special Education.* FRC links the Office for Special Education and its six U.S. regional centers and provides them with information for providing technical assistance to state education agencies. *National Information Center for Children and Youth with Disabilities (NICHCY, 1993-1998).* AED operates a national clearinghouse for the U.S. Department of Education on disabilities and related issues. NICHCY answers questions, links people with common concerns, and publishes newsletters and briefing papers.

f. Research

Research of all types has been crucial to the success of many AED projects; therefore, AED has made a concerted effort to build a high-quality research capability. The 12-person Behavioral Research Unit led by Dr. Susan Middlestadt, an internationally known behavioral researcher, provides AED projects with the support of a group of multilingual and multitalented researchers. Staff are skilled in quantitative, qualitative, and participatory research methods and have the language and country experience to allow the unit to work in all regions of the world. Most of the members have significant experience in health projects; all have developing country experience. AED also has a second research unit that focuses on youth development and policy research. Nearly all of AED's domestic programs contain major research components. Among the 50 communication specialists working on various projects, most are skilled in one or more areas of research, particularly in formative research and monitoring systems. Included in the appendices are descriptions of AED's research and evaluation experience.

2. Nurture/Center to Prevent Childhood Malnutrition

Nurture/Center to Prevent Childhood Malnutrition was founded in 1986. This private, nonprofit organization seeks to bridge the gap between research, education, and policy. Nurture's mission is to reduce malnutrition in disadvantaged communities worldwide by enabling mothers to make informed, nutritional choices for themselves and their children. Nurture also helped to develop and evaluate mother-to-mother breastfeeding support groups for low-income women in the U.S. Through its work with policy-makers, program managers, and NGOs, Nurture serves as an advocate for domestic and international policies that support families in their efforts to nourish and nurture their children. Nurture should complete a merger into AED by September 30, 1996.

3. Wellstart International

For more than a decade, Wellstart International, a California-based, nonprofit organization (formerly The San Diego Lactation Program), has been promoting the health of mothers, infants, and families through breastfeeding and optimal maternal and infant nutrition. Wellstart activities extend from prepregnancy through the completion of weaning and include a broad range of maternal, neonatal and infant health issues, psycho-social, family planning, and other matters which may enhance or interfere with breastfeeding and maternal and infant well-being during this phase of life. In 1993, WHO designated Wellstart as a Collaborating Center on Breastfeeding Promotion and Protection (with particular emphasis on lactation management education), thereby giving international recognition for Wellstart's high level of expertise. Wellstart has developed and successfully managed projects with funds from the U.S. Department of Health and Human Services, NIH, USAID, UNICEF, and WHO.

Wellstart has 14 years of experience in education and training, provision of clinical services, assessment and program design, policy analysis and development, and collaboration with national and international agencies and NGOs working in breastfeeding and maternal and infant nutrition. The four-week Lactation Management Education Program (run in English, Spanish, French and Russian) is considered by many to be a global "gold standard" for training in that subject area. Wellstart has also worked closely with UNICEF in breastfeeding promotion, including the Baby-Friendly Hospital Initiative. It designed the assessment method for BFHI and trained the first

group of master assessors/trainers. Much of the success of the Initiative has been attributed to Wellstart Associates who have served as assessors and trainers and been influential in making needed changes in national and institutional policies.

More than 600 leadership-level participants from 55 countries have begun working with Wellstart through its LME and Expanded Promotion of Breastfeeding programs. Known as Wellstart Associates, they have become a global network of expertise and technical resources for their countries and regions. In 29 countries, the activities of Associates have resulted in recognized programs and centers that provide education and technical assistance nationally and regionally. Wellstart is now completing guidelines for providing Affiliate status to centers and programs meeting standard criteria. This Affiliate Network of Excellence will help ensure sustainability and successful expansion into local, national, and regional communities.

Wellstart's faculty, technical advisers, adjunct faculty, and consultant group provide an outstanding breadth of expertise in all relevant areas, including:

- Scientific aspects of lactation and maternal and infant nutrition
- Clinical lactation management and maternity care practices
- Community outreach, working mother issues, and mother-to-mother support
- Policy review and development
- Code of marketing of breast milk substitutes
- Assessment, analysis, program planning, monitoring and evaluation
- Biomedical, behavioral, and operations research
- Pre-service, in-service and continuing education curriculum development
- Faculty development and technical training.

4. *La Leche League International (LLLI)*

Incorporated in 1956, LLLI is identified throughout the world as the promotion of breastfeeding. It is a 501(c)3 educational, volunteer service organization with headquarters in Schaumburg, Illinois. LLLI is served by 50 full-time employees and approximately 8,000 active volunteer Leaders in more than 60 countries. The organization has worked in developing countries for the past 30 years and currently extends outreach to mothers in nearly 100 countries. LLLI is registered as a PVO with USAID and is an NGO in consultative status with UNICEF and WHO. LLLI is a founding member of the World Alliance for Breastfeeding Action (WABA) and maintains associations with other organizations that support breastfeeding. It is also the world's largest resource for breastfeeding information, distributing more than three million publications to 60 countries annually. LLLI's Center for Breastfeeding Information contains approximately 12,000 research studies and case reports.

LLLI's sole mission is to help mothers breastfeed through education and mother-to-mother support and to promote a better understanding of BF as an important element in the healthy development of the baby and mother. LLLI pursues this mission principally through its nearly 3,000 community-based Mother Support Groups (MSGs). A network of more than 9,000 volunteer breastfeeding advocates, peer counselors, and approximately 8,000 active LLLI Leaders in more than 60 countries provide direct help to some 150,000 mothers monthly through MSGs, one-on-one counseling, speaking engagements, and informal contacts.

The League also has a long history of serving the medical community and national-level policy-makers. Its Professional Liaison Department assists leaders in working with the local medical community. Its 348 Breastfeeding Resource Centers are used by physicians, nurses, Peace Corps volunteers, missionaries, and public health offices throughout the world. LLLI is one of only six lay organizations accredited by the American Medical Association to offer continuing medical education credits to physicians.

5. *Population Services International*

PSI is a nonprofit organization established in 1970 and a registered PVO. The organization designs, develops, and operates maternal and child health, family planning, AIDS prevention, and micronutrient programs in developing countries. These activities include the social marketing and promotion of health products in the private sector at prices affordable to the poor and generic communications and education to

motivate target groups to adopt prudent health practices. PSI products include a variety of contraceptives for family planning and birth spacing, condoms for AIDS prevention, antibiotics for curing sexually transmitted diseases, ORS to combat diarrheal disease, impregnated mosquito nets for malaria control, and iodized salt. PSI is the largest, most cost-efficient private social marketing entity in the world in terms of products delivered and number of projects. In 1995 alone, PSI social marketing programs distributed more than 480 million condoms, 17.5 million cycles of pills, and approximately 36 million sachets of ORS. It is the only private international social marketing entity that focuses on serving lower-income people and distributes such a wide range of products for so many types of health interventions.

PSI has distributed more products worldwide than any other private organization engaged in social marketing. Its overall cost per couple-year-of-protection is low, including commodities, thereby making PSI the most cost-efficient social marketing entity serving lower income populations. PSI is also the first organization to market other noncontraceptive health products (e.g., ORS, antibiotics, and iodized salt) at low prices in the private sector. PSI works to: 1) foster local industry and service capabilities (e.g., market research, advertising, distribution, and manufacturing) related to health; and 2) train local organizations and individuals. PSI works in more than 40 Asian, African, and LAC countries.

B. COLLABORATING AGENCIES

1. CARE

CARE was founded in 1945 to provide humanitarian relief to those whose lives were devastated by World War II. Since then, CARE has helped more than a billion needy people in 125 countries. One of CARE's primary goals is to improve and protect the health of individuals and communities by achieving improvements in health knowledge and practices, increasing the quality and availability of health services, and improving the environmental and social conditions that lead to better health. Technical approaches include primary health care, reproductive health care, agriculture and natural resource conservation, food assistance, emergency response, and small economic development. In fiscal 1995 alone, CARE's activities touched the lives of 53.9 million people in 66 countries through: 1) 74 health projects in 27 countries reaching 8.8 million people, the majority being women of child-bearing age and children under five; 2) 22 population and reproductive health projects in 18 countries that directly assisted 496,057 needy people; 3) 40 emergency projects in 15 countries that assisted 15 million victims of war, ethnic strife, and natural disasters; and 4) A total of 390,068 metric tons of food distributed to 20 million needy people worldwide.

2. Catholic Relief Services

Catholic Relief Services (CRS) was founded in 1943 by the Catholic bishops of the United States to assist poor and disadvantaged peoples outside this country. In undertaking program activities, the organization collaborates with both religious and nonsectarian NGOs and with local governments. CRS has a budget of approximately \$317 million (1994). In 1994, CRS provided more than \$145 million for development assistance and \$146 million for disaster and emergency assistance. CRS funds programs in more than 70 countries with residential staff in 45.

Part of CRS' philosophy is to access the technical expertise of local individuals and organizations in designing and implementing projects. Staff work with a variety of NGOs, ministries, and local and expatriate consultants to help achieve development goals identified by the beneficiary populations and local counterparts. CRS has also benefitted from training sponsored by the Child Survival Support Program, the Centers for Disease Control and Prevention, BASICS, and Wellstart.

3. The World Vision Partnership (WV)

World Vision (WV) is an international partnership comprising 82 national offices and a coordinating international office. Since 1950, WV has been actively involved in programs that benefit children and their communities. In 1995, there were approximately 49 million beneficiaries, 1.1 million of which were sponsored children. Currently, WV is implementing nearly 5,000 relief and community development projects. Approximately

70% of these projects include a health component, such as breastfeeding, growth monitoring, oral rehydration therapy, nutrition, malaria, AIDS, acute respiratory infection, and immunization. At present, the aggregate value of resources raised to support all operations is more than \$400 million annually.

World Vision's objectives are carried out through an international partnership of 17 support offices, an international office, and 61 field offices managing and supporting programs in more than 100 nations. WV conducts emergency relief, community development, and leadership training projects that include health care and education, vocational training, agricultural production, and income generation. Traditionally, programs have targeted children and their communities through child sponsorship. WV is, however, also involved in large-scale, grant-funded projects in child survival, water resource management, reforestation, agriculture, and education. During the past eight years, WVRD's commitment to child survival and health activities has deepened. All regional offices now have health advisers, and WV is highly interested in strengthening the BCM component of its programs.

4. University Research Corporation (URC)

URC will provide on-call technical assistance in operations research, quality assurance and cost studies. Through the USAID Quality Assurance Project, URC has used operations research, training, and TA approaches to build quality improvement teams, determine client and community needs and expectations, conduct quality assessments of specific services, and structure QA monitoring systems. Under the LAC Health and Nutrition Sustainability contract, URC documented the costs and effectiveness of nutrition interventions. It has also created a guide to cost-effectiveness analysis of BF promotion.

5. Macro International (MI)

Macro's international reputation comes primarily from its work with the Demographics and Health Surveys (DHS) Project. It offers specialized skills in organizing and analyzing nationally representative surveys on fertility, infant and child mortality, family planning, maternal and child health, and child nutrition and in disseminating the findings to program managers and policy-makers. Macro has also conducted specialized analyses of data for AED's SARA Project, for example, Macro prepared country nutrition fact books for priority African countries.

6. Pathfinder

Pathfinder International has more than four decades of experience in providing technical assistance, funding, and supplies to public and private organizations in 80 countries to expand the availability, quality, and sustainability of family planning, maternal child health, and reproductive health programs. It is a nonprofit organization committed to increasing the number of individuals in developing countries who have access to, and voluntarily use, high-quality family planning and related health services.

VI. PERFORMANCE EVALUATION

PROJECTS	OBJECTIVE	REFERENCE	EVALUATION
<p>Communication for Child Survival; HEALTHCOM I & II (1985-1994) Worldwide</p>	<p>Develop and apply a public health communication methodology to the prevention and treatment of childhood illness including micronutrient deficiencies. Phase I focused on demonstration and dissemination of health communications strategies in 15 countries. Phase II focused on sustainability of behavior changes and institutionalization of effective health communication capacities.</p>	<p>USAID, Bureau for Science & Technology, Offices of Health & Education; Regional USAID Bureaus; USAID missions in project countries. Contact: R. Clay; H. Fluty (703)875-4761; (703)875-4526</p>	<p>"Overall, the team (Final Evaluation) found that HEALTHCOM has completed nearly all its objectives and can be considered a successful project. Both AED and USAID/Office of Health staff have earned high marks for their professionalism and conscientiousness in managing the project.... One of the strengths of HEALTHCOM is that it has effectively integrated the principles and practices of a number of different fields into its methodology, including communication research, development communication, social marketing, applied anthropology, instructional design, and behavioral psychology.... HEALTHCOM and its subcontractors are to be commended on the clarity of presentation in their reports.... HEALTHCOM has assembled a very impressive research portfolio, both in terms of quantity and in the uniformly high quality of work.... HEALTHCOM produced important media products in the course of supporting various child-survival interventions.... HEALTHCOM designed a wide range of promotional and educational materials."</p>
<p>Nutrition Communication Project (1987- 1995) Worldwide</p>	<p>Assess maternal and child nutrition problems, including micronutrient deficiencies. Create, implement, and evaluate communication programs that promote sound nutrition. Transfer technical skills in social marketing, communications, and nutrition education to personnel in organizations concerned with maternal and child health.</p>	<p>USAID; Office of Nutrition Contact: E. Chung (703)875-4074</p>	<p>"In terms of management of the Nutrition Communications Project, the final evaluation found that: (1) "AED continues to perform effectively in managing NCP activities and has excellent working relationships with R&D/N...NCP benefits from a highly professional and effective management team..."; (2) the project successfully collaborated with host-country counterpart institutions, PVOs/NGOs, and other donor institutions, and responded to field requests in a timely manner; (3) for the most part, project counterparts were satisfied with the technical assistance provided by NCP; and (4) project monitoring and evaluation strategies were thorough and resulted in a dynamic and flexible strategy." "Regarding the achievement of the project's original goals, purpose and outputs, this evaluation concludes that: the project will likely have accomplished most of its objectives by its current PACD, March 1995." (Final Evaluation) Project evaluations found improvements in behavior in all five country projects and also in nutritional status.</p>

PROJECTS	OBJECTIVE	REFERENCE	EVALUATION
Population Communication Services, I-V (1982-2000) Worldwide	Develop greater public awareness of family planning and promote wider use of freely chosen contraceptive methods; offer technical and financial assistance to agencies.	The Johns Hopkins University (prime contractor) Contact: J. Rimon (301)659-6273	External evaluations of the project have identified no problems related to AED subcontract.
Female Secondary School Assistance Program (1992-1994) Bangladesh	Assist in launching communications program aimed at promoting public awareness of girls attending secondary schools.	Japanese Special Fund, World Bank Contact: C. Verzossa (202)458-7379	Quotes from IDA representatives, "...best designed project IDA has ever supported in Bangladesh-and the only one to stimulate broad national interest." "Community support became so widespread that the government decided to expand the project concept into a new national program in 460 rural subdistricts."
Pakistan Child Survival Project (1990-1993) Pakistan	Assist government and USAID in their goal of improving child survival	Management Sciences for Health (prime contractor) Contact: D. Silimperi (703)516-2555 USAID Pakistan Mission	Government, NGOs, health professionals, and international agencies met in a seminar to determine how the project could be continued after funding ended. A special government resolution was passed, "Islamabad Health Education and Communication Resolution."
School Health Evaluation Support Project for Centers for Disease Control & Prevention Division of Adolescent School Health (1993-1996) USA	Support state education departments and selected local school systems to evaluate HIV/STD education programs.	Center for Disease Control, Prevention Division of Adolescent School Health Contact: Z. Stevenson (404)488-5387	Contract has been modified twice from \$2.5 million to \$5.4 million. More than 40 letters on file from stakeholders attesting to effectiveness of AED involvement
CDC AIDS Communication Support Project (1991-1996) USA	Support national, state, and local organizations to use health communications, behavioral sciences, and social marketing strategies for HIV prevention.	Centers for Disease Control Contact: M. Sheppherd (404)639-0956	Project size increased from \$12 million to more than \$18 million based on quality performance. Numerous letters provided attesting to satisfaction.

PROJECTS	OBJECTIVE	REFERENCE	EVALUATION
SAID Research & Reference Services (1990-1995) Washington, D.C.	Provide information services related to development policies, programs and experience, to USAID and to the development community.	USAID; Development Information Division of the Center for Development Information & Evaluation, Bureau for Policy & Program Coordination Contact: M. Brown (703)875-4849	One of many quotes from AID bureaus and offices found in the 1995 annual report, "These pages (briefings) will be used as models for others in AID to use in doing their own additional studies."
Support for Analysis and Research in Africa (SARA) (1992-1996)	Assist USAID and governments in increasing efficiency, effectiveness, equity and sustainability of health, nutrition, education and family planning systems.	USAID; Bureau for Africa Contact: H. Sukin (202)647-8907	Mid-term evaluation in 1994 and results were positive, thereby leading to extended project through 1997.
Sustainable Approaches for Nutrition in Africa (SANA) (1995-1998)	Promote effective nutrition programs by supporting selected activities consistent with Bellagio Declaration and global initiatives research and training for nutrition.	USAID; Bureau for Africa, Office of Sustainable Development Contact: H. Sukin (202)647-8907	Exceeded expectation to have one African institutional agreement in place. To date, four agreements have been secured.
Technologies for Primary Health Care (PRITECH); Phases I & II (1983-1993) Worldwide	Assist developing countries in reducing infant and child mortality through oral rehydration therapy and other proven methods.	Management Sciences for Health (prime contractor) Contact: (phase I) J. Alden; (phase II) G. Patterson (703)516-2555	Phase I was renewed in 1989 based on highly positive evaluation. Phase II evaluation results were also positive, thereby leading to the creation of the BASICS Project.

ATTACHMENT 3

STANDARD PROVISIONS

3.1 INELIGIBLE COUNTRIES (MAY 1986)

Unless otherwise approved by the USAID Agreement Officer, funds will only be expended for assistance to countries eligible for assistance under the Foreign Assistance Act of 1961, as amended, or under acts appropriating funds for foreign assistance.

3.2 NONDISCRIMINATION (MAY 1986)

(This provision is applicable when work under the grant is performed in the U.S. or when employees are recruited in the U.S.)

No U.S. citizen or legal resident shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity funded by this grant on the basis of race, color, national origin, age, handicap, or sex.

3.3 U.S. OFFICIALS NOT TO BENEFIT (NOV 1985)

No member of or delegate to the U.S. Congress or resident U.S. Commissioner shall be admitted to any share or part of this agreement or to any benefit that may arise therefrom; but this provision shall not be construed to extend to this award if made with a corporation for its general benefit.

3.4 INVESTMENT PROMOTION (JAN 1994)

No funds or other support provided hereunder may be used in a project or activity reasonably likely to involve the relocation or expansion outside of the United States of an enterprise located in the United States if non-U.S. production in such relocation or expansion replaces some or all of the production of, and reduces the number of employees at, said enterprise in the United States.

No funds or other support provided hereunder may be used in a project or activity the purpose of which is the establishment or development in a foreign country of any export processing zone or designated area where the labor, environmental, tax, tariff, and safety laws of the country would not apply, without the prior written approval of USAID.

No funds or other support provided hereunder may be used in a project or activity which contributes to the violation of internationally recognized rights of workers in the recipient country, including those in any designated zone or area in that country.

3.4 (Continued)

This provision must be included in all subagreements.

3.5 NONLIABILITY (NOV 1985)

USAID does not assume liability for any third party claims for damages arising out of this Agreement.

3.6 AMENDMENT (NOV 1985)

The Agreement may be amended by formal modifications to the basic agreement document or by means of an exchange of letters between the Agreement Officer and an appropriate official of the Recipient.

3.7 NOTICES (NOV 1985)

Any notice given by USAID or the recipient shall be sufficient only if in writing and delivered in person, mailed, or cabled as follows:

To the USAID Agreement Officer, at the address specified in the agreement.

To recipient, at recipient's address shown in the agreement or to such other address designated within the agreement.

Notices shall be effective when delivered in accordance with this provision, or on the effective date of the notice, whichever is later.

3.8 OMB APPROVAL UNDER THE PAPERWORK REDUCTION ACT (AUG 1992)

(This provision is applicable whenever any of the seven provisions below containing an information collection requirement is included in the grant.)

Information collection requirements imposed by this grant are covered by OMB approval number 0412-0510; the current expiration date is 8/31/97. Identification of the Standard Provision containing the requirement and an estimate of the public reporting burden (including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information) are set forth below.

Standard Provision	Burden Estimate
International Air Travel and Transportation	1 (hour)

100

3.8 (Continued)

Ocean Shipment of Goods	.5
Patent Rights	.5
Publications	.5
Negotiated Indirect Cost Rates - Predetermined and Provisional	1
Voluntary Population Planning	.5
Protection of the Individual as a Research Subject	1

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Procurement Policy and Evaluation Staff (M/OP/E), Agency for International Development, Washington, DC 20523-1435 and to the Office of Management and Budget, Paperwork Reduction Project (0412-0510), Washington, DC 20503.

3.9 INTERNATIONAL AIR TRAVEL AND TRANSPORTATION (DEC 1995)**(a) PRIOR BUDGET APPROVAL**

In accordance with OMB Cost Principles, direct charges for foreign travel costs are allowable only when each foreign trip has received prior budget approval. Such approval will be deemed to have been met when:

- (1) The trip is identified. Identification is accomplished by providing the following information: the number of trips, the number of individuals per trip, and the destination country(s);
- (2) The information noted at (a) (1) above is incorporated in: the proposal, the program description or schedule of the award, the annual workplan (initial or revisions), or amendments to the award; and
- (3) The costs related to the travel are incorporated in the approved budget of the award.

The Agreement Officer may approve travel which has not been incorporated in writing as required by paragraph (a)(2). In such case, a copy of the Agreement Officer's approval must be included in the agreement file.

(b) NOTIFICATION

3.9 (Continued)

(1) As long as prior budget approval has been met in accordance with paragraph (a) above, a separate Notification will not be necessary unless:

- (i) The primary purpose of the trip is to work with USAID Mission personnel, or
- (ii) The recipient expects significant administrative or substantive programmatic support from the Mission.

Neither the USAID Mission nor the Embassy will require Country Clearance of employees or contractors of USAID Recipients.

(2) Where notification is required in accordance with paragraph (1) (i) or (ii) above, the recipient will observe the following standards:

- (i) Send a written notice to the cognizant USAID Technical Office in the Mission. If the recipient's primary point of contact is a Technical Officer in USAID/W, the recipient may send the notice to that person. It will be the responsibility of the USAID/W Technical Officer to forward the notice to the field.
- (ii) The notice should be sent as far in advance as possible, but at least 14 calendar days in advance of the proposed travel. This notice may be sent by fax or e-mail. The recipient should retain proof that notification was made.
- (iii) The notification shall contain the following information: the award number, the cognizant Technical Officer, the traveler's name (if known), date of arrival, and the purpose of the trip.
- (iv) The USAID Mission will respond only if travel has been denied. It will be the responsibility of the Technical Officer in the Mission to contact the recipient within 5 working days of having received the notice if the travel is denied. If the recipient has not received a response within the time frame, the recipient will be considered to have met these standards for notification, and may travel.
- (v) If a subrecipient is required to issue a Notification, as per this section, the

3.9 (Continued)

subrecipient may contact the USAID Technical Officer directly, or the prime may contact USAID on the subrecipient's behalf.

(c) SECURITY ISSUES

Recipients are encouraged to obtain the latest Department of State Travel Advisory Notices before traveling. These Notices are available to the general public and may be obtained directly from the State Department, or via Internet.

Where security is a concern in a specific region, recipients may choose to notify the US Embassy of their presence when they have entered the country. This may be especially important for longterm posting.

(d) USE OF U.S. - OWNED LOCAL CURRENCY

Travel to certain countries shall, at USAID's option, be funded from U.S. - owned local currency. When USAID intends to exercise this option, USAID will either issue a U.S. Government S.F. 1169, Transportation Request (GTR) which the grantee may exchange for tickets, or issue the tickets directly. Use of such U.S.-owned currencies will constitute a dollar charge to this grant.

(e) THE FLY AMERICA ACT

- (1) The Fly America Act requires that all air travel and shipments under this award must be made on U.S. flag air carriers to the extent service by such carriers is available. The Comptroller General of the United States, by Decision B-138942 of June 17, 1975, as amended March 31, 1981, provided guidelines for implementation of Section 5 of the International Air Transportation Fair Competitive Practices Act (Fly America Act) of 1974 (49 U.S.C. 1517, as amended by Section 21 of Public Law 96-192).
- (2) U.S. flag air carrier service is considered available even though:
 - (i) Comparable or a different kind of service can be provided at less cost by a foreign air carrier;
 - (ii) Foreign air carrier service is preferred by or is more convenient for the agency or traveler; or
 - (iii) Service by a foreign air carrier can be paid for in excess foreign currency, unless U.S. flag air carriers decline to accept excess or near excess

3.9 (Continued)

- foreign currencies for transportation payable only out of such monies.
- (3) In determining availability of a U.S. flag air carrier, the following scheduling principles should be followed unless their application results in the last or first leg of travel to or from the United States being performed by foreign air carrier:
- (i) U.S. flag air carrier service available at point of origin shall be used to destination or in the absence of direct or through service to the farthest interchange point on a usually traveled route;
 - (ii) Where an origin or interchange point is not served by U.S. flag air carrier, a foreign air carrier shall be used only to the nearest interchange point on a usually traveled route to connect with U.S. flag air carrier service; or
 - (iii) Where a U.S. flag air carrier involuntarily reroutes the traveler via a foreign air carrier, the foreign air carrier may be used notwithstanding the availability of alternative U.S. flag air carrier service.
- (4) Travel to and from the United States: For travel between a gateway airport in the United States (the last U.S. airport from which the traveler's flight departs or the first U.S. airport at which the traveler's flight arrives) and a gateway airport abroad (that airport from which the traveler last embarks enroute to the U.S. or at which the traveler first debarks incident to travel from the U.S.), passenger service by U.S. flag air carrier will not be considered available if:
- (i) The gateway airport abroad is the traveler's origin or destination airport, and the use of U.S. flag air carrier service would extend the time in a travel status including delay at origin and accelerated arrival at destination, by at least 24 hours more than travel by foreign air carrier; or
 - (ii) The gateway airport abroad is an interchange point, and the use of U.S. flag air carrier service would require the traveler to wait six hours or more to make connections at that point or, delayed departure from or accelerated arrival at the gateway airport in the U.S. would extend the time in a travel status by at least six hours

3.9 (Continued)

more than travel by foreign air carrier.

- (5) Travel Between Points Outside the United States: Use of a foreign-flag air carrier is permissible if:
- (i) Travel by foreign air carrier would eliminate two or more aircraft changes enroute;
 - (ii) Where one of the two points abroad is the gateway airport enroute to or from the United States and the use of a U.S. flag air carrier would extend the time in a travel status by at least six hours more than travel by foreign air carrier; including accelerated arrival at the overseas destination or delayed departure from the overseas origin as well as delay at the gateway airport or other interchange point abroad; or
 - (iii) The travel is not part of a trip to or from the United States and the use of a U.S. flag air carrier would extend the time in a travel status by at least six hours more than travel by foreign air carrier including delay at origin, delay enroute and accelerated arrival at destination.
- (6) Short Distance Travel: Use of a foreign-flag air carrier is permissible, regardless of origin and destination, if the elapsed travel time on a scheduled flight from origin to destination airport by a foreign flag air carrier is three hours or less and service by a US flag air carrier would double the travel time.
- (7) Use of foreign air carrier service may be deemed necessary if a U.S. flag air carrier otherwise available cannot provide the foreign air transportation needed, or if use of such service will not accomplish the agency's mission. Travel and transportation on non-free world air carriers are not reimbursable under this award.
- (8) Where U.S. Government funds are used for reimbursement on other than U.S. flag air carriers for international transportation, the recipient shall include a certification in their own files involving such transportation which is essentially as follows:

"CERTIFICATION OF UNAVAILABILITY OF U.S. FLAG AIR CARRIERS. I hereby certify that the transportation service for personnel (and their personal effects) or property by certificated air carrier was unavailable for the following reason(s)." (State appropriate reason(s) as set forth above).

3.9 (Continued)

(f) COST PRINCIPLES

The recipient will be reimbursed for travel and the reasonable cost of subsistence, post differentials and other allowances paid to employees in international travel status in accordance with the recipient's applicable cost principles and established policies and practices which are uniformly applied to federally financed and other activities of the grantee.

If the recipient does not have written established policies regarding travel costs, the standard for determining the reasonableness or reimbursement for overseas allowance will be the Standardized Regulations (Government Civilians, Foreign Areas), published by the U.S. Department of State, as from time to time amended. The most current subsistence, post differentials, and other allowances may be obtained from the Agreement Officer.

(g) SUBAWARDS

This provision will be included in all subawards and contracts which require air travel and transportation under this award.

3.10 AID ELIGIBILITY RULES FOR GOODS AND SERVICES (AUG 1992)

(This provision is applicable when goods or services are procured under the grant.)

(a) Ineligible and Restricted Goods and Services: If AID determines that the grantee has procured any of the restricted or ineligible goods and services specified below, or has procured goods and services from unauthorized sources, and has received reimbursement for such purpose without the prior written authorization of the grant officer, the grantee agrees to refund to AID the entire amount of the reimbursement. AID's policy on ineligible and restricted goods and services is contained in Chapter 4 of AID Handbook 1, Supplement B, entitled "Procurement Policies".

(1) Ineligible Goods and Services. Under no circumstances shall the grantee procure any of the following under this grant:

- (i) Military equipment,
- (ii) Surveillance equipment,
- (iii) Commodities and services for support of police or other law enforcement activities,
- (iv) Abortion equipment and services,

3.10 (Continued)

- (v) Luxury goods and gambling equipment, or
 - (vi) Weather modification equipment.
- (2) Ineligible Suppliers. Funds provided under this grant shall not be used to procure any goods or services furnished by any firms or individuals whose name appears on the "Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs." AID will provide the grantee with a copy of these lists upon request.
- (3) Restricted Goods. The grantee shall not procure any of the following goods and services without the prior written authorization of the grant officer:
- (i) Agricultural commodities,
 - (ii) Motor vehicles,
 - (iii) Pharmaceuticals,
 - (iv) Pesticides,
 - (v) Rubber compounding chemicals & plasticizers,
 - (vi) Used equipment,
 - (vii) U.S. Government-owned excess property, or
 - (viii) Fertilizer.
- (b) Source and Nationality: The eligibility rules for goods and services based on source and nationality are divided into two categories. One applies when the total procurement element during the life of the grant is over \$250,000, and the other applies when the total procurement element during the life of the grant is not over \$250,000, or the grant is funded under the Development Fund for Africa (DFA) regardless of the amount. The total procurement element includes procurement of all goods (e.g., equipment, materials, supplies) and services. Guidance on the eligibility of specific goods or services may be obtained from the grant officer. AID policies and definitions on source (including origin and componentry) and nationality are contained in Chapter 5 of AID Handbook 1, Supplement B, entitled "Procurement Policies."
- (1) For DFA funded grants or when the total procurement element during the life of this grant is valued at \$250,000 or less, the following rules apply:
- (i) The authorized source for procurement of all goods and services to be reimbursed under the grant is AID Geographic Code 935, "Special Free World," and such goods and services must meet the source (including origin and componentry) and nationality requirements set forth in Handbook 1, Supp. B, Chapter 5 in accordance with the following order of

3.10 (Continued)

preference:

- (A) The United States (AID Geographic Code 000),
 - (B) The Cooperating Country,
 - (C) "Selected Free World" countries (AID Geographic Code 941), and
 - (D) "Special Free World" countries (AID Geographic Code 935).
- (ii) Application of order of preference: When the grantee procures goods and services from other than U.S. sources, under the order of preference in paragraph (b)(1)(i) above, the grantee shall document its files to justify each such instance. The documentation shall set forth the circumstances surrounding the procurement and shall be based on one or more of the following reasons, which will be set forth in the grantee's documentation:
- (A) The procurement was of an emergency nature, which would not allow for the delay attendant to soliciting U.S. sources,
 - (B) The price differential for procurement from U.S. sources exceeded by 50% or more the delivered price from the non-U.S. source,
 - (C) Compelling local political considerations precluded consideration of U.S. sources,
 - (D) The goods or services were not available from U.S. sources, or
 - (E) Procurement of locally available goods and services, as opposed to procurement of U.S. goods and services, would best promote the objectives of the Foreign Assistance program under the grant.
- (2) When the total procurement element exceeds \$250,000 (unless funded by DFA), the following applies: Except as may be specifically approved or directed in advance by the grant officer, all goods and services financed with U.S. dollars, which will be reimbursed under this grant must meet the source (including origin and componentry) and nationality requirements set forth in Handbook 1, Supp B, Chapter 5 for the authorized geographic code specified in the schedule of this grant. If none is specified, the authorized source is Code 000, the United States.

3.10 (Continued)

- (c) Marine Insurance: The eligibility of marine insurance is determined by the country in which it is placed. Insurance is placed in a country if payment of the insurance premium is made to, and the insurance policy is issued by an insurance company located in that country. Eligible countries for placement are governed by the authorized geographic code, except that if Code 941 is authorized, the Cooperating Country is also eligible. Section 604(d) of the Foreign Assistance Act requires that if a recipient country discriminates by statute, decree, rule, or practice with respect to AID-financed procurement against any marine insurance company authorized to do business in the U.S., then any AID-financed commodity shipped to that country shall be insured against marine risk and the insurance shall be placed in the U.S. with a company or companies authorized to do marine insurance business in the U.S.
- (d) Ocean and air transportation shall be in accordance with the applicable provisions contained within this grant.
- (e) Printed or Audio-Visual Teaching Materials: If the effective use of printed or audio-visual teaching materials depends upon their being in the local language and if such materials are intended for technical assistance projects or activities financed by AID in whole or in part and if other funds including U.S.-owned or U.S.-controlled local currencies are not readily available to finance the procurement of such materials, local language versions may be procured from the following sources, in order of preference:
- (1) The United States (AID Geographic Code 000),
 - (2) The Cooperating Country,
 - (3) "Selected Free World" countries (AID Geographic Code 941), and
 - (4) "Special Free World" countries (AID Geographic Code 899).
- (f) Special Restrictions on the Procurement of Construction or Engineering Services: Section 604(g) of the Foreign Assistance Act provides that AID funds may not be used for "procurement of construction or engineering services from advanced developing countries, eligible under Geographic Code 941, which have attained a competitive capability in international markets for construction services or engineering services." In order to insure eligibility of a Code 941 contractor for construction or engineering services, the grantee shall obtain the grant officer's prior approval for any such contract.

3.10 (Continued)

- (g) This provision will be included in all subagreements which include procurement of goods or services over \$5,000.

[End of Provision]

3.11 SUBAGREEMENTS (FEB 1995)

(This provision is applicable when subgrants or cooperative agreements are financed under the grant.)

- (a) All provisions of 22 CFR 226 and all Standard Provisions attached to this agreement shall be applied to subrecipients which meet the definition of "Recipient" in that part, unless a section specifically excludes a subrecipient from coverage.
- (b) Any subawards made with entities which fall outside of the definition of "Recipient" (such as Non-US organizations) will be made in accordance with USAID Handbook 13, Appendix 4D "Standard Provisions for Non-US Nongovernmental Grantees" except for the "Accounting, Audit and Records" Standard Provision. Recipients must apply the following guidelines when subawarding to entities which do not meet the definition of "Recipient".
- (c) A recipient that receives a USAID award and provides \$25,000 or more of it during its fiscal year to a sub-recipient (whether meeting the definition of "Recipient" or not) shall follow the guidelines of OMB Circular A-133. The recipient shall ensure that:
- (1) The nonprofit institution sub-recipients that receive \$25,000 or more have met the audit requirements of OMB Circular A-133, and that sub-recipients subject to OMB Circular A-128 have met the audit requirements of that Circular;
 - (2) Appropriate corrective action is taken within six months after receipt of the sub-recipient audit report in instances of noncompliance with Federal laws and regulations;
 - (3) They consider whether sub-recipients audits necessitate adjustment of the grantee's own records; and
 - (4) Each sub-recipient is required to permit independent auditors to have access to the records and financial statements as necessary for the grantee to comply with OMB Circular A-133.

3.12 LOCAL COST FINANCING (JUN 1993)

This provision is applicable when the total estimated procurement element for the life of the grant is valued over \$250,000 and the grant is not funded under DFA.

- (a) Financing local procurement involves the use of appropriated funds to finance the procurement of goods and services supplied by local businesses, dealers or producers, with payment normally being in the currency of the cooperating country.
- (b) All locally financed procurements must be covered by source and nationality waivers as set forth in AID Handbook 1, Supplement B, Chapter 5 with the following exceptions:
 - (1) Locally available commodities of U.S. origin, which are otherwise eligible for financing, if the value of the transaction is estimated not to exceed \$100,000 exclusive of transportation costs.
 - (2) Commodities of geographic code 935 origin if the value of the transaction does not exceed the local currency equivalent of \$5,000.
 - (3) Professional Services Contracts estimated not to exceed \$250,000.
 - (4) Construction Services Contracts estimated not to exceed \$5,000,000.
 - (5) Commodities and services available only in the local economy (no specific per transaction value applies to this category). This category includes the following items:
 - (i) Utilities including fuel for heating and cooking, waste disposal and trash collection;
 - (ii) Communications - telephone, telex, fax, postal and courier services;
 - (iii) Rental costs for housing and office space;
 - (iv) Petroleum, oils and lubricants for operating vehicles and equipment;
 - (v) Newspapers, periodicals and books published in the cooperating country;
 - (vi) Other commodities and services and related expenses that, by their nature or as a practical matter, can only be acquired, performed, or

3.12 (Continued)

incurred in the cooperating country, e.g., vehicle maintenance, hotel accommodations, etc.

- (c) All procurements under grants financed with DFA funds and grants with procurement elements of \$250,000 or less are subject to the guidance provided under standard provision "AID Eligibility Rules for Goods and Services."
- (d) Ineligible Goods and Services: Under no circumstances shall the grantee procure any of the following under this grant:
 - (1) Military equipment,
 - (2) Surveillance equipment,
 - (3) Commodities and services for support of police or other law enforcement activities,
 - (4) Abortion equipment and services,
 - (5) Luxury goods and gambling equipment, or
 - (6) Weather modification equipment.
- (e) Ineligible Suppliers: Funds provided under this grant shall not be used to procure any goods or services furnished by any firm or individual whose name appears on the "Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs." AID will provide the grantee with these lists upon request.
- (f) Restricted Goods: The grantee shall not procure any of the following goods and services without the prior written authorization of the grant officer:
 - (1) Agricultural commodities,
 - (2) Motor vehicles,
 - (3) Pharmaceuticals,
 - (4) Pesticides,
 - (5) Rubber compounding chemicals and plasticizers,
 - (6) Used equipment,
 - (7) U.S. Government-owned excess property, or
 - (8) Fertilizer.

3.12 (Continued)

- (g) If AID determines that the grantee has procured any of the restricted or ineligible goods and services specified in subparagraphs c. through e. above, or has received reimbursement for such purpose without the prior written authorization of the grant officer, the grantee agrees to refund to AID the entire amount of the reimbursement.
- (h) This provision will be included in all subagreements where local procurement of goods or services will be required.

3.13 PUBLICATIONS (AUG 1992)

(This provision is applicable when publications are financed under the grant.)

- (a) AID shall be prominently acknowledged in all publications, videos or other information/media products funded or partially funded through this grant, and the product shall state that the views expressed by the author(s) do not necessarily reflect those of AID. Acknowledgements should identify the sponsoring AID Office and Bureau or Mission as well as the U.S. Agency for International Development substantially as follows:

"This [publication, video or other information/media product (specify)] was made possible through support provided by the G/PHN/HN, Global, U.S. Agency for International Development, under the terms of Grant No. HRN-A-00-97-00007-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development."

- (b) Unless the grantee is instructed otherwise by the cognizant technical office, publications, videos or other information/media products funded under this grant and intended for general readership or other general use will be marked with the AID logo and/or U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT appearing either at the top or at the bottom of the front cover or, if more suitable, on the first inside title page for printed products, and in equivalent appropriate location in videos or other information/media products. Logos and markings of co-sponsors or authorizing institutions should be similarly located and of similar size and appearance.
- (c) The grantee shall provide the AID technical officer and POL/CDIE, Room 215, SA-18, Washington, DC 20523-1802, with one copy each of all published works developed under the grant and with lists of other written work produced under the grant.
- (d) In the event grant funds are used to underwrite the cost of

3.13 (Continued)

publishing, in lieu of the publisher assuming this cost as is the normal practice, any profits or royalties up to the amount of such cost shall be credited to the grant unless the schedule of the grant has identified the profits or royalties as program income.

- (e) Except as otherwise provided in the terms and conditions of the grant, the author or the recipient is free to copyright any books, publications, or other copyrightable materials developed in the course of or under this grant, but AID reserves a royalty-free nonexclusive and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use the work for Government purposes.

3.14 REGULATIONS GOVERNING EMPLOYEES (AUG 1992)

(The following applies to the grantee's employees who are not citizens of the cooperating country.)

- (a) The grantee's employees shall maintain private status and may not rely on local U.S. Government offices or facilities for support while under this grant.
- (b) The sale of personal property or automobiles by grantee employees and their dependents in the foreign country to which they are assigned shall be subject to the same limitations and prohibitions which apply to direct-hire AID personnel employed by the Mission, including the rules contained in 22 CFR Part 136, except as this may conflict with host government regulations.
- (c) Other than work to be performed under this grant for which an employee is assigned by the grantee, no employee of the grantee shall engage directly or indirectly, either in the individual's own name or in the name or through an agency of another person, in any business, profession, or occupation in the foreign countries to which the individual is assigned, nor shall the individual make loans or investments to or in any business, profession or occupation in the foreign countries to which the individual is assigned.
- (d) The grantee's employees, while in a foreign country, are expected to show respect for its conventions, customs, and institutions, to abide by its applicable laws and regulations, and not to interfere in its internal political affairs.
- (e) In the event the conduct of any grantee employee is not in accordance with the preceding paragraphs, the grantee's chief of party shall consult with the AID Mission Director and the employee involved and shall recommend to the grantee a course of action with regard to such employee.

3.14 (Continued)

- (f) The parties recognize the rights of the U.S. Ambassador to direct the removal from a country of any U.S. citizen or the discharge from this grant of any third country national when, in the discretion of the Ambassador, the interests of the United States so require.
- (g) If it is determined, under either (e) or (f) above, that the of such employee shall be terminated, the grantee shall use its best efforts to cause the return of such employee to the United States, or point of origin, as appropriate.

3.15 PARTICIPANT TRAINING (AUG 1992)

(This provision is applicable when any participant training is financed under the grant.)

- (a) Definition: A participant is any non-U.S. individual being trained under this grant outside of that individual's home country.
- (b) Application of Handbook 10: Participant training under this grant shall comply with the policies established in AID Handbook 10, Participant Training, except to the extent that specific exceptions to Handbook 10 have been provided in this grant with the concurrence of the Office of International Training. (Handbook 10 may be obtained by submitting a request to the Office of International Training (R&D/OIT), Agency for International Development, Washington, D.C. 20523.)
- (c) Orientation: In addition to the mandatory requirements in Handbook 10, grantees are strongly encouraged to provide, in collaboration with the Mission training officer, predeparture orientation (see Chapter 13 of Handbook 10) and orientation in Washington at the Washington International Center (see Chapter 18D of Handbook 10). The latter orientation program also provides the opportunity to arrange for home hospitality in Washington and elsewhere in the United States through liaison with the National Council for International Visitors (NCIV). If the Washington orientation is determined not to be feasible, home hospitality can be arranged in most U.S. cities if a request for such is directed to the grant officer, who will transmit the request to NCIV through R&D/OIT.

3.16 VOLUNTARY POPULATION PLANNING (JUN 1993)

(This provision is applicable to all grants involving any aspect of voluntary population planning activities.)

- (a) Voluntary Participation:

3.16 (Continued)

- (1) The grantee agrees to take any steps necessary to ensure that funds made available under this grant will not be used to coerce any individual to practice methods of family planning inconsistent with such individual's moral, philosophical, or religious beliefs. Further, the grantee agrees to conduct its activities in a manner which safeguards the rights, health and welfare of all individuals who take part in the program.
 - (2) Activities which provide family planning services or information to individuals, financed in whole or in part under this agreement, shall provide a broad range of family planning methods and services available in the country in which the activity is conducted or shall provide information to such individuals regarding where such methods and services may be obtained.
- (b) Voluntary Participation Requirements For Sterilization Programs:
- (1) None of the funds made available under this grant shall be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to practice sterilization.
 - (2) The grantee shall ensure that any surgical sterilization procedures supported in whole or in part by funds from this grant are performed only after the individual has voluntarily gone to the treatment facility and has given informed consent to the sterilization procedure. Informed consent means the voluntary, knowing assent from the individual after being advised of the surgical procedures to be followed, the attendant discomforts and risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and the option to withdraw consent anytime prior to the operation. An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducement or any element of force, fraud, deceit, duress, or other forms of coercion or misrepresentation.
 - (3) Further, the grantee shall document the patient's informed consent by (i) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the individual and by the attending physician or by the authorized assistant of

3.16 (Continued)

the attending physician; or (ii) when a patient is unable to read adequately a written certification by the attending physician or by the authorized assistant of the attending physician that the basic elements of informed consent above were orally presented to the patient, and that the patient thereafter consented to the performance of the operation. The receipt of the oral explanation shall be acknowledged by the patient's mark on the certification and by the signature or mark of a witness who shall be of the same sex and speak the same language as the patient.

- (4) Copies of informed consent forms and certification documents for each voluntary sterilization procedure must be retained by the grantee for a period of three years after performance of the sterilization procedure.

(c) Prohibition on Abortion-Related Activities:

- (1) No funds made available under this grant will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to women to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and (v) lobbying for abortion.
- (2) No funds made available under this grant will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.

- (d) The grantee shall insert this provision in all subsequent subagreements and contracts involving family planning or population activities which will be supported in whole or part from funds under this grant.

3.17 PROTECTION OF THE INDIVIDUAL AS A RESEARCH SUBJECT
(AUG 1995)

(This provision is applicable when research funded by this grant is conducted on human subjects.)

- (a) Safeguarding the rights and welfare of human subjects in

3.17 (Continued)

research supported by USAID is the responsibility of the organization to which support is awarded. USAID has adopted the Common Federal Policy for the Protection of Human Subjects, Part 225 of Title 22 of the Code of Federal Regulations (the "Policy"). Additional interpretation, procedures, and implementation guidance of the Policy are found in USAID General Notice entitled "Procedures for the Protection of Human Subjects in Research Supported by USAID", issued April 19, 1995, as from time to time amended (a copy of which is attached to this grant). USAID's Cognizant Human Subjects Officer (CHSO) in AID/W has oversight, guidance, and interpretation responsibility for the Policy.

- (b) Recipient organizations must comply with USAID policy when humans are the subject of research, as defined in 22 CFR section 225.102(d), funded by the grant and recipients must provide "assurance", as required by 22 CFR section 225.103, that they follow and abide by the procedures in the Policy. See also Section 5 of the April 19, 1995, USAID General Notice which sets forth activities to which the Policy is applicable.

The existence of a bona fide, applicable assurance approved by the Department of Health and Human Services (HHS) such as the "multiple project assurance" (MPA) will satisfy this requirement. Alternatively, organizations can provide an acceptable written assurance to USAID as described in 22 CFR section 225.103. Such assurances must be determined by the CHSO to be acceptable prior to any applicable research being initiated or conducted under the grant. In some limited instances outside the U.S., alternative systems for the protection of human subjects may be used provided they are deemed "at least equivalent" to those outlined in Part 225 (see 22 CFR 225.101[h]). Criteria and procedures for making this determination are described in the General Notice cited in the preceding paragraph.

- (c) Since the welfare of the research subject is a matter of concern to USAID as well as to the organization, USAID staff, consultants and advisory groups may independently review and inspect research and research processes and procedures involving human subjects, and based on such findings, the CHSO may prohibit research which presents unacceptable hazards or otherwise fails to comply with USAID procedures. Informed consent documents must include the stipulation that the subject's records may be subject to such review.

3.18 USE OF POUCH FACILITIES (AUG 1992)

(This provision is applicable when activities under the grant will take place outside of the United States.)

- (a) Use of diplomatic pouch is controlled by the Department of

3.18 (Continued)

State. The Department of State has authorized the use of pouch facilities for AID grantees and their employees as a general policy, as detailed in items (1) through (6) below. However, the final decision regarding use of pouch facilities rest with the Embassy or AID Mission. In consideration of the use of pouch facilities, the grantee and its employees agree to indemnify and hold harmless, the Department of State and AID for loss or damage occurring in pouch transmission:

- (1) Grantees and their employees are authorized use of the pouch for transmission and receipt of up to a maximum of .9 kgs per shipment of correspondence and documents needed in the administration of assistance programs.
- (2) U.S. citizen employees are authorized use of the pouch for personal mail up to a maximum of .45 kgs per shipment (but see (a)(3) below).
- (3) Merchandise, parcels, magazines, or newspapers are not considered to be personal mail for purposes of this standard provision and are not authorized to be sent or received by pouch.
- (4) Official and personal mail pursuant to a.1. and 2. above sent by pouch should be addressed as follows:

Name of individual or organization (followed by
letter symbol "G")
City Name of post (USAID/_____)
Agency for International Development
Washington, D.C. 20523-0001

- (5) Mail sent via the diplomatic pouch may not be in violation of U.S. Postal laws and may not contain material ineligible for pouch transmission.
 - (6) AID grantee personnel are not authorized use of military postal facilities (APO/FPO). This is an Adjutant General's decision based on existing laws and regulations governing military postal facilities and is being enforced worldwide.
- (b) The grantee shall be responsible for advising its employees of this authorization, these guidelines, and limitations on use of pouch facilities.
- (c) Specific additional guidance on grantee use of pouch facilities in accordance with this standard provision is available from the Post Communication Center at the Embassy or AID Mission.

**3.19 CONVERSION OF UNITED STATES DOLLARS TO LOCAL CURRENCY
(NOV 1985)**

(This provision is applicable when activities under the grant will take place outside of the United States.)

Upon arrival in the Cooperating Country, and from time to time as appropriate, the grantee's chief of party shall consult with the Mission Director who shall provide, in writing, the procedure the grantee and its employees shall follow in the conversion of United States dollars to local currency. This may include, but is not limited to, the conversion of currency through the cognizant United States Disbursing Officer or Mission Controller, as appropriate.

3.20 PUBLIC NOTICES (AUG 1992)

(This provision is applicable when the cognizant technical office determines that the grant is of public interest and requests that the provision be included in the grant.)

It is AID's policy to inform the public as fully as possible of its programs and activities. The grantee is encouraged to give public notice of the receipt of this grant and, from time to time, to announce progress and accomplishments. Press releases or other public notices should include a statement substantially as follows:

"The U.S. Agency for International Development administers the U.S. foreign assistance program providing economic and humanitarian assistance in more than 80 countries worldwide."

The grantee may call on AID's Office of External Affairs for advice regarding public notices. The grantee is requested to provide copies of notices or announcements to the cognizant technical officer and to AID's Office of External Affairs as far in advance of release as possible.

3.21 RIGHTS IN DATA (AUG 1992)

(This provision is applicable whenever data will be produced under the grant.)

(a) Definitions

"Data" means recorded information (including information relating to the research, testing, or development of any drug or device requiring approval for use in the United States), regardless of form or the media on which it may be recorded. In the aggregate these data may be in the form of reports, articles, manuals, or publications. The term includes technical data and computer software. The term does not

3.21 (Continued)

include financial reports or other information incidental to grant administration.

"Form, fit and function data" means data relating to items, components, or processes that are sufficient to enable physical and functional interchangeability, as well as data identifying source, size, configuration, mating, and attachment characteristics, functional characteristics, and performance requirements but specifically excludes the source code, algorithm, process, formulae, and flow charts of the software.

"Limited rights" means the rights of the Government in limited rights data as set forth in the following Limited Rights Notice:

- "These data are submitted with limited rights. These data may be reproduced and used by the Government with the limitation that they will not, without written permission of the Grantee, be used for purposes of manufacture nor disclosed outside the Government.
- "This Notice shall be marked on any reproduction of these data, in whole or in part."

"Limited rights data" means data (other than computer software) that embody trade secrets, or are commercial or financial and confidential or privileged, to the extent that such data pertain to items, components, or processes developed at private expense, including minor modifications thereof.

"Restricted computer software" means computer software developed at private expense and that is a trade secret; is commercial or financial and is confidential or privileged; or is published copyrighted computer software, including minor modifications of such computer software.

"Technical data" means data (other than computer software) which are of a scientific or technical nature.

"Unlimited rights" means the right of the Government to use, disclose, reproduce, prepare derivative works, distribute copies to the public, and perform publicly, in any manner and for any purpose, and to permit others to do so.

(b) Allocation of Rights

- (1) Except as provided in paragraph (c) of this provision regarding copyright, the Federal Government shall have unlimited rights in --

3.21 (Continued)

- (i) Data first produced in performance of this Grant;
 - (ii) Form, fit and function data delivered under this Grant;
 - (iii) Data delivered under this Grant (except for restricted computer software) that constitutes manuals or instructional and training material for installation, operation or routine maintenance and repair of items, components, or processes delivered or furnished for use under this Grant; and
 - (iv) All other data delivered under this Grant unless provided otherwise for limited rights data or restricted computer software in accordance with paragraph (d) of this provision.
- (2) The Grantee shall have the right to --
- (i) Use, release to others, reproduce, distribute, or publish any data first produced or specifically used by the Grantee in the performance of this Grant;
 - (ii) Protect from unauthorized disclosure and use those data which are limited rights data or restricted computer software to the extent provided in paragraph (d) of this provision;
 - (iii) Substantiate use of, add or correct limited rights, restricted rights, or copyright notices;
 - (iv) Establish claim to copyright subsisting in data first produced in the performance of this Grant to the extent provided in subparagraph (c) of this provision.

(c) Copyright

- (1) Data first produced in the performance of this Grant. The Grantee may establish, without prior approval of AID, claim to copyright subsisting in scientific and technical articles based on or containing data first produced in the performance of this Grant and published in academic, technical or professional journals, symposia proceedings or similar works. The prior express written permission of AID is required to establish claim to copyright subsisting in all other data first produced in performance of this Grant. For computer software and

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3.21 (Continued)

other data the Grantee grants to the Government, and others acting on its behalf, a paid-up nonexclusive, irrevocable worldwide license in such copyrighted data to reproduce, prepare derivative works and display publicly by or on behalf of the Government.

- (2) Data not first produced in the performance of this Grant. The Grantee shall not, without prior written permission of AID incorporate in data delivered under this Grant any data not first produced in the performance under this Grant and which contains the copyright notice of 17 U.S.C. 401 or 402, unless the grantee identifies such data and grants to the Government, or acquires on its behalf, a license of the same scope as set forth above in paragraph (c).

- (3) Removal of copyright notices. The Government agrees not to remove any copyright notices placed on data delivered under this Grant and to include such notice on all reproductions of such data.

- (d) Protection of limited rights data and restricted computer software

When data other than that listed in subparagraph (b) (1) (i), (ii) and (iii) of this provision are specified to be delivered under this Grant and qualify as either limited rights data or restricted computer software, if the Grantee desires to continue protection of such data, the Grantee shall withhold such data and not furnish them to the Government under this Grant. As a condition to this withholding, the Grantee shall identify the data being withheld and furnish form, fit, and function data in lieu thereof.

- (e) Subagreements

The Grantee has the responsibility to obtain from subgrantees and those who work in collaboration with the Grantee in performance of this Grant all data and rights necessary to fulfill the Grantee's obligations under this Grant. If a subgrantee or collaborator refuses to accept terms affording the Government such rights, the Grantee shall promptly bring such refusal to the attention of AID and not proceed without authorization from AID.

- (f) Relationship to patents

Nothing contained in this provision shall imply a license to the Government under any patent or be construed as affecting the scope of any license or other right granted to the Government.

ATTACHMENT 4

STANDARDS FOR USAID-FUNDED PUBLICATIONS

The following standards are intended as general guidelines for the production of USAID-funded publications that fall within the scope of those requiring USAID (LPA) approval.

The purpose of establishing basic standards is to enable LPA to work in a cooperative effort with agency bureaus and field missions to produce informative, professional and cost-effective products that meet the needs of a designated audience. The audience and distribution plans must be clearly defined and justification given that a real need exists for the proposed publication.

We are fully aware that there will be situations that warrant exceptions to these standards. Exceptions will be made by LPA on a case-by-case basis.

I. Publications Intended for a U.S. Audience, Including Congress:

- A. Use of color: Two-color maximum for both cover and text (black or blue ink, generally used for text, counts as one color). In the case of publications such as conference proceedings, one color is the standard.
- B. Paper: For both cover and text, use the most cost-effective stock that suits the publication's purpose. Make every effort to use recycled paper. Do not use heavy stock.
- C. Photos: Black-and-white.
- D. Content: Emphasize results achieved toward sustainable development through USAID programs. NOTE: In most cases, LPA will ask for a separate textual (ASCII) version of the final document for possible posting on USAID's Internet, which at present can support text only.
- E. Design: Avoid expensive folds/paper cuts, inserts/foldouts, die cuts, embossing, foil stamps and other design elements that add additional expense.

II. Reports Required by Congress

Most reports should be in typewritten, xeroxed format and respond specifically to what is required by statute.

III. Use of Metric Units of Measurement

Unless a waiver is granted, metric units are to be used in accordance with Executive Order 12770. Traditional units may be shown in parentheses after metric.

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IV. Use of Agency Logo

The USAID logo (or the name of the agency written out) should be displayed prominently, e.g., on the cover or title page.

V. Approval Form

LPA is developing a "request-for-approval" form that will be put on the agency-wide computer network as a macro to simplify and streamline the approval process. Information that will be required is as follows: type and design/format of publication; justification for its need; clearly defined audience and distribution plans; print run; budget breakdown including costs for photographic services (if a contract photographer is used), writing, editing, design, layout and printing; whether OE or program funds are being used; and plans to evaluate the effectiveness of the product.

STANDARDS FOR USAID-FUNDED VIDEO PRODUCTIONS

The following standards are intended as general guidelines for USAID-funded video productions that require USAID (LPA) approval.

The purpose of establishing these basic standards is to enable LPA to work in cooperation with agency bureaus and field missions to produce informative, professional and cost-effective programs that meet the needs of the designated audience. The audience and distribution plans must be clearly defined. The purpose and production plans must be justified and must support a real need.

We are aware that USAID video productions generally fall into two categories--those produced for information/education of U.S. audiences, and those produced with program funds for largely foreign audiences. These guidelines will help missions decide which programs warrant video productions and how these should be produced.

We are also aware that certain situations will justify exceptions to these standards. Exceptions will be made by LPA on a case-by-case basis.

I. Basic Guidelines

- A. Content: Videos intended for U.S. audiences, including Congress, should portray concrete results or chronicle a USAID success story. The video should not be a "promo" for a contractor or a specialized technical report aimed at a narrow audience of experts. Videos produced with program funds for foreign audiences would usually be training tapes or other instructional material. Also, LPA will not approve video recordings of conference proceedings that can more appropriately be shared as written transcripts or audiocassette recordings.
- B. Format: The program should be shot in a professional television format: BETA, BETA-SP, or 3/4". Only viewing copies should be made in VHS. Programs may be shot in American TV standard (NTSC) or in PAL or SECAM TV standard.
- C. Producers: Direct contracts must comply with OFPP Letter No. 79-4 which establish a "Government-Wide Contracting System for Motion Picture and Videotape Productions" (as required by OFPP by OFPP letter 79-4.) The designated production team must have a track record producing information/education programs or other professional broadcast products. A brief list of previously produced programs should be included.
- D. Length: The video should be no more than 15 minutes, unless there is a strong justification.
- E. Copies: The number should be determined by the bureau/mission and reflected in the production budget. Viewing copies for

NGOs, PVOs and local officials should be in VHS. Copies for local TV placement must be in 3/4" or BETA. A copy of the master of the finished program must be sent to the LPA video archive.

II. Approval Form

To simplify the approval process, LPA is developing a macro for the "request-for-approval" form that will be put on the agency wide computer network. The following information will be required.

- A. A general description of the subject of the video.
- B. The intended audience and a detailed distribution plan.
- C. Whether OE or program funds will be used.
- D. Budget breakdown to include costs for the following items:
 - Pre-production: research, script, shooting schedule (where the video will be shot);
 - Production: how many shooting days (include travel days), how much per day for the crew plus equipment. Please note: where possible, a local crew should be used; and
 - Editing: how many hours, how much per hour, how much for graphics and titles.
- E. Discussion of plans to evaluate the script and the "rough cut" for the effectiveness of the product.

Note: All videos produced with USAID funds must be deposited in the LPA video archive. This includes all "source" tapes, plus a copy of the completed master program.