

**ENGENDERHEALTH
Management Review
October 2001**

Cooperative Agreement No. HRN-A-00-98-00042-00

MANAGEMENT REVIEW: TABLE OF CONTENTS

SECTION 1: SCOPE OF WORK

SECTION 2: RESPONSES:

RESULTS AND RESULTS FRAMEWORK

STRATEGY

PROJECT MANAGEMENT

COLLABORATION WITH OTHER CA'S & BILATERALS

ORGANIZATION AND STAFFING

FINANCIAL MANAGEMENT

RELATIONSHIP WITH USAID

APPENDIX 1: COST-SHARE CONTRIBUTIONS

SECTION II SCOPE OF WORK

MANAGEMENT REVIEW ENGENDERHEALTH

OCTOBER 23, 2001

Results and the Results Framework

1. What progress has been made toward accomplishing Results 1-6 under this CA? How do these results contribute to the state-of-the-art of FP RH services? Please specify 2000-01 key results achieved with (a) core funds and (b) field support, or a combination.
2. Are core-funded activities on track as planned? Are there gaps or shortfalls in achievements? If so, what factors contributed and how might these be addressed?
3. For the 2000 Management Review, EngenderHealth developed specific annual targets for various indicators under each Result. What has been your experience to date using these annual targets? Are targets such as these a useful management tool? Has the existence of specific targets enhanced, detracted from, or otherwise impacted program implementation or planning?
4. Last year EngenderHealth developed a new schematic presentation of the results framework showing how activities at the country level support USAID mission objectives and eventually USAID agency goals. For which countries has this schematic been adopted to show how specific in-country activities contribute to Mission SO and IRs and *through* them contribute to global SOs and IRs? Have these diagrams been presented to the respective Missions? If so, what has been the reaction? Is this an effective communication tool, or an unnecessary step?
5. The cost sharing contribution goal under this agreement is 25 percent. Please attach a list of contributions by source (similar to last year) and indicate which contributions you anticipate will be attributed to this agreement versus other agreements which also require cost sharing. Have any new challenges developed since last year regarding achieving the 25 percent cost sharing goal?
6. How do activities carried out with matching funds contribute to the objective of the CA? What results have been achieved that would not have been possible if USAID funds were the only funds available?

Strategy

1. In the 2000 Management Review, EngenderHealth was asked what changes in the Cooperative Agreement (CA) would make it more responsive to the expressed needs of USAID at the global and country levels. EngenderHealth responded that they could provide more TA in the areas of quality management of large clinic-based service delivery programs and involving men (including young men) in RH service delivery.
 - a) What is the comparative advantage of EngenderHealth within these broader areas relative to other cooperating agencies? Which of EngenderHealth's areas of expertise are unique and which are redundant (essentially the same but implemented with different types of partners or in different countries) with those of other cooperating agencies?
 - b) What changes would need to be made in the agreement or in implementing the agreement in order for USAID to receive maximum benefit from EngenderHealth's unique expertise?

2. In response to a separate question regarding the evolution of RH in developing countries, EngenderHealth indicated that involving men in RH health is needed to take RH programs to the next level of effectiveness and impact.
 - a) If EngenderHealth was specifically charged with increasing men's participation, what strategy would you use to achieve this?
 - b) If core funding was made available in FY 2002, what could be reasonably accomplished in the 2002-3 program cycle and how much would it cost? What would be needed longer term in order to have sustained impact?
3. What do you see as the future emerging issues and/or priorities for achieving the USAID program objectives and vision? What are the principal strategic gaps?

Project Management

1. In the 2001-2002 EngenderHealth Annual Workplan it is noted that there have been major changes in the level of field support from a number of Missions as well as changes in the countries themselves. How has EngenderHealth adapted to deal with these changes?
2. Given that EngenderHealth is authorized to receive funding from diverse USAID accounts and different directives (e.g., DA, ESF, Pop, CS, HIV), what processes are in place to ensure that in-country activities are consistent with funding directives? How does EngenderHealth ensure that in-country programs have the appropriate expertise to carry out activities that are consistent with funding directives?
3. EngenderHealth developed a new mechanism for tracking priority core-funded activities, the Quarterly Progress Report. How do you envision using this new tool? How soon after the end of the quarter can USAID expect to receive a copy of the report? How do you anticipate the information gleaned from preparing and reviewing this report being used?
4. In the 2000 Management Review, you noted that EngenderHealth was moving in the direction of being able to track not only workplan objectives in IMIS (integrated management information system) but also outputs as they are achieved. Is this still the goal and has any progress been made in the past year? Is it proving to be useful?

Collaboration with Other Cooperating Agencies and Bilateral Projects

1. What has been your experience collaborating with CMS and NGO/PVO Networks? What are the challenges in these collaborations? How could these collaborations be improved? What has been your experience collaborating with Advance Africa and CATALYST? What are the challenges in these collaborations? How could these collaborations be improved? Given the current situation of Advance Africa, CATALYST and EngenderHealth (funding levels, technical expertise and key personnel), what might the best-case collaboration scenario look like?
2. The July 23 meeting of Service Delivery, Training and Research CAs, was intended to be the beginning of a process to link Service and Training CAs with Research CAs in order to get research findings implemented in country programs and to inform researchers as to the questions needing answers. What kind of follow up is needed to further this process and who needs to do it (USAID/W, Missions, CAs, other)?
3. Which research findings from the July 23 meeting do you plan to implement and how do you plan to get those findings into your programs? How has the material John Stenback presented at the July 23 meeting been incorporated into your updated counseling materials?

4. In the 2000 management review you noted in response to Collaboration Question 2 "it is a challenge to get the information disseminated and utilized widely through[out] the field." Have you learned any lessons in the last year about translating SOTA information and approaches into practice?
5. In the 2000 management review you noted under Collaboration Question 3 that EngenderHealth would follow up on TA provided to India and Bolivia on Informed Choice and meeting Tiahrt Amendment requirements. What kind of follow up activities were done? What was the impact of the initial TA? Do you perceive a need for this kind of TA in other countries? Which countries appear to be at greatest risk of Tiahrt violations?

Organization and Staffing

1. EngenderHealth has recently changed its organizational structure. Please describe any significant changes in responsibilities, lines of authority and or staffing levels. How does this new structure contribute to, detract from or otherwise impact the effective and efficient achievement of results under the CA?
2. What positions are now vacant and what progress has been made in filling these positions?

Financial Management

1. Does analysis of EngenderHealth's annual baseline and quarterly expenditures by country reports indicate that implementation is proceeding as planned?
2. Is financial reporting from the field adequate and submitted to headquarters on time? What is the quality of the information coming in from the field?
3. What actions, if any, should be taken to improve financial management?

Relationship with USAID

1. How does EngenderHealth's current relationship with G/PHN contribute to, detract from or otherwise impact the effective and efficient achievement of results under the CA? How could communication be improved? Are requests for information and or assistance reasonable and supported with adequate core funding?
2. How is the quality of EngenderHealth's relationship with the USAID missions it serves? Please be specific if the relationship with any particular mission has been challenging. Does G/ PHN contribute to, detract from or otherwise impact the effective and efficient relationship with missions? Is there something G/PHN could do to enhance the relationship between AVSC and missions?
3. Are there any other outstanding issues from EngenderHealth's perspective that need to be discussed?

SECTION 2 RESPONSES

RESULTS AND THE RESULTS FRAMEWORK

1. WHAT PROGRESS HAS BEEN MADE TOWARD ACCOMPLISHING RESULTS 1-6 UNDER THIS CA? HOW DO THESE RESULTS CONTRIBUTE TO THE STATE OF THE ART OF FP/RH SERVICES? PLEASE SPECIFY 2000-01 KEY RESULTS ACHIEVED WITH (A) CORE FUNDS AND (B) FIELD SUPPORT FUNDS, OR A COMBINATION.

The *Annual Report to USAID, July 1, 2000 – June 30, 2001* documents achievements related to Results 1-6 under the cooperative agreement. A summary of our results during the fiscal year follows:

- **Availability:** EngenderHealth provided technical, financial and material support to 31 countries in such important reproductive health areas as female sterilization, postpartum family planning, vasectomy, comprehensive PAC, quality improvement and informed choice, among others.
- **Quality:** Improving the quality of services continued to be an important area of focus, with EngenderHealth supporting 111 institutions in 24 countries. In addition, EngenderHealth supported client-focused research in Nepal, South Africa, Cambodia, Mexico, Guatemala, and the Dominican Republic. Findings from these studies on informed choice and consent for sterilization, cervical cancer and client satisfaction have helped us to learn more about how we can better provide services that meet their needs.
- **Use:** EngenderHealth programs in thirteen countries provided an estimated 439,010 Couple Years of Protection for FY00:01. These include 38,152 female sterilizations, 6,059 vasectomies, 19,614 implant insertions, and 7,881 IUD insertions.
- **Capacity building:** Technical and programmatic tools, in a variety of media, now exist on institutionalizing men's reproductive health in program design and services (curriculum); taking PAC services to scale (report); and improving infection practices (CD-ROM in Spanish), among others. Through our work, norms and national policies affecting sterilization, postabortion care and quality improvement have changed, allowing individuals greater access to better quality services.

Our results contribute to the *state-of-the-art of family planning/reproductive health services* by:

- Continuing specialized expertise for sterilization and related clinic-based services
- Documenting lessons from the field
- Supporting the provision of family planning and related services within a framework of individual rights, client and provider perspectives, and quality and safety of service delivery
- Developing state-of-the-art publications, job aids, and reports that contribute to improved practices and enhanced knowledge regarding best practices

Examples of key results supported *primarily with field support funds* include:

- 2,295 service delivery sites in 25 countries providing quality FP/RH services
- 1,033 sites in 19 countries providing female sterilization services
- 1,114 sites providing services to men, including 354 sites in 13 countries providing vasectomy services
- 758 service delivery sites in 14 countries providing contraceptive services to postpartum women
- 439,010 Couple Years of Protection for FY00/01
- Research completed on informed consent for sterilization in the Dominican Republic and informed choice for female sterilization in Guatemala. Together with a study in Mexico, this research explores regional issues related to informed consent and informed choice from the perspectives of clients and providers.
- An assessment of permanent and long-term contraceptive services in Tanzania, then used by the MOH to develop a 3-year program strategy
- Review of sterilization services in Bangladesh

Examples of key results supported with *field support, core, and private funds* are:

- 201 sites providing quality postabortion care services
- Publication of *Health-Sector Reform and Reproduction Health in Transition: Meeting the Challenge in Tanzania, Bangladesh, and Colombia*

Examples of key results supported with *core funds* are:

- Research that documents the effectiveness of ligation and excision with fascial interposition for vasectomy
- Publication of *Men's Reproductive Health Curriculum, Section 1* (working draft)
- Publication of *Reference Manual: Laparoscopic sterilization overview*
- Publication of revised *Cost Analysis Tool*
- Publication of *Taking Postabortion Care Services to Scale: An International Workshop*
- Publication of *AVSC Working Paper #13: The Quality of Care Management Center in Nepal: Improving Services with Limited Resources*
- Translation into Spanish of *Counseling the Postabortion Patient: Training for Service Providers*
- Translation into Spanish of *Infection Prevention Multimedia Package: Training CD-ROM and Reference Booklet*

2. ARE CORE-FUNDED ACTIVITIES ON TRACK AS PLANNED? ARE THERE GAPS OR SHORTFALLS IN ACHIEVEMENTS? IF SO, WHAT FACTORS CONTRIBUTED AND HOW MIGHT THESE BE ADDRESSED?

This Management Review is taking place just following the completion of the first quarter of FY 2001 Workplan (July 1, 2001 to June 30, 2002). A quarterly report is currently under preparation by EngenderHealth (due 4-6 weeks past the end of the quarter, i.e., no later than November 15, 2001). Therefore it is too soon to tell if there are gaps or shortfalls in achievement. There are a few factors that have affected implementation, however, and these are noted below:

- EngenderHealth's global program teams are increasingly focused on diversifying donor support in order to help overall with achieving the 25% match (discussed further in question 5 & 6 below) and leveraging the core USAID funds allocated. Our staff increasingly are responding to opportunities which often cannot be predicted and, when successful, result in the revision of timelines for achieving benchmarks of progress. For example, during the first quarter of FY 2001, our PAC team has been developing opportunities for support from Swedish SIDA (to replicate a pilot PAC program in maternity hospitals in Kenya), the Open Society Institute (for MVA equipment review with PATH) and the International Rescue Committee (for providing assistance to IRC staff to provide PAC services in stable refugee settings). The challenge will be to balance the need to diversify and leverage resources with the need to maintain momentum on existing commitments.
- The attacks on September 11, 2001 have hit those who live and work in New York City hard. In addition to several days of disruption of communications and commuting, other activities included: the revision and update of emergency preparedness procedures for our headquarters and field offices; making arrangements for a NY-based NGO (Helen Keller International) who lost space in the WTC attack to be housed at EngenderHealth in the interim; providing staff with updates, including one on the meaning of our work in light of the 9/11 events; and keeping our network of staff updated re travel and travel advisories.

Our management response for better managing the "big picture" of our strategic priorities in the face of a changing resource base was to reorganize the Programs Division at EngenderHealth and to clarify roles and responsibilities and the relationships among global and field staff. This will be described in more detail in the section on **Organization and Staffing**.

3. FOR THE 2000 MANAGEMENT REVIEW, ENGENDERHEALTH DEVELOPED SPECIFIC ANNUAL TARGETS FOR VARIOUS INDICATORS UNDER EACH RESULT. WHAT HAS BEEN YOUR EXPERIENCE TO DATE USING THESE ANNUAL TARGETS? ARE TARGETS SUCH AS THESE A USEFUL MANAGEMENT TOOL? HAS THE EXISTENCE OF SPECIFIC TARGETS ENHANCED, DETRACTED FROM, OR OTHERWISE IMPACTED PROGRAM IMPLEMENTATION OR PLANNING?

In 2000, EngenderHealth developed benchmarks for the cooperative agreement, related to availability (sites supported), quality (client satisfaction studies), use (services utilization), and capacity building (E&R studies, technical and programmatic approaches, meetings sponsored, professional papers and presentations).

The benchmarks for availability and use have not proven to be particularly useful. This is due to changes in our portfolio from year to year that affect the number of countries in which we are working. Missions going bilateral or changing their strategies and portfolios affect these changes.

It is therefore very difficult to predict from year to year a consistent increase in the number of sites supported and number of clients served.

The benchmarks for quality and capacity building are more predictable, although much of the reported work is also driven by Mission and in-country program priorities, which may change throughout a given fiscal year. These benchmarks also include globally-funded products which may be more easily planned for and developed.

In short, however, the benchmarking has been less useful than initially hoped for. The benchmarking has not been fully integrated into program planning, and given our changing environment it does not appear that it would be extremely useful for planning purposes. The benchmarking has neither added to nor detracted from existing program planning. We also have not received much feedback from USAID as to its utility from their perspective.

4. LAST YEAR ENGENDERHEALTH DEVELOPED A NEW SCHEMATIC PRESENTATION OF THE RESULTS FRAMEWORK SHOWING HOW ACTIVITIES AT THE COUNTRY LEVEL SUPPORT USAID MISSION OBJECTIVES AND EVENTUALLY USAID GOALS. FOR WHICH COUNTRIES HAS THIS SCHEMATIC BEEN ADOPTED TO SHOW HOW SPECIFIC IN-COUNTRY ACTIVITIES CONTRIBUTE TO MISSION SO AND IR'S AND THROUGH THEM CONTRIBUTE TO GLOBAL SO'S AND IR'S? HAVE THESE DIAGRAMS BEEN PRESENTED TO THE RESPECTIVE MISSIONS? IF SO, WHAT HAS BEEN THE REACTION? IS THIS AN EFFECTIVE COMMUNICATION TOOL, OR AN UNNECESSARY STEP?

While this provided a good theoretical framework for conceptually linking the results framework for the global CA and the field activities, its practical application has been elusive. In fact, we have not been able to pilot this or adopt it to country programs, mostly because it would have required a substantive level of effort for what amounted to a "marketing tool" for the global CA. Instead, this FY we have included in our country workplans a statement about which Mission SO/IR's are supported through the activities. Also, many Mission's require quarterly reports on key indicators. These are provided directly by our country staff to the Missions without involvement of the Program Management or Evaluation teams. We will be reviewing these this year to see how they relate (or not) to the CA results framework.

5. THE COST SHARING CONTRIBUTION GOAL UNDER THIS AGREEMENT IS 25 PERCENT. PLEASE ATTACH A LIST OF CONTRIBUTIONS BY SOURCE (SIMILAR TO LAST YEAR) AND INDICATE WHICH CONTRIBUTIONS WILL BE ATTRIBUTED TO THIS AGREEMENT VERSUS OTHER AGREEMENTS WHICH ALSO REQUIRE COST SHARING. HAVE ANY NEW CHALLENGES DEVELOPED SINCE LAST YEAR REGARDING ACHIEVING THE 25 COST SHARING GOAL?

Please see Appendix 1 which lists progress to date on cost share. We are on target for achieving the match at the end of the five years of the CA. This represents a remarkable achievement, as EngenderHealth was only a few short years ago nearly 90% "dependent" on USAID funding, and in particular, funding from the central CA.

Several challenges remain:

- Many donors want to support something unique, and many do not want to be leveraging (or in their words contributing to) another donor's goals and objectives. We have often heard from donors that they do not want to fund something "that the government already funds." Our challenge is to balance our need to match and provide cost-share to USAID-supported activities while doing something new or sufficiently different.
- Many donors are interested in issues and research and not in the broader "nuts and bolts" support for service delivery and capacity-building for services. Further, support is less likely to be longer-term and geared more to short term gains (often not sustainable).
- Many donors are not as technically savvy as USAID, and so there is a naivete about what can be accomplished (with relatively small, short-term amounts of money). Managing these expectations is difficult and time-consuming. The management and reporting requirements for small pots of funding can be as daunting as for some of the larger grants, and often, private donors are not willing to cover the full share of indirect costs. There is a real cost to diversification, as we must often allocate unrestricted private funds to supplement these grants. (This is true for UNFPA and Packard, as well as several other smaller donors/foundations.)
- We have also had some modest success at securing bilateral grants from USAID (Bangladesh, Ghana, Kenya and Nigeria) and each of these has a cost share component. In the first two years of the agreement, our main focus was on achieving and tracking the cost-share goal of 25%. Now, we must add to the management of cost-share the issue of tagging contributions to different agreements and determining the best fit for each.

6. HOW DO ACTIVITIES CARRIED OUT WITH MATCHING FUNDS CONTRIBUTE TO THE OBJECTIVE OF THE CA? WHAT RESULTS HAVE BEEN ACHIEVED THAT WOULD NOT HAVE BEEN POSSIBLE IF USAID FUNDS WERE THE ONLY FUNDS AVAILABLE?

The overall objective of the CA is to increase the availability of quality clinic-based family planning and other selected reproductive health services (notably PAC). This CA provides the anchor and an institutional base for EngenderHealth's overall goal which is to improve the quality of *facility-based* reproductive health services in three main content areas: 1) family planning with special emphasis on long-term and permanent methods; 2) HIV STI prevention, and 3) maternity services, including PAC. Our aim is to mobilize service providers and clinic sites to improve access and quality of services at the facility level, while building capacity to support these providers and sites at the institutional level. Whether the content is for FP (supported by USAID largely) or another aspect of RH (supported both by USAID and others), the work is transferable and supports a larger base of expertise about how to support service delivery objectives. Therefore, although the work we perform for USAID under the CA is somewhat more focused, it is entirely consistent and in sync with the activities for which we raise funds from other donors.

A major way that matching funds contribute to the CA is that private funding has enabled us to work in countries where EngenderHealth is not receiving field support for purposes wholly consistent with the CA. For example, EngenderHealth was awarded Packard funding in *Ethiopia* for a five-year project designed to take clinic-based FP services to scale in partnership

with the Family Guidance Association of Ethiopia in Packard's focus geographic areas (Amhara, Oromia and Addis Ababa). In *Honduras* and *Guatemala*, EngenderHealth has received funding from the Summit Foundation in order to work on both PAC and MAP in countries to complement activities conducted with USAID field support and bilateral funding. The Tides Foundation is supporting a pilot project to conduct a social marketing campaign for no-scalpel vasectomy services in collaboration with Population Services International in *Kenya*. In *Guinea*, EngenderHealth has recently received an award from the Aloca Foundation to expand and improve family planning services in health centers associated with its mining complexes in two areas, Boke and Sangredi. These are all recent or on-going, so results data is not yet available, but the expectation is that all of these activities will yield outcomes that contribute to the CA's results framework and indicators.

Two additional examples of results achieved through the match that would not be otherwise achieved:

- **Expanding post-abortion care services:** Expanding the availability of post-abortion care services was an important new focus under this CA. Core USAID funding has been very important to supporting this effort by enabling us to support a global team to work on global leadership activities (such as the international meeting on Tacking PAC to Scale in Kenya in 2000) as well as to support PAC programs in the field. In 1999, the Packard Foundation awarded EngenderHealth the first half of a six-year strategi to expand access to PAC around the world. This grant enabled us to support additional countries (and additional sites within USAID-supported countries) as well as to support region-based PAC coordinators who are able to provide more cost-effective and appropriate TA to programs within their regions.

This combined funding of PAC by both USAID and Packard has really pushed the implementation of PAC throughout our network of field programs. Presently PAC services are supported in 18 of the 28 countries in which we have active programs. Eight (8) of these are funded by Packard with the rest from USAID or other donors. (Note: USAID support for PAC is provided to EngenderHealth also through the PRIME project as well as through two small OR grants from Population Council's Frontiers Project.) While many of these are in the pilot stage, several countries are working on expansion strategies. Another important outcome of this work is the gaining of valuable lessons on taking a new service to scale in several countries. Also Packard is an important source of funding for MVA equipment and PAC research on Service Delivery Implications of Misoprostol Use, which would not be funded by USAID.

- **Expanding male reproductive health services, including vasectomy, in Pakistan:** EngenderHealth has recently concluded a project funded by the Nippon Foundation to undertake a male involvement project in the Punjab Province of Pakistan. The goals of this project were to develop knowledge and commitment for male involvement among service providers and decision-makers; to increase the number of trained service providers; to improve the knowledge and understanding of men and women about male involvement; and to increase the number of men who adopt positive FP and RH behavior and practices.

The achievements of this project have been exceptional, after a long and difficult start. (This project took off once under the care and attention of a global MAP staff person based in Bangkok.) The project resulted in the creation of various resrouces that local agencies and

institutions can use. Through it we have identified successful male involvement strategies that can be replicated through the country. It has demonstrated that when well-planned efforts are made to provide male reproductive health services, men will actively participate in such activities. Most importantly, it's greatest contribution is the establishment of evidence-based best practices for providing RH services to men through a partnership with the Punjab Population Welfare Department, Memorial Christian Hospital Shilok Jallapur Jattan Hospital, the Behbud Association of Pakistan, and the Balistan Health and Educational Foundation. (Final report available on request.)

STRATEGY

1. IN THE 2000 MANAGEMENT REVIEW, ENGENDERHEALTH WAS ASKED WHAT CHANGES IN THE CA WOULD MAKE IT MORE RESPONSIVE TO THE EXPRESSED NEEDS OF USAID AT THE GLOBAL AND COUNTRY LEVELS. ENGENDERHEALTH RESPONDED THAT THEY COULD PROVIDE MORE TA IN THE AREAS OF QUALITY MANAGEMENT OF LARGE CLINIC-BASED SERVICE DELIVERY PROGRAMS AND IN INVOLVING MEN (INCLUDING YOUNG MEN) IN RH SERVICE DELIVERY.

A). WHAT IS THE COMPARATIVE ADVANTAGE OF ENGENDERHEALTH WITHIN THESE BROADER AREAS RELATIVE TO OTHER COOPERATING AGENCIES? WHICH OF ENGENDERHEALTH'S AREAS OF EXPERTISE ARE UNIQUE AND WHICH ARE REDUNDANT (ESSENTIALLY THE SAME BUT IMPLEMENTED WITH DIFFERENT TYPES OF PARTNERS OR IN DIFFERENT COUNTRIES) WITH THOSE OF OTHER COOPERATING AGENCIES?

EngenderHealth has long-standing and unique experience in the establishment of facility-based, clinical services that has been applied to a range of clinical reproductive health services.

Quality management and quality improvement are essential elements of service delivery. Our comparative advantage is that quality management and quality improvement are integral components of our technical assistance, and of program design. For example, when we introduce or expand PAC services at a site or within an institution, we equip the site or institution with QI approaches and tools at the same time that they are equipped with PAC programming and implementation knowledge and skills. Similarly, when we collaborate on the introduction of quality management, our QI approaches and tools are structured to help sites and institutions think through the scope of reproductive health services that their clients might need. Could PAC services be introduced where there are none, or expanded to better serve the needs of a broader range of clients? In addition, EngenderHealth has worldwide experience and expertise in informed choice and medical monitoring, and continues to be in the forefront of innovation and implementation in these areas.

The clients' rights and providers' needs framework that underlies our QI approaches and tools enables us to incorporate many issues of concern to achieve USAID's program objectives and vision. These include the responsiveness of services to client rights and needs, informed choice and informed consent, reducing missed opportunities to provide services, provider motivation, competence and performance, the incorporation of gender into programs, the integration of family planning and STI prevention, responding to the current and future needs of adolescent populations, etc. In addition to our own field activities, our work has been adopted, adapted and tested in many CA programs and EngenderHealth is sought as a technical partner on many collaborative activities.

B). WHAT CHANGES WOULD NEED TO BE MADE IN THE AGREEMENT OR IN IMPLEMENTING THE AGREEMENT IN ORDER FOR USAID TO RECEIVE MAXIMUM BENEFIT FROM ENGENDERHEALTH'S EXPERTISE?

The Cooperative Agreement is already a fairly broad vehicle for implementation and allows the flexibility for dealing with a range of services (clinic-based FP, PAC and HIV prevention) through a variety of approaches for improving the effectiveness of services (choice, quality improvement, clinical oversight, involving men). We do not believe the agreement needs to be changed per se. However, the question of EngenderHealth's strategic advantage is sometimes blurred because the CA is focused mainly on specific methods or types of services while other CA mandates are focused on an approach or technical process related to service delivery (for example, PI, training, QA, research, communication, scaling up best practices, etc.). Implementing an agreement focused on expanding service delivery outcomes requires us to deal with some of these technical approaches, hence, the perceived blurring of mandate. Therefore, the only change we might want is to see a somewhat broader acceptance that EngenderHealth's CA, while focused on particular services in clinical settings, also includes technical interventions such as training and quality.

2. IN RESPONSE TO A SEPARATE QUESTION REGARDING THE EVOLUTION OF RH IN DEVELOPING COUNTRIES, ENGENDERHEALTH INDICATED THAT INVOLVING MEN IN RH IS NEEDED TO TAKE RH PROGRAMS TO THE NEXT LEVEL OF EFFECTIVENESS AND IMPACT.

A). IF ENGENDERHEALTH WAS SPECIFICALLY CHARGED WITH INCREASING MEN'S PARTICIPATION, WHAT STRATEGY WOULD YOU USE TO ACHIEVE THIS?

EngenderHealth's strategy to increase men's constructive involvement in RH would focus on two levels -- the service-delivery level and the community level -- and would address both the supply and demand aspects of increasing men's involvement in RH. From the supply side, this would involve ensuring that, to the extent possible, comprehensive clinical services are available for men and that attitudinal and organizational barriers affecting the provision of RH services for men are addressed at the service delivery level. This would include the provision of basic information on male reproductive health to all staff who work in a facility, working with providers to address organizational and attitudinal barriers that affect the provision of RH services for men, equipping providers to better communicate and counsel men and their partners, and training providers on clinical skills such as the diagnosis, treatment, and management of diseases and disorders of the male reproductive system.

From the demand side, EngenderHealth's efforts would focus at linking the service delivery level to the community level. The strategy would involve establishing partnerships with others to reach out to men of all ages with special communication and marketing strategies such as the provision of information, education, and counseling in places where men often congregate or in workplaces. Additionally, building on our social marketing experiences with adolescents and older men in the United States to build shared use of family planning

and influence healthy behaviors, EngenderHealth would work with communities to provide positive messages about the involvement of men in RH. This could include, for example, training key community leaders to provide information about men's involvement to their community or using the mass media to promote services for men within the community.

B). IF CORE FUNDING WAS MADE AVAILABLE IN FY 2002, WHAT COULD BE REASONABLY ACCOMPLISHED IN THE 2002-3 PROGRAM CYCLE AND HOW MUCH WOULD IT COST? WHAT WOULD BE NEEDED LONGER TERM IN ORDER TO HAVE SUSTAINED IMPACT?

Building on lessons learned from MAP evaluation efforts as well as the present work being done to develop the Comprehensive Men's RH Curriculum, core funding in the 2002-3 program cycle would focus on implementing evidence-based programming along the lines of the above strategy in three countries. An additional \$150,000 would be needed to supplement current levels of core funding to support field-based programming efforts. To ensure sustained impact of men's RH programming in the long-term, at least \$500,000 would be needed for these field projects over a period of three years.

3. WHAT DO YOU SEE AS THE FUTURE EMERGING ISSUES AND/OR PRIORITIES FOR ACHIEVING THE USAID PROGRAM OBJECTIVES AND VISION? WHAT ARE THE PRINCIPAL STRATEGIC GAPS?

There are two basic issues and priorities from our perspective. The first relates to a technical content area and the second is to how we do our work:

- Despite efforts to date, there is still a lack of focus on integrating reproductive health services *at the service delivery level*. Many programs continue to be implemented in a vertical manner and there are insufficient, effective linkages between various reproductive health services. Additionally, there is insufficient attention to gender concerns in the provision of reproductive health services. Therefore, to achieve USAID's program objectives and vision, the focus should be on integrating and building strong linkages between various RH services at the service delivery and community levels. Specific priority areas should include integrating STI/HIV prevention into family planning services and RH care for adolescents (including young men). We need to find ways to make gender relevant to service providers so that gender perspectives can be woven throughout programs to ensure that both men and women's needs are met in the provision of RH services.
- In the last several years, there has been real focus and attention within USAID regarding the State-of-the-Art, Best Practices and technical innovation. EngenderHealth has certainly participated in these activities wholeheartedly and has itself worked hard to maintain innovation as an organizational priority. Our observation is that the strategic gap isn't on the generation of new knowledge, but rather on how to scale these up and implement into service delivery in the field. It seems that the field in which we work gives more credence to researching the effects of pilot efforts than we do on slogging it out in the practical implementation of large-scale programs. Perhaps this observation is due in part to the fact that global programs are more focused on research and state of the art, whereas bilateral projects are responsible for the nuts and bolts of scaling up services. Perhaps it is because it

is difficult to evaluate and draw conclusions from large-scale and complex programs. Although we don't have a solution here, we believe the field would benefit from more attention and exchange among people involved in the art of implementing large-scale service programs, and for some renewed attention to the basics of programming.

PROJECT MANAGEMENT

1. IN THE 2001-2002 ENGENDERHEALTH ANNUAL WORKPLAN IT IS NOTED THAT THERE HAVE BEEN MAJOR CHANGES IN THE LEVEL OF FIELD SUPPORT FROM A NUMBER OF MISSIONS AS WELL AS CHANGES IN THE COUNTRIES THEMSELVES. HOW HAS ENGENDERHEALTH ADAPTED TO DEAL WITH THESE CHANGES?

The “up and down” trend regarding field support funding for particular countries continues, however, the good news is that the overall field support levels have been maintained (and are slightly increased). Countries that have gone “off the screen” from the previous year include Senegal, Paraguay and Kenya. New field support was received for Bangladesh, and there are discussions underway for potential field support funding for Guinea.

We have had two major responses in adapting to this circumstance:

First, we have placed more effort into developing clear and accountable procedures for opening and closing field offices so that each person charged with either scenario does not need to “re-invent the wheel” and can develop a sound plan. There is a great level of effort associated with the management of field offices, and we have amassed some good lessons learned (which we have shared with other NGO’s, when asked).

Second, in reorganizing the Programs Division (more on this in the section on Organization and Staffing), we have gone back to a regional structure for our Field Operations and have assigned regional directors to particular geographic areas. Prior to this we assigned responsibility for overseeing country programs across regions to encourage cross-fertilization. However, while good for giving staff different opportunities, it seemed impractical for managing an ever-changing portfolio. We anticipate that this change will help provide more continuity and flexible response in a changing environment.

2. GIVEN THAT ENGENDERHEALTH IS AUTHORIZED TO RECEIVE FUNDING FROM DIVERSE USAID ACCOUNTS AND DIFFERENT DIRECTIVES (E.G., DA, ESF, POP, CS, HIV), WHAT PROCESSES ARE IN PLACE TO ENSURE THAT IN-COUNTRY ACTIVITIES ARE CONSISTENT WITH FUNDING DIRECTIVES? HOW DOES ENGENDERHEALTH ENSURE THAT IN-COUNTRY PROGRAMS HAVE THE APPROPRIATE EXPERTISE TO CARRY OUT ACTIVITIES THAT ARE CONSISTENT WITH FUNDING DIRECTIVES?

Our financial management system is able to segregate funds by fund source and geography. The challenge isn’t from the accounting perspective, but rather there has been an issue of getting clear expectations between EngenderHealth field and USAID Mission staff. We have not

sufficiently tracked the issue of funding directives for these different accounts as part of the process of negotiating and finalizing field support numbers.

With respect to the issue of whether we have the expertise to carry out activities consistent with funding directives, for the most part, we believe that the only real question has been when funding comes in for child survival activities. (We believe we have the expertise to implement HIV prevention activities in the places where this has been received (Nigeria and South Africa). EngenderHealth does not currently include child survival as a core competency, nor is it one that we intend to grow through our staff. However, in those instances where we are provided with this money, our response is to ensure the appropriate level of technical expertise through partnership, consultant advice or through adding qualified local or international staff (as in Cambodia).

3. ENGENDERHEALTH DEVELOPED A NEW MECHANISM FOR TRACKING PRIORITY CORE-FUNDED ACTIVITIES, THE QUARTERLY PROGRESS REPORT. HOW DO YOU ENVISION USING THIS NEW TOOL? HOW SOON AFTER THE END OF THE QUARTER CAN USAID EXPECT TO RECEIVE A COPY OF THE REPORT? HOW DO YOU ANTICIPATE THE INFORMATION GLEANED FROM PREPARING AND REVIEWING THIS REPORT BEING USED?

We plan to use the quarterly report as a tool to track and monitor progress on major activities supported with USAID core funds. The format includes projected benchmarks developed by each of the global teams, and they will report on progress as well as any problems with implementation. This provides the Program Management Team with a more focused tool for reviewing the "big picture" and will enable us to reallocate both funds and people as needed to deliver on major expected outputs. Staffing and level of effort continue to be a huge issue for us, as the global teams are involved in a) global leadership research and program activities, b) providing TA to field programs and c) responding to opportunities for diversification of resources. This tool will be used to manage the discussion around these topics as we implement throughout the year.

We anticipate that the report will be ready 4-6 weeks following the end of the quarter (i.e., no later than the 15th of the month following the end of the quarter).

4. IN THE 2000 MANAGEMENT REVIEW, YOU NOTED THAT ENGENDERHEALTH WAS MOVING IN THE DIRECTION OF BEING ABLE TO TRACK NOT ONLY WORKPLAN OBJECTIVES IN IMIS (INTEGRATED MANAGEMENT INFORMATION SYSTEM) BUT ALSO OUTPUTS AS THEY ARE ACHIEVED. IS THIS STILL THE GOAL AND HAS ANY PROGRESS BEEN MADE IN THE PAST YEAR? IS IT PROVING TO BE USEFUL?

IMIS now allows programs to update their workplans with *actual activities* (outputs to be compared with planned activities) and *actual outcomes* (directly linked to objectives and focused on results). EngenderHealth programs (country, global, and support) can print out their workplans with updated information that helps to track progress. Workplans can be updated on a

quarterly or ongoing basis. In addition, IMIS now has reporting fields for all the *results and indicators* included in the annual report, which can also be updated on an ongoing basis and which are also included in the workplan report print-outs.

Some programs have already integrated the IMIS workplan and reporting process into their regular planning, monitoring, and evaluation, and report that this process is useful. For other programs, additional staff development will be required to enhance the quality of the workplan, to clarify terminology, and to continue establishing the link between planning and evaluation. Because country workplans, in particular, are based on field needs and varying contexts, IMIS is capturing a lot of "bottom-up" input that is difficult to roll up and synthesize. This fiscal year, we will be including staff development on these issues at the Program Managers meeting scheduled for February 2002, as well as planning additional forums and training opportunities.

COLLABORATION WITH OTHER CA'S AND BILATERALS

1. **WHAT HAS BEEN YOUR EXPERIENCE COLLABORATING WITH CMS AND NGO/PVO NETWORKS? WHAT ARE THE CHALLENGES IN THESE COLLABORATIONS? HOW COULD THESE COLLABORATIONS BE IMPROVED? WHAT HAS BEEN YOUR EXPERIENCE COLLABORATING WITH ADVANCE AFRICA AND CATALYST? WHAT ARE THE CHALLENGES IN THESE COLLABORATIONS? HOW COULD THESE COLLABORATIONS BE IMPROVED? GIVEN THE CURRENT SITUATION OF ADVANCE AFRICA, CATALYST AND ENGENDERHEALTH (FUNDING LEVELS, TECHNICAL EXPERTISE AND KEY PERSONNEL), WHAT MIGHT THE BEST-CASE COLLABORATION SCENARIO LOOK LIKE?**

Collaboration with CMS: EngenderHealth signed a central "Consulting Services Agreement" with CMS in March 2000. The consulting agreement was negotiated post award as EngenderHealth was not a proposed subcontractor on the Deloitte bid for the Commercial Market Strategies. The SOW for the agreement is two-fold: for EngenderHealth to provide up to three technical briefings per year for CMS staff; and for EngenderHealth to participate in technical reviews of CMS program initiatives. To date, EngenderHealth has provided one technical briefing for CMS staff which included a general orientation to agency programs and technical strengths, and an overview of QI approaches and tools.

EngenderHealth has two country level subcontracts with CMS, one in Ghana and one in Nepal. In Ghana, we are collaborating with CMS to develop and implement a RH program for employees of Frandesco Ltd., a large corporation in Ghana. In Nepal, we are working with CMS to provide training to staff from the Nepal Fertility Care Center in HIV STIs, antenatal care and family planning. In addition, Engenderhealth is providing technical assistance for the development of a clinical monitoring system.

The central level agreement between Engenderhealth and CMS has not been utilized by CMS as originally intended. We are not clear on the reasons for this though initially we were proactive about communications and attempted on numerous occasions to follow-up and reach commitment for moving forward. From our perspective, there appears to be little interest on the part of CMS to use Engenderhealth as a technical resource. We have not actively pursued any business under this agreement during the last year. Negotiation of the two country-level subcontracts went fairly smoothly and are currently being implemented.

Collaboration with NGO/PVO Networks: EngenderHealth has provided or will provide the following TA to NGO/PVO Networks: in Armenia (cancelled), Ethiopia, Malawi and Nepal. The technical assistance covers a variety of areas of EngenderHealth expertise such as contraceptive technology updates, orientations to quality improvement approaches, strengthening PAC referral and services, workshop on integrating HIV/STI in FP, youth friendly services for young men. This assistance is provided via a seconded staff person at 30% time (effective July 2001) to serve as Senior Technical Advisor on Family Planning (STAFP) to the project. The STAFP provides advice on programming efforts to integrate family planning use and improved

practices into on-going programs of NGO/PVO Networks and also coordinates short-term technical assistance provided by EngenderHealth's staff.

Overall, the experience has been a positive one due, in large part, to the commitment of the PVO Networks management team to making this work. Now that an EngenderHealth staff member has been seconded to the project there is good on-going communication and engagement in the project. Assigning a single individual to oversee implementation has helped keep on top of budget and insure diverse inputs are done in timely manner. Another thing that has worked well is to have close country-level collaboration to generate buy-in, finalize inputs and to ensure that TA is appropriate and sufficient within budget limitations.

There were challenges in getting this collaboration up and running, mostly because there was a delay in finalizing the core funding allocation (with some confusion caused by having this money come from EngenderHealth's core allocation rather than as additional funding) and identifying a staff secondment. Regarding the budget process, we were given an allocation and then worked backwards based on commitments made. The activities we are supporting are all appropriate and fit within the objectives of the NGO Networks project, but it is a series of discrete activities and not a cohesive program of TA. The fact that the secondment is for 30% is more related to what the budget can handle rather than the possible needs of the project. In one case the activity specific budget was not realistic. If NGO/PVO Networks had more funding, we would revisit the level of effort required as part of an overall effort at a more cohesive review of FP programs and their technical assistance requirements. We would aim to have earlier input into identifying the opportunities for assistance so that this funding is no longer perceived of as an "extra pot of money" the PVO partners can access.

Advance Africa/CATALYST: We don't have a track record of collaborating with these groups yet other than some initial discussions about how to collaborate on a working group on scaling up best practices. EngenderHealth staff have participated in Advance Africa's efforts to plan a CA's meeting in Africa on scaling up best practices. We are not aware of any potential yet to collaborate at the field levels, as for the most part, these projects are working in different countries. We were also looking forward to a "Services Team" meeting with USAID which would include the three services CA's, and the opportunity to explore potential for collaboration.

In order to determine a "best case" scenario for collaboration, we need to have a *shared* understanding of the relative strengths and mandates of these groups as well as a concrete notion of the specific outcome we are trying to achieve together. One of the major lessons learned in partnering is that the relationship must have a purpose that drives the partnership agreement, and that the relationship must benefit (and make sense to) all who participate. Facilitating this understanding takes deliberate attention, i.e., resources and time. The best-case scenario would be that someone is assigned (by USAID) to facilitate a process whereby various options for collaboration are explored, designed and then adequately resourced.

2. THE JULY 23RD MEETING OF SERVICE DELIVERY, TRAINING AND RESEARCH CA'S WAS INTENDED TO BE THE BEGINNING OF A PROCESS TO LINK SERVICE AND TRAINING CA'S WITH RESEARCH CA'S IN ORDER TO GET RESEARCH FINDINGS IMPLEMENTED IN COUNTRY PROGRAMS AND TO

INFORM RESEARCHERS AS TO THE QUESTIONS NEEDING ANSWERS. WHAT KIND OF FOLLOW-UP IS NEEDED TO FURTHER THIS PROCESS AND WHO NEEDS TO DO IT (USAID/W), MISSIONS, CA'S, OTHERS)?

The July 23d meeting was useful in that it raised awareness about the need to be more service delivery-oriented in terms of planning and implementing research findings. However, the actual meeting focused more on the substance of interesting research findings than on the process of *how* research findings should be incorporated. Large meetings are useful for generating awareness of important issues, however, they are not as useful for generating practical plans for moving forward and concrete next steps (particularly if the next steps involve many stakeholders).

A suggestion for follow-up is to have more focused discussion and attention during the annual workplanning process between USAID and CA's about their research agendas and priorities for the year, and how they relate to field-based implementation of services and or training. Other ideas follow:

- Service CA's: Demonstrate implementation of research findings in programs through the inclusion of examples in annual reports; identify and communicate new or specific research findings they believe need attention; demonstrate the use of research as a program management tool
- Research CA's: Demonstrate proactive involvement of Service and Training CA's in identification of research questions, research design, implementation and dissemination/reporting.
- USAID Missions: Encourage use of research as a program management tool.
- USAID/W: Continue to coordinate and emphasize the importance of this issue with Missions and the CA community.

3. WHICH RESEARCH FINDINGS FROM THE JULY 23RD MEETING DO YOU PLAN TO IMPLEMENT AND HOW TO YOU PLAN TO GET THOSE FINDINGS INTO YOUR PROGRAMS? HOW HAS THE MATERIAL JOHN STANBACK PRESENTED AT THE JULY 23RD MEETING BEEN INCORPORATED INTO YOU UPDATED COUNSELING MATERIALS?

The majority of research findings presented during this meeting have already been implemented in EngenderHealth programs, according to the needs of those programs. Indeed, EngenderHealth is often a collaborator on research and then uses those findings to improve program implementation. Two examples are:

- Integrating STI prevention and care into RH services (presentations by MSH and Pop Council). See case study #7, page 26 of EngenderHealth's Annual Report to USAID (FY 2000/2001). This case study documents the results of expanding access to quality RTI STI services through static facilities and reproductive and child health camps in Uttar Pradesh, India. Also, EngenderHealth is presently working with USAID to develop program guidance on Integration.

- Operations Research says do this right now! (Presentation by the Population Council). EngenderHealth pioneered the work on Inreach described in this presentation in its East African programs in the 1990's. Inreach was the subject of an EngenderHealth working paper and findings from our programmatic work in East Africa were published in *Studies in Family Planning*.

Gender issues are woven throughout EngenderHealth's work (our MAP program, in the context of our informed choice and HIV/STI work, throughout our QI approaches and tools). Adolescent reproductive health is an increasingly important part of our work and is being addressed through our PAC work, through MAP, and through informed choice.

EngenderHealth's counseling curriculum is currently undergoing revision and new evidence will be incorporated into that work. Moreover, EngenderHealth medical and program staff routinely receives information on new evidence or literature like the information summarized in Stanback's presentation. Field staff are encouraged to share this information with our counterparts in country programs. They use the information in activities such as the development or revision of standards and guidelines, the adaptation of those standards and guidelines into training curriculae, the implementation of those standards and guidelines through supervisory and quality improvement activities (in-reach, whole-site training, staff updates, etc.)

4. IN THE 2000 MANAGEMENT REVIEW YOU NOTED IN RESPONSE TO COLLABORATION QUESTION 2 "IT IS A CHALLENGE TO GET THE INFORMATION DISSEMINATED AND UTILIZED WIDELY THROUGH[OUT] THE FIELD." HAVE YOU LEARNED ANY LESSONS IN THE LAST YEAR TRANSLATING SOTA INFORMATION AND APPROACHES INTO PRACTICE?

The biggest challenge in dissemination is not in getting the message or the information out there, but doing it in a way that enables program managers to hear and use the information. The information needs to be clear, but it also needs to be linked to some issue or context that is relevant to the field program. We need to remember that our field staff are steeped in implementation and this doesn't make it easy for the kind of reflection needed to determine and follow through on new SOTA information. Our biggest lesson learned is that it doesn't work to just send out the information, but that we need to be more deliberate and focused in getting this used. Some things we are trying this year are noted below:

- Instead of using e-mail to communicate new information, we are posting information to relevant site on our intranet so that people will have the information available "just in time" when they need it.
- In one of our staff development workshops (on taking quality improvement approaches to scale, February 2001), we held to strict criteria in selecting staff to participate so that we could ensure appropriate follow-up regarding the application of SOTA following the workshop.
- The PAC team (with Packard funding) was able to support regional PAC coordinators who in effect serve as technical resources within their regions on SOTA in PAC. While we can't

afford to do this in all technical content areas. decentralizing this function has had a major impact on taking things to scale more quickly.

5. IN THE 2000 MANAGEMENT REVIEW YOU NOTED UNDER COLLABORATION QUESTION 3 THAT ENGENDERHEALTH WOULD FOLLOW-UP ON THE TA PROVIDED TO INDIA AND BOLIVIA ON INFORMED CHOICE AND MEETING TIAHRT REQUIREMENTS. WHAT KIND OF FOLLOW-UP ACTIVITIES WERE DONE? WHAT WAS THE INITIAL IMPACT OF THE TA? DO YOU PERCEIVE A NEED FOR THIS KIND OF TA IN OTHER COUNTRIES? WHICH COUNTRIES APPEAR TO BE AT GREATEST RISK?

Regarding India: EngenderHealth's Advances in Informed Choice (AIC) global team continued to provide TA to the Mission and the Regional Legal Advisor throughout much of the year via informal consultation by Harriet Stanley. We provided input on the USAID assessment plan, but did not participate in the assessment, as had been originally intended, because of schedule shifts. This input included a review of policies, document and program design in preparation for the Tiahrt assessment team's visit. The assessment (February 2001) concluded that there weren't any Tiahrt violations in the IFPS Project. The next step was to organize another workshop for CA's, SIFPSA and USAID for April 2001 based on the successful workshop we conducted in FY 1999. The objectives were to 1) Develop common understanding of what is/what isn't a Tiahrt violation, 2) Discuss how to integrate the use of on-going monitoring tools for Tihart into project monitoring, and 3) Develop a reporting plan for potential violations. This workshop has been postponed, and we have not heard plans for rescheduling.

Regarding Bolivia: Between July 2000 and June 2001, EngenderHealth supported 22 informed choice (IC) workshops in which participants were oriented to principles of choice and the requirements of the Tiahrt amendment. Participants were guided in how to conduct a self-assessment of the status of choice in their programs and to develop action plans to strengthen IC. A total of 615 healthcare professionals from the MOH, national and regional levels, and PROCOSI participated. Action plans for specific service sites were developed. In addition, in some cases district-level plans were developed. Each NGO represented in PROCOSI for a given district developed an action plan based on a COPE-type evaluation completed on informed choice.

In addition, an IC/ Tiahrt workshop was conducted for all PROSALUD personnel (a total of 163 providers participated). 778 participants attended workshops that examined the National Norms for Voluntary Surgical Female Contraception, including the informed consent document.

Results of these efforts include an increased commitment on the part of Bolivian health care institutions to examine and strengthen IC in health services; inclusion of IC as part of the national norms on contraception; regulation and implementation of counseling services; implementation of action plans at individual sites to improve IC in service delivery (e.g., establishing privacy for clients).

We have had greater impact in Bolivia, as noted above, than in India, where reporting is still an issue and, to our knowledge, SIFPSA has still not endorsed a monitoring and reporting protocol developed as part of the extensive TA EngenderHealth provided in FY 1999. However, the orientation workshops we facilitated were very well received, and the Mission was happy with the monitoring and reporting protocol we drafted for their and SIFPSA's consideration. We managed to frame the issues in broader IC terms, rather than in the narrow Tiahrt perspective, and introduced the notion of IC vulnerabilities, rather than strict Tiahrt violations.

Regarding a perceived need for similar TA in other countries, we believe that workshops to heighten awareness of Tiahrt and broader IC vulnerabilities may be indicated for some programs. Where conditions exist that could create vulnerabilities (see list below), safeguards are crucial. TA in programming to ensure IC may be needed. The EngenderHealth toolkit to orient program personnel to fundamental concepts and to factors that challenge and protect IC at different levels is an important job aid that could help Mission staff and implementing partners.

Regarding those countries "at risk" of Tiahrt violations, we note the following:

- Despite the USAID assessment findings, we believe there is reason for concern in India, where vulnerabilities exist.
- Any country in which performance-based funding, benchmarks, or reporting on CYP exist is potentially vulnerable to IC and Tiahrt problems.
- Programs with single-method FP programming (e.g. sterilization in Bangladesh) could create bias among providers, with potential for targeting clients (even in training programs)
- Programs implementing health sector reform, with focus on motivating providers to provide specific services, raises potential concerns about quotas, targets, incentives and provider bias—either officially or unofficially (e.g., Cambodia).

ORGANIZATION AND STAFFING

1. ENGENDERHEALTH HAS RECENTLY CHANGED ITS ORGANIZATIONAL STRUCTURE. PLEASE DESCRIBE ANY SIGNIFICANT CHANGES IN RESPONSIBILITIES, LINES OF AUTHORITY AND/OR STAFFING LEVELS. HOW DOES THIS NEW STRUCTURE CONTRIBUTE TO, DETRACT FROM OR OTHERWISE IMPACT THE EFFECTIVE AND EFFICIENT ACHIEVEMENT OF RESULTS UNDER THE CA?

The last major change in how program work is organized at EngenderHealth was done in April 1997 prior the start of the Cooperative Agreement. Since that time, the Programs Division included two areas, Country Programs and Global Innovations. There were two other related "support" divisions that were critical to the program work -- Knowledge Management and the Technical Resource (medical). This structure was developed to enable the flexible allocation of staff (via an annual Human Reallocation Process [HRA] process) to multidisciplinary teams to cope with shifting program directions, priorities and funding.

There were several benefits to this structure, including management's ability to assign staff to different teams as funding and priorities shifted, as well as to expose staff to different topics, work teams and opportunities. However, following the development of a new strategic plan and vision and an even more unpredictable funding environment with twin sets of opportunities and threats, we decided in early 2001 to examine the strengths and weaknesses of how we were organized to effectively implement our programs. The result of our review was to realign our current structure to create an integrated Program Division that has responsibility for overseeing and supporting field-based and global leadership programs and that includes the clinical oversight as well as some key knowledge management functions.

The Programs Division is led by an expanded Program Management Team that includes the following staff and functions:

- Lynn Bakamjian, Senior VP for Programs: Lynn has overall responsibility for the development, implementation and evaluation of field programs and global leadership activities in support of EngenderHealth's strategy and mission. She will continue to serve as Project Director for the USAID-funded CA (Program for VSC and Related Services) and has responsibility for determining program priorities, and overseeing the strategic assignment of program and technical staff and the management of critical relationships with donors and partners.
- Director of Field Operations, Santiago Plata, Bangkok-based: The Field Operations Director will have responsibility for the strategic and operational oversight of regional and country programs. He will supervise the regional directors, coordinate the overall strategy and portfolio for country programs, lead the annual workplanning and evaluation process and recommend priorities for country programs, and help to broker the implementation of global activities in field-based programs.

- Sara Gardner, Director, Global Programs. Sara, in close collaboration with the Deputy Director (see below), is responsible for the oversight of EngenderHealth's global leadership programs. She will lead the annual workplanning and evaluation process for global programs, set overall project and business development priorities for the global teams, as well as coordinate a process to identify and implement priorities for staff development.
- Karen Beattie, Deputy Director, Global Programs/Director of Research and Development (R&D). Karen will serve as Deputy Director for Global Programs, working closely with Sara on the above, with the added role of overseeing the process for development of new content and approaches through global research and pilot program activities. She will lead the processes for setting the research priorities in consultation with field and global programs and for reviewing research protocols and providing TA to global and field programs. Sara and Karen will divide supervisory responsibility for the global teams so that each will supervise no more than 4 each.
- Medical Director, VACANT: The Medical Director position is responsible for the strategic oversight of medical affairs and clinical monitoring of EngenderHealth's program activities. S/he will set medical service delivery standards and guidelines for field activities; represent EngenderHealth on medical issues on the USAID CA (as key personnel); provide technical direction to clinical staff and consultants assigned to field-based and global programs; and serve as a technical expert on emerging issues, trends and technologies in clinic-based health care. While we are recruiting for a new medical director, Carmela de Cordero will serve on the Program Management Team in an acting capacity.
- Marcia Mayfield, Director of Evaluation & Monitoring: Marcia will continue to be responsible for guiding the agency's capacity to plan and evaluate programs and to synthesize and share the findings to improve current and future programs. She will define the framework and approach for evaluating agency programs; coordinate the dissemination of findings and lessons learned from programs.

The reorganization has also consolidated Field Operations into distinct regions, with 4-7 countries per region, each led by a regional director who is responsible for all aspects of operations in country programs. The regions will consist of the following:

- Asia/Near East: Bangladesh, Cambodia, India, Jordan, Pakistan, Philippines, Nepal, Vietnam (VACANT, Regional Director)
- The Americas: Bolivia, Colombia, Dominican Republic, Guatemala, Honduras, United States (Andrea Eschen, Regional Director)
- West Africa: Guinea, Ghana, Senegal (Isaiah N'Dong, Regional Director)
- East and Southern Africa: Ethiopia, Kenya, Malawi, Nigeria, Republic of South Africa, Tanzania, Uganda (David Adriance, Regional Director)
- Eastern Europe/Central Asia: Russia, Turkey, Uzbekistan (John Pile, Regional Director. John will also serve as a Senior Technical Advisor/Reproductive Health for the NGO Networks project.)

Providing technical assistance via sub-contracts is a growing part of EngenderHealth's program portfolio. The purpose of this unit is to provide assistance and support to programs in the negotiation and development of partnership agreements, to serve as a clearinghouse for MOU's

and other types of agreements, and to coordinate headquarters support for bilateral and other projects. Therefore, we have created a small team to oversee EngenderHealth's global and other partnerships and sub-contracts, as well as to assist with backstopping bilateral projects managed by EngenderHealth. Connie O'Connor will serve as the senior manager overseeing this unit

Through the realignment, we will maintain our current global program teams for Informed Choice, Men as Partners, and Quality Improvement as these are important elements of our strategy to increase the effectiveness and quality of services. Given the success in our fund-raising and development efforts, we needed to regroup some of the teams in order to ensure we were maintaining adequate focus in content areas. We now have three "content" teams: Family Planning, Maternity (which will include PAC as a component of maternity services), and HIV/STI. In addition, we will establish another team to oversee the piloting through R&D of other reproductive health services. This team will oversee work in Cervical Cancer and other research projects that are exploratory in nature. Managers for these teams are noted below:

- Family Planning: (VACANT)
- Maternity/Post-Abortion Care: Mary Nell Wegner/Lorelei Goodyear
- HIV/STI: Julie Becker
- Other RH services/R&D: Mark Barone
- Advances in Informed Choice: Jan Kumar
- Men as Partners: Manisha Mehta
- Quality Improvement: Erin Mielke

There are two major benefits afforded to the agreement. First, the Program Management Team has been expanded to include staff responsible for managing aspects of the CA, which had previously been managed out of separately led organizational divisions. This consolidation will facilitate communication and coordination of activities and bring things closer to program implementation. Second, we did not have staff devoted to FP, as our assumption was that our expertise in this area was integrated throughout the organization. However, we recognize the need to pay special attention to clinical family planning and sterilization to maintain our skills as well as to contribute to strategy and innovation in an area where we are considered leaders. This change also helps clarify roles and responsibilities, and will enable us to manage cross-cutting issues more effectively.

2. WHAT POSITIONS ARE NOW VACANT AND WHAT PROGRESS HAS BEEN MADE IN FILLING THESE POSITIONS?

We now have three major vacancies: the Medical Director, Asia Regional Director and the Family Planning Manager. The Medical Director recruitment has been underway for a few months, and we are screening and interviewing candidates. This is probably one of the more difficult positions to fill, and we are redoubling our efforts given its priority. The Asia Regional Director is newly vacant, given Santiago Plata's promotion to Director of Field Operations. We are developing both a recruitment and transition plan to assure adequate leadership and coverage

in the region. We anticipate that the FP manager will be a change of assignment for an internal candidate and this will happen within the month.

FINANCIAL MANAGEMENT

1. DOES ANALYSIS OF ENGENDERHEALTH'S ANNUAL BASELINE AND QUARTERLY EXPENDITURES BY COUNTRY REPORTS INDICATE THAT IMPLEMENTATION IS PROCEEDING AS PLANNED?

Yes, an analysis of program expenditures (through June 30, 2001) indicates that spending is tied to program implementation, particularly at the country field level. Most country programs do a good job of managing their pipelines. In fact, those with a surplus of field support funding at the end of the year had anticipated that this balance would be available for implementation this year (in consultation with USAID Missions). EngenderHealth's efforts at improving budgeting and managing pipelines has resulted in less variance overall.

2. IS FINANCIAL REPORTING FROM THE FIELD ADEQUATE AND SUBMITTED TO HEADQUARTERS ON TIME? WHAT IS THE QUALITY OF THE INFORMATION COMING IN FROM THE FIELD?

Field offices provide monthly reports on expenditures to headquarters. Reports are due on the 5th business day of the subsequent month and are generally received on time unless prior arrangements have been made with NY Finance. This information then needs to be combined with data from headquarters on expenditures made on behalf of the country program. This process takes time, and often there is the need for communication between the field and headquarters on questions regarding charges.

Our field staff provide accurate information via these reports and in the past year there has been improved coordination with NY Finance representatives on questions when they arise. Additionally, we have provided local in country training to our Finance representatives over the past year, including on-line access to our accounting system which has greatly improved the communications and quality of financial data.

3. WHAT ACTIONS, IF ANY, SHOULD BE TAKEN TO IMPROVE FINANCIAL MANAGEMENT?

Many actions have already been taken as a result of a change in senior management (in 2000) within our Finance Office. Several improvements have been made, including increased attention to regular and monthly reconciliation of accounts, more time devoted to analysis of variances in expenses and fund balances, clearer roles and responsibilities among Finance and Program staff for financial management, and improved morale and stability. With regard to future improvements, we are looking to continue to develop and implement innovative financial systems agency wide, including in the field, based on technology already available to us. These include extending online time reporting system for field personnel, ASP field office reporting and applications and new budgeting software. We are also looking to increase the level of

training performed both in NY and the field for non-Finance users to ensure proper financial management of funds.

RELATIONSHIP WITH USAID

1. HOW DOES ENGENDERHEALTH'S CURRENT RELATIONSHIP WITH G/HPN CONTRIBUTE TO, DETRACT FROM, OR OTHERWISE IMPACT THE EFFECTIVE AND EFFICIENT ACHIEVEMENT OF RESULTS UNDER THE CA? HOW COULD COMMUNICATION BE IMPROVED? ARE REQUESTS FOR INFORMATION AND/OR ASSISTANCE REASONABLE AND SUPPORTED WITH ADEQUATE CORE FUNDING?

From our perspective, the relationship is a good one in large part because there has been continuity in the personnel managing both sides of the relationship. Although personnel within the USAID Family Planning Services Division and the official CTO for the CA have changed, we have had the same Senior Technical Advisor (and the same Project Director) since the award in 1998. This has been very helpful for managing an agreement in which the basic assumptions regarding how things would work have changed (for example, the introduction of Field Support was not anticipated). In addition, efforts by the Office of Population and the FPSD to regularize the process and timing for workplan development, management reviews, portfolio reviews, and core funding negotiations have certainly helped us in managing expectations and responding to the needs of those who oversee our work at USAID. With our recent reorganization, we feel that we have the means in place for managing the agreement with adequate core funding.

With the reorganization of USAID and the review of USAID's portfolio of cooperative agreements and contracts, we are entering a time of increasing uncertainty regarding funding for the future. Our basic assumption remains that we are a valued partner for USAID. We also fully recognize that we cannot count on USAID to assure our organization's sustainability as in the past. Therefore, open and frank communication (to the extent possible within the confines of procurement integrity) will be enormously helpful to us in the coming months so that we can best anticipate and plan for continuing our good work in an effective manner.

2. HOW IS THE QUALITY OF ENGENDERHEALTH'S RELATIONSHIP WITH THE USAID MISSIONS IT SERVES? PLEASE BE SPECIFIC IF THE RELATIONSHIP WITH ANY PARTICULAR MISSION HAS BEEN CHALLENGING. DOES G/PHN CONTRIBUTE TO, DETRACT FROM OR OTHERWISE IMPACT THE EFFECTIVE AND EFFICIENT RELATIONSHIP WITH MISSIONS? IS THERE SOMETHING G/PHN COULD DO TO ENHANCE THE RELATIONSHIP BETWEEN ENGENDERHEALTH AND MISSIONS?

At the present time, we are not aware of any particular challenges with USAID Missions in the 16 missions where we have received field support. Earlier in the year, there were some issues which we believe to have been resolved, namely:

- **Cambodia:** There was some concern about the program activities proposed for the current workplan period, and following some written back and forth between the Mission and our

country office, we believe this has been resolved. Because of the size and breadth of the program, Evelyn Landry has been relocated to Cambodia to serve as a senior technical advisor for the Asia region on research and evaluation. She will work with our country staff to strengthen monitoring and evaluation and to document results both within the region and in Cambodia.

- **Republic of South Africa:** The workplan was overhauled in response to changing priorities of a new HPN officer. The new workplan has a focus on HIV prevention and includes a new partner, HOPE Worldwide.
- **Malawi:** We recently learned that the HPN officer is concerned about EngenderHealth's ability to manage a large program from Nairobi and in particular coordinate effectively with other CA's. We agree, and our plan for this year is to identify and support an in-country representative as well as to ensure that the person has adequate backstopping from our regional office in Nairobi.

The best thing that USAID/Washington can do is to keep the lines of communication flowing. You often hear before we do that there is a problem, and by continuing to share these situations with us, we are able to trouble shoot and work them out.

3. ARE THERE ANY OTHER OUTSTANDING ISSUES FROM ENGENDERHEALTH'S PERSPECTIVE THAT NEED TO BE DISCUSSED?

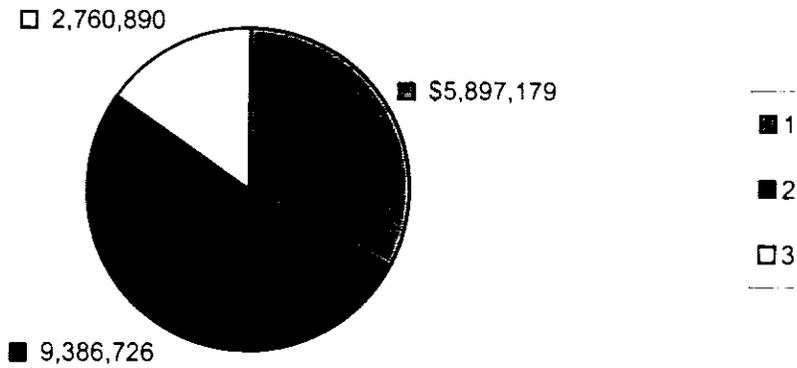
See the note about regarding communications regarding the impact of the USAID reorganization on USAID's portfolio of central grants and cooperative agreements.

APPENDIX I COST SHARE CONTRIBUTIONS

ENGENDER HEALTH
 Cost Share Report - Expenditures
 as of 6/30/01

Cost Share Fund Name	10/1/98-3/31/99	4/1/99-6/30/00	7/1/00-6/30/01	Total
Unrestricted Funds	\$ 1,108,114	\$ 2,629,623	\$ 2,159,442	\$ 5,897,179
Private Foundations	(1,266,858)	4,757,972	5,895,613	9,386,726
Contracts	729,375	1,300,916	730,599	2,760,890
Total Cost Share Funds	\$ 570,630	\$ 8,688,510	\$ 8,785,654	\$ 18,044,795
US AID Revenue	15,007,577	23,904,000	19,251,000	58,162,577
Cost Share Percentage	4%	36%	46%	31%

Cost Share Funds



Fund #	Fund Name	10/1/98-3/31/99	4/1/99-6/30/00	7/1/00-6/30/01	Total
	Unrestricted Funds	1,108,114	2,629,623	2,159,442	5,897,179
118	Abrahamson/Guinea	-	-	21,290	21,290
140	Summit Fndtn/GUA & HON	-	-	6,152	6,152
142	Hewlett III	180,232	-	139,848	320,080
145	Brush Fndtn/DR	-	-	14,956	14,956
147	Packard/Ethiopia	189,856	-	80,108	269,964
152	Hewlett Foundation	(403,844)	6,747	-	(397,097)
153	Garretson-Wade	-	2,672	12,428	15,101
154	Packard/Cambodia	-	-	145,142	145,142
157	Mellon Foundation	(41,967)	4,598	-	(37,369)
158	Latin America Fund	(239,488)	(44,530)	-	(284,018)
160	Anonymous/Vietnam	-	-	11	11
161	Compton Foundation	-	32,065	-	32,065
162	Prospect Hill	(12,924)	60,001	6,185	53,263
163	Bergstrom Fund	(71,491)	451,333	121,424	501,326
166	Patterson Fund/Africa	59,625	(29,133)	11,307	41,769
167	MacArthur Foundation/MAP	(28,698)	2,137	-	(26,501)
169	Buffett Foundation/Vietnam	67,756	320,765	111,778	500,299
170	Edey/Madagascar/Guinea	-	(5,516)	124,317	114,802
171	Turner Foundation/MAP	20,559	18,478	44,208	81,246
172	Packard/Uganda	28,075	(380)	-	27,695
173	Packard/Nigeria	1,381	-	-	1,381
174	Nippon Foundation/Pakistan	78,350	116,983	81,486	276,819
176	Packard	(137,453)	171,634	109,414	143,595
179	Packard/NP-Training	(1,704)	-	-	(1,704)
180	Ford Foundation/MAP-Egypt	-	2,213	-	2,213
181	CEMUBAC/Senegal	104	10,163	(1,930)	8,337
183	Gates Foundation (Research)	(506,577)	304,084	124,933	(77,560)
184	Gates Foundation (Publishing)	(494,591)	48,566	199,261	186,236
185	Mellon Foundation (II)	38,042	186,885	265,757	490,684
186	OSI/Internet Technology	-	17,000	-	17,000
187	OSI/Makhalla RH/FP	10,000	-	11,258	21,258
188	Moriah Fund/PAC/Colombia	25,000	36,557	7,467	69,024
189	Weyerhaeuser/MAP/Peru	-	9,379	21,722	31,101
190	Hewlett Foundation II	75,023	276,931	643,575	995,529
191	Dickler Foundation/PAC/Malawi	-	261	-	261
192	The Andean Initiative	(102,125)	44,578	25,832	(31,715)
193	Packard Foundation/PAC	-	689,788	1,296,810	1,986,598
194	Gates/Alliance Project	-	1,481,607	2,210,022	3,691,629
196	Thomton - HSR	-	17,988	29,517	47,505
197	SIDA grant/PAC Workshop	-	43,114	2,745	45,859
198	PAC Workshops	-	53,913	(11,507)	42,405
199	Commitment to Colombia	-	-	40,098	40,098
	Allowable Cost Share - Foundations	(1,266,858)	4,757,972	5,895,613	9,386,726
200	ODA/Ekaterinberg Study	(709)	(18,089)	-	(18,799)
203	DFID - Kenya	24,310	-	-	24,310
205	Japan-US Common Agenda/STDs	-	-	-	-
206	PHI-DOH AIDS/STDs	-	6,214	5,075	11,289
207	DOH-UNFPA (Phil)	-	2,301	-	2,301
208	Colombia/SSC (local contract)	-	62	4,912	4,974
209	Colombia/SDS (local contract)	-	3,400	6,054	9,454
210	Colombia/Boyaca (local contract)	-	-	3,310	3,310
211	Colombia/Soacha	-	-	1,740	1,740
298	FCI Maternity Care	-	-	41,981	41,981
299	FCF/Philippines	-	-	2,727	2,727
317	SIDA/Kenya contract	-	828	96,249	97,077
324	UNC/SALSA	-	13,481	-	13,481
327	Packard/Ethiopia	-	32,813	736	33,548
328	Columbia Univ-COPE/QI (RHL)	-	83,926	265,125	351,050
331	Tulane Univ/Vasectomy Study	9,856	13,285	-	25,141
333	PSI Zimbabwe FP Training	-	-	4,394	4,394
334	Pathfinder/Vietnam-MedEd Wkshp	-	-	9,885	9,885
337	IRC/PAC/TA	-	-	5,148	5,148
338	UNFPA Kenya COPE-CH	-	-	21,675	21,675
347	UNFPA-RHL program	-	-	1,972	1,972
348	UNFPA-Kyrgyzstan	-	363	-	363
349	UNFPA-KYR/96/PO3 (B)	-	31,695	-	31,695
350	UNFPA-Uzbekistan	1,724	264	-	1,988
353	UNFPA - Pakistan	198,702	198,702	1,277	398,681
359	UNFPA-KYR/96/PO3	56,041	84,141	-	140,182
360	UNFPA-UZB/96/PO2	75,437	109,367	-	184,804

Fund #	Fund Name	10/1/98-3/31/99	4/1/99-6/30/00	7/1/00-6/30/01	Total
361	UNFPA-KYR/96/PO2	2,573	29,766	9,767	42,105
362	UNFPA - Nigeria	(397)	-	-	397
365	UNFPA-Mongolia	140,054	456,059	210,921	807,034
366	UNFPA-LA/MAP	18,576	8,922	8,628	36,127
367	UNFPA - UKRAINE	49,142	-	-	49,142
369	UNFPA-LA Reg Ster Study	3,997	208	-	4,204
370	UNFPA - CARS Conference	(5,924)	-	-	5,924
371	UNFPA-NIR/98/PO1/C	146,369	98,096	21,695	266,160
372	UNFPA-Vietnam (CTU)	1,434	-	-	1,434
376	COPE-MON/99/PO7	-	-	2,168	2,168
378	WHO (QI)	2,994	5,120	557	8,671
379	UNFPA-Uzbekistan UZB/97/P04	5,195	-	-	5,195
380	UNICEF-Russia contract	-	77,908	3,909	81,816
381	UNFPA-Uganda (new)	-	33,776	-	33,776
382	UNFPA/COL-RH Norms	-	13,861	419	14,281
383	UNICEF/GHA/97/HN/91	-	3,458	-	3,458
384	UNICEF - Guinea COPE/CH	-	4,990	234	5,224
	Contract Cost Share Funds	<u>729,375</u>	<u>1,300,916</u>	<u>730,599</u>	<u>2,760,890</u>
	Total Allowable Cost Share Funds	570,630	8,688,510	8,785,654	18,044,795
	Revenue - US AID Coop Agreement	15,007,577	23,904,000	19,251,000	58,162,577
	Cost Share Percentage	4%	36%	46%	