



**ASSESSMENT
OF
ADVANCE AFRICA
AND THE
CATALYST CONSORTIUM**

**Laurel Cobb
Gerard Bowers
Nina Frankel
Maria Mamlouk**

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ACRONYMS

ADAR	Asociación para el Desarrollo Amazónico Rural (Peru)
AED	Academy for Educational Development
AGROVIDA	Asociación de Promoción Agraria y Defensa de la Vida
ANE	Bureau for Asia and the Near East (USAID)
APHA	American Public Health Association
APROPO	Apoyo a Programas de Población (Peruvian NGO)
ASPEFAM	Asociación Peruana de Facultades de Medicina (Peruvian Association of Faculties and Schools of Medicine)
ASPEFEEN	Asociación Peruana de Facultades y Escuelas de Enfermería (Association of Faculties and Schools of Nurses)
ASPEFOBST	Asociación Peruana de Escuelas y Facultades de Obstetricia (Peruvian Association of Faculties and Schools of Midwives)
BCC	Behavior change communication
CA	Cooperating agency
CAFME	Commission for the Accreditation of Faculties and Schools of Medicine (Peru)
CAFS	Centre for African Family Studies
CBD	Community-based distribution
CCP	Central Contraceptive Procurement
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CHAPPL	Caring for HIV and AIDS, Prevention and Positive Living initiative (CDC)
CRS	Catholic Relief Services
CSI	Clinical Services Improvement Project (Egypt)
CTO	Cognizant technical officer
CYP	Couple year of protection
D&C	Dilation and curettage
DHS	Demographic and Health Survey
DOMCCP	Diocese of Mutare Community Care Program
DRC	Democratic Republic of Congo
DTT	Deloitte Touche Tohmatsu
EFPA	Egyptian Family Planning Association
FAWE	Forum for African Women Educationalists
FAWEMO	Forum for African Women Educationalists/Mozambique
FAWEZI	Forum for African Women Educationalists/Zimbabwe
FEMAP	Mexican Federation of Private Associations for Health and Community
FGC	Female genital cutting
FHI	Family Health International
FON	Obstetric and Neonatal Functions (software)
FP	Family planning
FY	Fiscal year
GH/PRH/SDI	Bureau for Global Health, Office of Population and Reproductive Health, Service Delivery Improvement Division
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HKI	Helen Keller International
HPN	Office of Health, Population and Nutrition (USAID/Zimbabwe)
HSDS	Health Services Delivery and Support Program (JHU)
IEC	Information, education, and communication
IMCI	Integrated management of childhood illness
INPPARES	Instituto Peruano de Paternidad Responsable (International Planned Parenthood Federation affiliate, Peru)
IQC	Indefinite quantity contract
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IR	Intermediate Result

IUD	Intrauterine device
IWG	Integration Working Group
JHU	Johns Hopkins University
JHU/HCP	Johns Hopkins University/Health Communications Project
JSI	John Snow, Inc.
KAP	Knowledge, attitudes, and practices
MAQ	Maximizing Access and Quality Initiative
MCA	Millennium Challenge Account
MCDI	Medical Care Development International (Mozambique)
MCH	Maternal and child health
MINSA	Ministerio de Salud
MIS	Management information system
MMR	Movimiento Manuela Ramos
MOH	Ministry of Health
MOH&CW	Ministry of Health and Child Welfare (Zimbabwe)
MOH/CH	Ministry of Health, Division of Community Health (Mozambique)
MOHP	Ministry of Health and Population (Egypt)
MSH	Management Sciences for Health
MTCT	Mother-to-child transmission
NGO	Nongovernmental organization
OBSI	Optimal Birth Spacing Initiative
PAC	Postabortion care
PAHO	Pan American Health Organization
PHC	Primary health care
PHR _{plus}	Partners for Health Reform _{plus} Project
PMIS	Performance monitoring and improvement system
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
PVO	Private voluntary organization
REDSO	Regional Economic Development Services Office (USAID)
RFA	Request for application
RFP	Request for proposal
RH	Reproductive health
RUDO	Rural Unity for Development Organization
SAAJ	Serviço de Saúde Amigo do Adolescente e Jovem
SANRU III	Santé Rural III project
SCF/UK	Save the Children/United Kingdom
SO	Strategic Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STRIVE	Support to Replicable, Innovative, Village/Community-level Efforts program (CRS)
TAHSEEN	Tahseen Sihatna Bi Tanzeem Usritna (CATALYST/Egypt)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/GH	Bureau for Global Health (USAID)
VCT	Voluntary counseling and testing
WAHO	West African Health Organization
WHO	World Health Organization
WHO/AFRO	World Health Organization/Africa Regional Office
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPC	Zimbabwe National Family Planning Council

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EXECUTIVE SUMMARY

This report presents the findings of the assessment conducted in May and June 2004 of the Advance Africa and CATALYST consortia, the recipients of five-year cooperative agreements funded by the United States Agency for International Development's Bureau for Global Health (USAID/GH), which were obligated on October 29, 2000. Advance Africa and the CATALYST Consortium contribute to the bureau's achieving the following Strategic Objectives (SOs):

- Advance and support voluntary family planning and reproductive health programs worldwide (Advance Africa and CATALYST)
- Increased use of key maternal health and nutrition interventions (Advance Africa and CATALYST)
- Increased use of improved, effective and sustainable responses to reduce HIV transmission and mitigate the impact of the HIV/AIDS pandemic (Advance Africa)

The objective for Advance Africa and CATALYST is "increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and nonclinical programs." The Intermediate Results (IRs) are:

- IR 1: Increased access to and improved quality of FP/RH clinical and nonclinical programs
- IR 2: Increased capacity for informed FP/RH decision-making among clients and communities
- IR 3: Increased capacity of public and private sectors to sustain quality FP/RH service delivery programs
- IR 4: Scaled-up and improved FP/RH service delivery programs through technical collaboration with other agency/donor/foundation programs

Both cooperative agreements were awarded for \$92 million over five years, with the expectation that there would be major demand for the services they would offer. For neither cooperative agreement, however, has demand been as high as anticipated. To date, Advance Africa has been obligated \$28.8 million. Of the total obligations, Advance Africa core funds totaled \$15.6 million, and field support amounted to \$13.2 million. Through February 2004, CATALYST's total obligations amounted to approximately \$57.1 million, of which \$17.7 million are core funds, and \$39.4 million are field support. Sixty-eight percent of CATALYST's field support comes from two large buy-ins, one from Peru and the other from Egypt.

Advance Africa is a cooperative agreement managed by a consortium of six organizations: Management Sciences for Health (MSH), the prime contractor; Academy for Educational Development (AED); Family Health International (FHI); the Centre for

African Family Studies (CAFS); the Forum for African Women Educationalists (FAWE); and Deloitte Touche Tohmatsu (DTT). The project works with clinical and nonclinical programs to reposition family planning, improve access to and the quality of reproductive health services, and mitigate HIV/AIDS in high prevalence Sub-Saharan Africa, with country programs in Mozambique, Angola, Zimbabwe, Democratic Republic of Congo (DRC), and Senegal. Promoting birthspacing as a health intervention to reduce maternal and infant mortality is a major initiative. Salient project activities include strategic planning, training, capacity building, and technical collaboration with other agency or foundation programs.

The CATALYST Consortium is a partnership of five organizations: AED, the Centre for Development and Population Activities (CEDPA); Meridian Group International, Inc.; Pathfinder International (lead/recipient organization); and PROFAMILIA/Colombia. CATALYST was designed to increase the use of sustainable, quality family planning and reproductive health (FP/RH) services and healthy practices through clinical and nonclinical programs. Anticipated results included increased access to and improved quality of FP/RH clinical and nonclinical programs; increased capacity for informed FP/RH decision-making by clients and communities as well as of the public and private sectors to sustain quality FP/RH programs; and scaled-up and improved FP/RH service delivery through technical assistance to other agency/donor/foundation programs. CATALYST has seven field offices located in Bolivia, Egypt, India, Nepal, Pakistan, Peru, and Yemen; CATALYST indicates it has also provided short-term inputs or technical support in 15 additional countries.

This report highlights the significant contributions that both CATALYST and Advance Africa have made to globally disseminating the importance of birthspacing to maternal and child health. Advance Africa and CATALYST have worked with USAID to present the clear and compelling data demonstrating that three to five-year birth intervals result in reduced morbidity and mortality for mothers and infants. The results are twofold: globally, a greater awareness of the health reasons for spacing, and a willingness of countries wary of and/or unconvinced about family planning to reconsider it on new repositioned grounds. Both consortia have held important regional conferences on birthspacing; CATALYST has additionally facilitated outreach on the Optimal Birth Spacing Initiative (OBSI) to the cooperating agency (CA) community, governments, and other donors. Both consortia are working with national programs at various levels to revise policy documents. However, it appears that to date only one country—Mozambique, with Advance Africa technical assistance—has formally revised national policies, standards, or protocols to act upon the heightened awareness about optimal birthspacing.

While in the critical area of OBSI and repositioning family planning CATALYST and Advance Africa have had a common theme and while the Strategic Objective and Intermediate Results for both cooperative agreements are the same, as USAID wrote in the scope of work for this assessment, “both programs have evolved independently and autonomously, with their own unique opportunities and challenges largely based on their regional focus.”

Three factors constrain assessing Advance Africa and CATALYST’s achievements. The first constraint is that while there are considerable process data, there are a lack of output

data for the respective project indicators agreed upon by USAID and the two CAs.¹ The second constraint, which is related to the first, is the relatively short time line for implementation of many of the programs, delayed implementation of some activities, or the inherently short-term nature of the intervention requested by Missions. The third constraint is the fact that many USAID Missions have different indicators than those outlined in the USAID/Washington cooperative agreements. (See tables 3 and 4 in the report body, which present the key contributions of Advance Africa and CATALYST, respectively.)

IR 1: INCREASED ACCESS TO AND IMPROVED QUALITY OF FP/RH CLINICAL AND NONCLINICAL PROGRAMS

Both Advance Africa and CATALYST contributed to IR 1.

Advance Africa

Advance Africa has contributed to increased access to and improved quality of FP/RH clinical and nonclinical programs in three principal ways: expansion of services, training of service providers, and management procedures and tools.

In Zimbabwe, Advance Africa, together with the Zimbabwe National Family Planning Council (ZNFPC), has succeeded in reorienting and expanding the country's longstanding community-based distribution network from being narrowly focused on family planning to a more holistic approach. Family planning activities at the community level have been broadened to include HIV/AIDS awareness, dual protection messages, and referrals to voluntary counseling and testing (VCT). Due to the introduction of depot holder and satellite models of service provision, clients have increased contraceptive security and more convenient access to services. Clients in 16 districts in eight provinces now have access to a wider network of trained personnel who are able to refer to facilities with staff equipped to offer more integrated services. Client referrals from community-based distributors to VCT centers increased 694 percent from October 2002 to September 2003, referrals from community-based distributors for family planning increased by 352 percent, the distribution of oral contraceptives increased by 662 percent, and the distribution of condoms increased by 411 percent during the same period.

In the DRC, Advance Africa has provided technical assistance to the Santé Rural II (SANRU II) primary health care project to increase the use of modern contraception in 13 health zones, including two that have a large number of internally displaced persons. Provider training has facilitated the provision of FP services to over 9,000 clients.

While most of Advance Africa's other field activities have been either short-term technical inputs or programs that have begun only in the last year or so, better trained personnel, more holistic programmatic approaches, and enhanced management tools are concrete results. In Senegal, family planning indicators were developed and integrated into the national health care monitoring system. In Mozambique, Advance Africa has standardized nongovernmental organization (NGO) monitoring and evaluation data,

¹ The body of the report contains the output indicators established by USAID, Advance Africa, and CATALYST for each of the projects' IRs.

instituted quarterly coordination meetings, and developed indicators that allow maximizing the benefit of service delivery encounters.

CATALYST

CATALYST has worked to increase access to and improve the quality of FP/RH clinical and nonclinical programs in four ways: OBSI, postabortion care (PAC), expanding method mix, and integration. Contributions have been the most significant in OBSI and PAC.

CATALYST has had a global leadership role in OBSI. It has hosted regional conferences, aggregated medical research on the subject, overseen a literature review, conducted qualitative research, disseminated findings among USAID CAs and donors, and built support among Missions, governments, host country institutions, donors, and pharmaceutical companies. In 2003, CATALYST hosted a regional OBSI conference in Guatemala that resulted in the incorporation of birthspacing messages into the Mission's program through inclusion in training materials, counseling protocols, and messages to reposition family planning. In 2004, CATALYST hosted a major Peruvian OBSI conference that strongly positioned family planning in terms of saving lives and potentially, positively repositioned family planning after recent difficult years. Excellent reports from CATALYST qualitative research in Bolivia, Peru, Egypt, India, and Romania document the difficulties women face in spacing births and integrate gender issues with family planning.

In PAC, CATALYST expanded the program in Peru from 8 to 62 hospitals (emergency obstetric care, including PAC); facilitated a PAC web site; held a regional conference that led to the introduction of PAC in Guatemala, Nicaragua, and the Dominican Republic; introduced PAC into Bolivia, where it has been expanded to serve 19,000 women; and shared its model in Egypt. In Bolivia, CATALYST trained 722 providers from 62 different hospitals in postabortion care. CATALYST data indicate that women receiving services in Bolivian PAC programs are choosing to use modern methods of family planning at higher rates (37 percent of all PAC clients in 2003) than the national average (25 percent in the Demographic and Health Survey [DHS] 1998).

Many activities to increase access to and improve the quality of FP/RH clinical and nonclinical programs, as measured by CATALYST indicators, were only recently begun and, to date, are small scale. For instance, in Egypt, 9 months after CATALYST (TAHSEEN) began community mobilization and clinic renovation in five rural Upper Egypt villages, CATALYST concluded, "Increases in total FP clients, youth clients and low-parity clients have not yet been seen in the five rural health units where TAHSEEN has renovated facilities and trained providers. CATALYST service statistics for those five clinics show no increase in the number of family planning clients a day (an average of five visits per clinic per day), of the percentage of clients under the age of 25 (a decline from 14 to 11 percent), or of the percentage of low-parity clients (25 to 24 percent). However, the number of female clients for all services increased by 24 percent, and client satisfaction in general, as measured by exit interviews, increased significantly. CATALYST will be working to intensify activities to increase demand for FP/RH services in these villages and in other villages where it is expanding its integrated community mobilization model.

IR 2: INCREASED CAPACITY FOR INFORMED FP/RH DECISION-MAKING AMONG CLIENTS AND COMMUNITIES

Both CATALYST and Advance Africa contributed to IR 2. Although for a variety of reasons both projects have limited quantitative data on the indicators demonstrating increased capacity, both projects are implementing activities to identify and target those who make FP/RH decisions for themselves and those who can enable behavior change for others.

Advance Africa

Advance Africa is targeting youth, expanding community networks, enlisting increased male involvement, and integrating life skills education into school curricula. Key to Advance Africa's work has been the buy-in of clinic and nonclinic providers who use positive peer pressure to disseminate appropriate messages and facilitate referrals.

Advance Africa collaborated with FAWE in Mozambique, Zimbabwe, and Senegal to promote life skills education for adolescents and thus enhance their decision-making capacity. In Senegal, FAWE proposed to highlight risks of female genital cutting in elementary and high schools in the hope of creating support among life skills education in primary and secondary schools for adolescent girls. Advance Africa states that the focus of the project in each country was determined by the local organizations according to cultural and social acceptability; hence, overall, many of the youth-related interventions, especially in Zimbabwe, are giving precedence to advocating abstinence over providing services.

Advance Africa is expanding community networks in Zimbabwe, Mozambique, and Angola. In Mozambique, community health committees have been effective in raising local awareness of FP/RH issues, including optimal birthspacing. Theater groups are spreading similar messages in Angola.

Advance Africa had relatively limited opportunity to highlight gender or formally integrate it into its country programs because none of the USAID Missions requested any specific technical assistance in this area. Nor do long-term gender interventions appear to be a priority of most African political agendas.

CATALYST

CATALYST's work with civil society and community leaders, reaching out to men, identification of gender-based violence and gender and rights, linkages to social programs (nonhealth activities) and youth-related programs (service delivery as well as gender violence) potentially hold many models for replication. In Peru, data from an activity with youth in a Yes! kiosk in Lima indicate that youth's knowledge of different methods and the correct use of condoms increased. Baseline studies have been undertaken with major programs in Egypt, India, Bolivia, and Peru; final studies are planned.

In rural Upper Egypt, CATALYST targets women and young people in a comprehensive approach to development that focuses on behavior change, quality improvement of

services, community involvement, linkages to other sectors (such as agricultural workers), and engagement of local health authorities and religious leaders. It included an innovative coeducational peer education activity at Minia University in which 21 male and female students were trained to be educators on such themes as premarital counseling, delaying age of first marriage, and the harmful effects of female genital cutting. Most participants, both male and female, described the training as being life changing. CATALYST's behavior change communication program in Minia includes radio, programming, plays, and puppet shows to promote key FP/RH messages.

IR 3: INCREASED CAPACITY OF PUBLIC AND PRIVATE SECTORS TO SUSTAIN QUALITY FP/RH SERVICE DELIVERY PROGRAMS (CATALYST)

CATALYST was responsible for activities contributing to IR 3, which were to be measured in terms of public/private sector program costs covered by program income and partnerships with other entities. CATALYST's contributions lie in the area of forming partnerships with the commercial sector. CATALYST has worked with three major contraceptive manufacturers, with positive results, to help disseminate OBSI research, to fund conferences, and to expand the role of the commercial sector in FP/RH service delivery in Peru. With CATALYST support, 381 physicians and midwives in 10 cities were trained in syndromic management of sexually transmitted infections and provided with supplies for prevention and treatment. Approximately 471 midwives in Lima's peri-urban slums are providing contraceptives at low prices. In the Dominican Republic, through this collaboration, 20,000 units of a dedicated emergency contraceptive pill were made available to an NGO (data are not available, however, on the number of women receiving services). Additionally, CATALYST has developed a corporate social responsibility toolkit for USAID and other managers who might be interested in beginning corporate social responsibility programs.

IR 3: IMPROVED AWARENESS OF THE IMPORTANCE OF THE HEALTH BENEFITS OF FP AMONG AFRICAN POLICYMAKERS (Advance Africa)

Advance Africa had this alternate IR 3, for which it was responsible.

Repositioning family planning and advocating for additional integrated FP/RH programs represent one of Advance Africa's hallmark initiatives. Advance Africa's advocacy efforts have targeted policymakers and program managers to highlight family planning as an essential primary health care (PHC) intervention to reduce escalating maternal and child mortality rates, rather than as a means of fertility control. Advance Africa's collaborative work with the World Health Organization/Africa Regional Office (WHO/AFRO) and other partners of the Reproductive Health Task Force on this agenda yielded development and promotion of the 10-year family planning framework as guidance for countries on how to revitalize family planning programs and ensure a comprehensive approach to maternal and child health. The framework will be presented for adoption at the 54th session of the WHO Regional Committee for Africa, August 30–September 3 in Brazzaville, Republic of Congo, by the 46 ministers of health from the member states.

Through workshops and meetings in Mozambique, the DRC, and Zimbabwe (and one scheduled for Angola later this year), Advance Africa has worked successfully to reposition family planning as an essential means to reduce high maternal and infant mortality. Advance Africa technical assistance to the Ministry of Health (MOH) in Mozambique to elaborate a family planning strategy that will be incorporated into a broader maternal mortality reduction strategy will codify family planning and longer birth intervals as health interventions. This will be one of the first instances around the world of countries moving on a national level to change policies in light of the new evidence on the benefits of three to five-year birth intervals.

IR 4: SCALED-UP AND IMPROVED FP/RH SERVICE DELIVERY PROGRAMS THROUGH TECHNICAL COLLABORATION WITH OTHER AGENCY/DONOR/FOUNDATION PROGRAMS

CATALYST was solely responsible for IR 4. CATALYST scaled up² programs through adding services, increasing coverage of target groups, and replicating interventions.

As indicated, CATALYST has expanded PAC in a number of countries. In some countries (Bolivia, Peru, and Egypt), it has had an active program; in other countries, PAC has begun as a result of CATALYST's inspiration. For example, after Nicaraguan participants returned from a CATALYST PAC conference, they began a PAC program in Nicaragua using non-USAID funds. In Peru, CATALYST has expanded emergency obstetric care capacity within health institutions on a nationwide basis to reduce maternal mortality, improve the quality and availability of treatment of complications of incomplete abortions, and provide post-PAC family planning services. To date, 1,000 health professionals in 50 hospitals have been trained. CATALYST has also expanded the community-based programs of consortium partner CEDPA in India, and on a global level, has expanded awareness of OBSI as a health intervention for women and children.

CATALYST has worked to expand and replicate programs by networking with other organizations to mobilize resources to expand coverage and by linking to smaller projects that implement different components of reproductive health. Examples include using USAID/Bolivia funds to expand youth services to 13 new facilities and creating a network of midwives in the city of Lima's RedPlan Salud, which began in 5 districts in Lima and is currently serving 21 districts. CATALYST identifies over 17 instances in which it has cooperated with other CAs, foundations, bilateral and multilateral donors, and government agencies in such topics as cosponsoring conferences, holding joint training sessions, designing strategies in a participatory manner, and joint review of research protocols.

Expansion of OBSI programs at the field level, in countries served by both CATALYST and Advance Africa, remains the challenge for the future.

There were critical management and leadership problems in the beginning years, which delayed implementation in both consortia; however, both projects have recovered from those early difficult years. In the first two years, Advance Africa experienced severe disruptions and staff changes; funding was much less than expected, partially due to a lack of marketing; and the closure of three regional Advance Africa

² Scale up is a term used to indicate expansion and replication of a program, often to the national level.

offices led to the loss of talented professionals. These events and the growing perception within the consortium that USAID was disenchanted with the project, apparently led to a sense of detachment from the project for some members of the consortium. The consortium leader, MSH, has resolved the situation, which is now stable and productive, albeit on a limited basis in four countries, and is preparing for an orderly and methodical end of project.

CATALYST also experienced major disruptive staff changes. The current project director is the fourth (including an acting director for several months) since the project began; the current deputy director is the third. With the new project director, however, CATALYST believes it has been able to progress beyond the early difficult years. Staff morale and productivity are high and CATALYST expansion is underway. New programs are beginning in Nepal, Laos, and Yemen; the Pakistan program is being reborn. In Peru and Egypt, recipients of large Mission field support, CATALYST has offices with 45 staff members as well as contracts for specialized activities. CATALYST/Egypt, now working in one governorate in 5 villages in community mobilization, is planning to expand such activities to 80 villages in six governorates by March 2005.

The assessment report includes sections on the USAID Mission perspective on the two projects, USAID management, and considerations for USAID future directions. Most of the Mission staffs interviewed or responding in writing to Mission surveys were pleased with the responsiveness and technical quality of both consortia. However, the history of the two projects serves as a caution against awarding multiple successor projects; it also demonstrates the importance of USAID marketing for a new project.

A number of challenges remain for a centrally funded project, which a future project should address:

- OBSI and repositioning of family planning,
- meeting the needs of youth,
- PAC,
- FP and HIV/AIDS linkages,
- gender,
- expanding best practices,
- role of the commercial sector, and
- educating women and couples about available contraceptive options.

Contraceptive supply (not a responsibility of either Advance Africa or CATALYST) was a challenge in three of the four countries visited by the assessment team (Zimbabwe, Mozambique, and Peru); contraceptives were in short supply—leading to occasional stockouts in areas served by CATALYST and Advance Africa. In the case of Peru, stockouts in the public sector were reportedly nationwide. Such shortages/stockouts call into question the purpose and value of projects designed to promote demand for FP/RH services, expand and replicate FP/RH services, or to effect qualitative improvements in FP/RH service delivery programs.

Three trends may affect Mission demand for a centrally funded FP/RH project:

- declining demand for the services of centrally managed FP programs, as indicated by the low levels of field support funds being provided to the two projects by USAID Missions;³
- Missions continue to resist a plethora of CAs; and
- some USAID Missions will continue to depend on centrally managed projects to address critical, high-priority components of their assistance strategies.

Moreover, new types of Mission-level requirements appear to be emerging and could be usefully addressed by centrally managed projects. These include a need to more directly support the Agency’s growing responsibilities to address FP/RH needs in conflict-prone, transitional, and fragile/failing states (five roles that centrally managed projects might have in such states are presented in the report) as well as a role for centrally managed projects in support of USAID Missions’ program phaseout and graduation strategies.

RECOMMENDATIONS

IR 1: Increased Access to and Improved Quality of FP/RH Clinical and Nonclinical Programs

- USAID should continue to support through follow-on mechanisms its technical leadership in
 - OBSI;
 - PAC, stressing the importance of all five elements; and
 - integration.
- Advance Africa should document the lessons learned from the Zimbabwe expanded community-based distribution (CBD) program so that this successful program initiative might be resuscitated and replicated once conditions improve.

IR 2: Increased Capacity for Informed FP/RH Decision-Making Among Clients and Communities

Before phaseout, CATALYST should evaluate as rigorously as possible, document, and disseminate the process and results of its behavior change work to reduce gender-based violence in the models cited here (i.e., the work with university youth in Egypt, Pakistan [as appropriate], and Peru).

IR 3: Increased Capacity of Public and Private Sectors to Sustain Quality FP/RH Service Delivery Programs (CATALYST)

A follow-on USAID service delivery project should have a strong component strengthening the capacity of the NGO and commercial sectors.

³ Recent buy-ins to CATALYST from the Nepal, Yemen, and Pakistan Missions demonstrate Mission demand for some form of central project and for the services CATALYST has offered. (In contrast to Advance Africa, CATALYST has continued to market itself.)

IR 3: Improved Awareness of the Importance of the Health Benefits of FP Among African Policymakers (Advance Africa)

- Insofar as possible, USAID Missions should ensure that contraceptive supply can meet increased demand arising from successful repositioning family planning strategies.
- In addition to underscoring the health and social benefits of longer birth intervals, repositioning family planning strategies should more prominently address gender mainstreaming and women's empowerment issues.

IR 4: Scaled-Up and Improved FP/RH Service Delivery Programs Through Technical Collaboration With Other Agency/Donor/Foundation Programs

USAID should pursue, on a priority basis, efforts to replicate and expand programs that

- create a favorable policy environment for effective birthspacing and
- incorporate quality of care factors that enable women to make informed spacing decisions that contribute to their own health and the health of their children.

Best Practices

- The lessons learned from Advance Africa's expanded CBD experience in Zimbabwe should be documented and highlighted as a best practice to facilitate a revival and expansion of the program when circumstances are more inviting.
- If warranted by the findings of the upcoming evaluation of the Best Practices Compendium, USAID should plan to find a place for the compendium in another CA, or to include continued responsibility for the compendium's development and dissemination in the scope of work of a follow-on activity to the Advance Africa/CATALYST projects.
- USAID should promote broader use of the compendium as well as broader reference to best practices in general by requiring that all project proposals, responses to requests for applications/requests for proposals (RFAs/RFPs), and task orders demonstrate the submitters' due diligence in researching best practices that might be relevant to the proposal. Proposals for USAID funding should identify specific best practices considered by the submitter, describe how those best practices are reflected in the proposal, and/or explain why the relevant best practices were considered but rejected.
- CATALYST should produce a comprehensive summary of the best practices that are currently being implemented. Such a summary, succinctly packaged as a list of best practices in order of priority, would greatly enhance the project's legacy.

Gender

- In view of the reluctance or indifference of some Missions to gender as a priority objective, USAID/Washington should exercise increased technical leadership to promote the adoption of this agency priority by USAID Missions.
- Given the high levels of gender violence documented through CATALYST reports and in demographic and health surveys around the world as well as the role of gender violence in unwanted pregnancy, USAID should ensure that referral for gender-related violence, detected during PAC treatment and counseling, should be part of comprehensive PAC services, and that all CA reproductive health projects raise awareness of and address gender-based violence in its different ramifications.

Systems and Management

- USAID/Washington, CATALYST, and specific USAID Missions should establish clear understandings regarding the likelihood—or absence thereof—of a project extension beyond September 30, 2005.
- Before launching a follow-on project, USAID/Washington should attempt to establish, via enquiries to USAID Missions, the extent of market demand for a follow-on project and determine the approximate levels of field support funding that Missions might be prepared to make available for the new project.
- Immediately after launching a follow-on activity (should USAID/Washington decide to do so), the Agency should support the implementing agency(s) efforts to inform USAID Missions regarding the new project's objectives, its usefulness to the Missions, and means by which Missions could access the project's services.

The Consortium Mechanism

When USAID prepares its solicitation for a follow-on activity, it should make clear to prospective bidders that the Agency does not assume that larger groupings of prospective implementing partners (organized, for example, as consortia or as a prime contractor with multiple subcontractors) have any intrinsic advantage over smaller groupings (e.g., of one to three implementing agencies). Rather, the essential criterion to be addressed by offerors would be to demonstrate that they either have available or can quickly access the technical and managerial skills required to implement the follow-on project. (Offerors would still be required to demonstrate, as called for by Agency policy, an appropriate level of participation in the project by minority-owned and/or small and disadvantaged organizations.)

USAID Future Actions

- USAID should develop one follow-on project to the current CATALYST and Advance Africa projects. The project should be global, multipurpose, flexible, and structured to facilitate access by its primary users—USAID Missions.
- The project design should take into account, inter alia,
 - the Agency’s uncompleted work;
 - the changing mission of the Agency—to address the special requirements of conflict-prone, fragile, and failing states; and
 - the needs of Missions in the process of developing or implementing phaseout or graduation strategies.
- USAID/Washington should poll USAID Missions where CATALYST and Advance Africa–supported projects are currently underway to identify activities that will require continued support (i.e., from a centrally managed project) after September 30, 2005. USAID/Washington should identify these activities in its RFA/RFP as first-response tasks for the successful bidder(s).
- Grantee/contractor monitoring and evaluation responsibilities to USAID/Washington should be streamlined to reflect only those core-funded/technical leadership activities directly sponsored by USAID/Washington. The frequency of grantee/contractor reports to USAID/Washington might also be reduced.
- USAID/Washington and the Missions should ensure that a fundamental enabling factor—adequate contraceptive supplies—is addressed or is being addressed before requesting or approving new initiatives to be implemented under centrally managed FP/RH projects.

I. BACKGROUND

BUREAU FOR GLOBAL HEALTH STRATEGIC OBJECTIVES

The Advance Africa and CATALYST consortia are the recipients of five-year cooperative agreements funded by the U.S. Agency for International Development (USAID) Bureau for Global Health (GH) and managed by the Service Delivery Improvement Division of the Office of Population and Reproductive Health (GH/PRH/SDI). Both projects originated from the same procurement document, a request for proposal (RFP) issued by USAID in fiscal year (FY) 2000.

Advance Africa and CATALYST contribute to the bureau's achieving its Strategic Objectives (SOs):

- SO 1: Advance and support voluntary family planning and reproductive health programs worldwide
- SO 2: Increased use of key maternal health and nutrition interventions
- SO 3: Increased use of key child health and nutrition interventions
- SO 4: Increased use of improved, effective and sustainable responses to reduce HIV transmission and mitigate the impact of the HIV/AIDS pandemic
- SO 5: Increased use of effective interventions to reduce the threat of infectious diseases of major public health importance

Advance Africa and CATALYST contribute directly to the achievement of SOs 1 and 2. Advance Africa also contributes to the achievement of SO 4.

The objective for Advance Africa and CATALYST is *increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and nonclinical programs*. The Intermediate Results (IRs) are:

- IR 1: Increased access to and improved quality of FP/RH clinical and nonclinical programs
- IR 2: Increased capacity for informed FP/RH decision-making among clients and communities
- IR 3: Increased capacity of public and private sectors to sustain quality FP/RH service delivery programs
- IR 4: Scaled-up and improved FP/RH service delivery programs through technical collaboration with other agency/donor/foundation programs

The scope of work for this assessment notes that “while the strategic objective and the intermediate results for both cooperative agreements are the same, both programs have

evolved independently and autonomously, with their own unique opportunities and challenges largely based on their regional focus” (see appendix A).

The indicators for Advance Africa and CATALYST are shown in the scope of work. These indicators were submitted to the Office of Procurement for modification to each cooperative agreement and were approved. For both projects, the revised indicators more accurately reflect the nature of the CATALYST and Advance Africa portfolios after field support allocations have been made and country programs are being implemented. As a result, they reflect the interests of USAID/Washington and Missions as well as funding allocations made available for evaluation purposes at the country level. Along with the change in essential indicators, Advance Africa has also made a change to IR 3, which reads, “Improved awareness of the importance of the health benefits of FP among African policymakers.”

PROGRAM DESCRIPTION

Advance Africa

The cooperative agreement for the Advance Africa project is managed by a consortium of six organizations: Management Sciences for Health (MSH), lead contractor; the Academy for Educational Development (AED); Family Health International (FHI); the Centre for African Family Studies (CAFS); the Forum for African Women Educationalists (FAWE); and Deloitte Touche Tohmatsu (DTT). The project has been obligated \$28,842,878, which includes estimated FY 2004 obligations of \$2,850,000. Of the total obligations, core funds totaled \$15,617,288; field support funds amounted to \$13,225,590.

The project works with clinical and nonclinical programs to reposition family planning, improve access to and the quality of reproductive health services, and mitigate HIV/AIDS in high prevalence Sub-Saharan Africa, with country programs in Mozambique, Angola, Zimbabwe, the Democratic Republic of Congo (DRC), and Senegal. (It has also provided short-term technical assistance to Benin, Ethiopia, and Rwanda.) Promoting birthspacing as a health intervention to reduce maternal mortality is a major initiative. Salient project activities include strategic planning, training, capacity building, and technical collaboration with other agency or foundation programs.

Advance Africa has demonstrated technical leadership by developing and honing several practical management tools for improving and expanding programs at the field level. Strategic mapping is a participatory planning process to help managers identify and address program gaps and weaknesses. The Best Practices Compendium is an interactive database that enables managers to identify and share state-of-the-art practices that are replicable and can be adapted to local contexts and expanded.

CATALYST Consortium

The CATALYST cooperative agreement is managed by a partnership of five organizations: AED; the Centre for Development and Population Activities (CEDPA); Meridian Group International, Inc.; Pathfinder International (lead); and PROFAMILIA/Colombia.

The five-year cooperative agreement was authorized on October 29, 2000, for \$92,199,828. As of February 2004, total obligations amounted to \$57,137, 897, of which \$17,733,000 are USAID core funds, and \$39,404,897 are USAID Mission funds (field support, of which buy-ins from Egypt and Peru represent close to 68 percent of the project's total field support funds). CATALYST's analysis of remaining project field support funds for Bolivia, Egypt, India, Laos, Nepal, Pakistan, and Peru indicate that there are no anticipated problems in funds being spent by the end of the project.

The CATALYST Consortium was designed to increase the use of sustainable, quality family and reproductive health (FP/RH) services and healthy practices through clinical and nonclinical programs. Anticipated results included increased access to and improved quality of FP/RH clinical and nonclinical programs; increased capacity for informed FP/RH decision-making by clients and communities as well as of the public and private sectors to sustain quality FP/RH programs; and replicated, expanded, and improved FP/RH service delivery through technical assistance to other agency/donor/foundation programs.

As of January 2004, CATALYST had seven field offices located in Bolivia, Egypt, India, Nepal, Pakistan, Peru, and Yemen. The project also has supported USAID activities in over 15 countries in Southeast and South Asia, Central and South America, the Middle East, and Eastern Europe. CATALYST also collaborates with other USAID cooperating agencies (CAs), bilateral and multilateral donors, and nonprofit organizations to introduce innovations in the field of FP/RH and to disseminate information on important research findings.

CATALYST has contributed to FP/RH service delivery by

- providing technical leadership to improve the quality of care in FP/RH health in clinical and nonclinical services;
- complementing USAID bilateral health programs through the application of best practices, innovations, and lessons learned from other countries;
- creating opportunities for technical assistance and collaboration among less developed countries;
- developing linkages between health and nonhealth programs; and
- expanding FP/RH services through partnerships with private commercial sector and nongovernmental organizations (NGOs) to address the unmet needs of men, youth, and underserved populations.

CATALYST has been responsive to USAID/Washington and to Missions by implementing an extremely broad range of activities. However, as CATALYST noted in its first management review (October 29, 2000–August 31, 2001), many activities, even in the first year, differed significantly from those proposed in the cooperative agreement. In response to Mission requests, CATALYST has implemented a range of activities beyond FP/RH service delivery, including a role as a broker for Missions, a role as a

direct implementer (in addition to provision of technical assistance or training) in Egypt, and work in Peru, funded through \$12 million field support, on a program in which RH is only a small part of the total program. In Peru, the CATALYST portfolio has included primary and curative health care activities as well as activities to develop civil society, including work with professional societies and medical schools toward a program of medical certification and accreditation, and technical assistance for regional health planning, regional education planning, and strengthening the cold chain for childhood immunizations.

METHODOLOGY

The four-person assessment team reviewed project documentation, including but not limited to the Advance Africa and CATALYST cooperative agreements, self-assessment reports, annual work plans and budgets, management results review documents, research and technical reports, quarterly and progress reports, and other relevant correspondence. During preparation time together in Washington, D.C., the team interviewed Advance Africa and CATALYST headquarters staffs and the projects' USAID cognizant technical officers (CTOs) and conducted telephone interviews with overseas USAID Mission staffs and personnel from consortium member agencies (see appendix B for persons contacted).

To assess Advance Africa project activities in depth, two team members undertook field visits to Zimbabwe and Mozambique. The two team members responsible for CATALYST visited field programs in Peru and Egypt. (See appendix C for schedules and appendix D for country reports.) Site visit methodology comprised meetings with relevant USAID Mission and project staffs in-country and field trips to selected implementation sites. (These visits were not evaluations of those country programs.) Although the funding level for the four countries varies significantly according to USAID design of this assessment, the level of effort for each country visit was the same; the objective was to become acquainted with the program as an example in order to jointly assess the global programs of Advance Africa and CATALYST.

Table 1
Assessment of Country Visits

CA and Country	Level of USAID Funding
Advance Africa, Zimbabwe	1,361,688
Advance Africa, Mozambique	6,613,700
CATALYST, Peru	12,114,417
CATALYST, Egypt*	14,546,480

*Plus \$3 million added in April 2004

Following the country visits, the teams reconvened in Washington to compare notes and follow up and validate findings with relevant parties.

A challenge in developing this report was balancing the findings for two CAs in one report with a page limitation. One way of ensuring fairness was to resolve that no data or data analysis received after the team meetings in Washington would be considered unless the team had made a factual error in reporting the data supplied to the team by that time. A second way was to give priority to findings from actual team visits and to quantitative output data rather than listing all unobserved or unverified inputs. A final consideration

was proportionality; there are more data on CATALYST in this report than on Advance Africa because CATALYST's funding and expenditures have been twice those of Advance Africa.

II. IR 1: INCREASED ACCESS TO AND IMPROVED QUALITY OF FP/RH CLINICAL AND NONCLINICAL PROGRAMS

FINDINGS FOR ADVANCE AFRICA

Advance Africa has four indicators to assess its contribution to *increased access to and improved quality of family planning and reproductive health (FP/RH) clinical and nonclinical programs*. The indicators and their anticipated source of data follow.

Table 2
Advance Africa Program Indicators for IR 1 and Data Sources

Program Indicators	Source
Number of fully functioning FP/RH service delivery points accredited according to local standards	Service statistics, service delivery point assessments, and inventory
Number of mother-to-child transmission (MTCT) sites where more than 75 percent of clients receive FP counseling and services	Service statistics
Percentage of HIV/AIDS clients receiving FP at MTCT sites	Service statistics, exit interviews
Percentage of FP clients whose cases are managed in compliance with the local quality standards	Service delivery point assessments

Advance Africa has relatively limited data for measuring achievement in terms of these indicators for several reasons. One reason cited is that Advance Africa’s indicators at the central level differ from those employed in the field. Another cited reason is that field programs have focused on recording implementation progress in terms of process indicators, such as the number of people trained. Assessments in terms of output indicators of access or quality have not been performed, reportedly because, with the exception of the Zimbabwe country program, most of Advance Africa’s field activities have been either short-term technical activities or programs that have begun only in the last year or so.

Notwithstanding initial implementation challenges, Advance Africa appears to have increased access to and improved the quality of FP/RH clinical and nonclinical programs through its country programs in Zimbabwe, Mozambique, Senegal, the DRC, and Angola. Particularly noteworthy in table 3 on the following page is the positive Zimbabwe trend line in the community-based distribution (CBD) program. These data are described in detail below. On a global level, Advance Africa has developed such management tools as strategic mapping, best practices, and Performance Monitoring Plus/ACCOMPLISH (monitoring and evaluation models) that field tests indicate have the potential to greatly enhance access to as well as the quality of FP and RH services.

Table 3
Performance Data for Selected Advance Africa Programs

Country	Activity and/or Indicator	Available Data
Zimbabwe	Expanded CBD program, Zimbabwe National Family Planning Council (ZNFPC) <ul style="list-style-type: none"> ▪ Male condom and oral contraceptive distribution ▪ Referrals for voluntary counseling and testing (VCT), sexually transmitted infections (STI), HIV/AIDS services 	2001 baseline: 170,000 condoms/year; 50,000 oral contraceptives/year in project districts Accomplishments: <ul style="list-style-type: none"> ▪ 2002: 200,000 oral contraceptives; 670,000 condoms ▪ 2003: 350,000 oral contraceptives; 700,000 condoms ▪ 2002: 100 VCT; 200 STI and HIV/AIDS ▪ 2003: 830 VCT; 500 STI and HIV/AIDS Persons trained: 9 group leaders, 54 community-based distributors, 222 depot holders
	Mission hospital and orphans/vulnerable children programs just getting underway	No data available
Democratic Republic of Congo	Program startup in 10 zones (after 9 months of project activity)	<ul style="list-style-type: none"> ▪ September 2003 training in Varga (15 nurses trained) ▪ 223 health care providers trained in five provinces ▪ 9,210 clients served (91,961 injectable contraceptives, 1,321 oral contraceptives, 97 IUDs, 15,930 condoms) ▪ Brochures developed to educate readers on health benefits of optimal birthspacing
Angola	Demonstration FP project in a postwar context	<ul style="list-style-type: none"> ▪ Equipment renovation at 14 sites ▪ Trained 26 nurses in FP/RH and optimal birthspacing ▪ Trained 27 nurses in logistics planning and management ▪ Established behavior change communication (BCC) strategy
Mozambique	Reduce maternal mortality through improved emergency obstetric care/postabortion care (PAC) activities <ul style="list-style-type: none"> ▪ Training in infection control ▪ Materials development ▪ Rehabilitation of maternity units 	<ul style="list-style-type: none"> ▪ 120 provincial trainers and 240 elementary nurses and midwives from target provinces trained in biosafety ▪ Six infection control manuals for elementary nurses and community health agents adapted; 5,000 manuals printed and distributed ▪ Information, education, and communication (IEC) posters on biosafety developed, distributed, and observed at facilities in target provinces
	Support development of the Ministry of Health (MOH) family planning policy and strategy	<ul style="list-style-type: none"> ▪ Optimal Birth Spacing Initiative (OBSI)/repositioning family planning workshop held in December 2003 ▪ Consultant facilitating the MOH with strategic planning process
	Improve supervision of community health care activities	<ul style="list-style-type: none"> ▪ Training modules and manuals on integrated supervision of community health developed ▪ 35 central level staff and 185 provincial staff trained in integrated supervision
	Reposition family planning	35 central level staff, 185 staff trained/retrained in family planning
	NGO coordination in six provinces	Development of <i>Intelligent Indicators</i> and <i>Value Added Tools</i> for program managers
Senegal	Strengthening health monitoring	<ul style="list-style-type: none"> ▪ FP indicators identified ▪ Monitoring guide used in all regions of Senegal
	Integrate PAC into NGOs (SANFAM and ASBEF)	<ul style="list-style-type: none"> ▪ Two medical doctors and 15 midwives and nurses of SANFAM and ASBEF trained in PAC service delivery ▪ PAC services available in nine SANFAM and ASBEF clinics

In Zimbabwe, Advance Africa and ZNFPC have succeeded in reorienting and expanding the country's longstanding CBD network from being narrowly focused on family planning to a more holistic approach. In response to a survey that highlighted the excess burden placed on CBD agents, ZNFPC added two new distribution models to enhance service delivery:

- a depot holder model, which involved training personnel (depot holders) to resupply condom and oral contraceptive clients and to disseminate preventive health messages at the village level, and
- a satellite model, where the CBD agent would be stationed at a prearranged location in her catchment area on specified days (as opposed to conducting door-to-door services). (See Zimbabwe country report in appendix D for further details.)

Through the expanded CBD program, family planning activities at the community level have been broadened to include HIV/AIDS awareness, dual protection messages, and referrals to VCT. In addition, clients have increased contraceptive security and more convenient access to services. Field visits and interviews with staff indicate that community-based providers themselves feel more confident about their responsibilities. Survey data confirm that clients too are pleased to have improved access to more comprehensive services. An effort is also being made to recruit new staff members that are more reflective of and responsive to local demographics and to enlist increased male participation/cooperation in RH decision-making. Data collected from Population Services International (PSI) New Start VCT centers suggest that community-based referrals generated from the expanded CBD program are contributing to an increased demand for VCT services.

Similarly, in collaboration with four Mission hospitals operating in some of these districts, Advance Africa/Zimbabwe is improving service quality by imbuing HIV/AIDS clinic staff and outreach workers through training with the importance of family planning as a health intervention to reduce maternal mortality and enhance child health. Since earlier this year, Advance Africa has also been collaborating with several NGOs working with adolescent orphans and vulnerable children to integrate FP and HIV/AIDS information and appropriate services into ongoing support activities. Thus, clients in 16 districts in eight provinces now have access to a wider network of trained personnel who are able to refer them to facilities with staff equipped to offer more integrated services.

Sadly, as exemplary a model as this has proven, the economic and political circumstances of the operating environment are such that escalating the expanded CBD program to additional districts is unlikely in the near future. High staff turnover and defection, waning morale, and dwindling resources at ZNFPC's central level have undermined the organization's ability to be a reliable and effective USAID partner in this initiative. Even if this were not the case, Brooke Amendment stipulations that restrict support to Zimbabwean government institutions, coupled with reductions in funding to USAID population programs in general, hamper the expansion and replication of prospects at present. Nevertheless, it is crucial that an effort be made to document the lessons learned

from the expanded CBD program so that these successful program initiatives can be easily resuscitated, replicated, and expanded once conditions improve.

Advance Africa has contributed to enhancing access to and the quality of FP/RH health services in Mozambique through training relevant staff in family planning (a service delivery component that had been neglected for over a decade), infection control and integrated supervision, and rehabilitating and equipping selected maternity hospitals to improve their quality of care. Some of the activities underway in Mozambique are a carryover from a previous John Snow, Inc. (JSI) FP/RH project that ended in mid-2003 that focused on PAC and other interventions to reduce maternal mortality rather than family planning. It is only fairly recently, as a result of Advance Africa advocacy efforts (primarily via visits from the deputy director from headquarters), that the MOH has embraced family planning/optimal birthspacing as a health intervention. (This is discussed in greater detail under IR 4 as well as in the Mozambique country report.) Follow up of trained staff is a source of concern insofar as only 185 of the 356 that will be trained are expected to receive follow up before the end of the project. (See appendix D for the country report.)

Advance Africa also serves as a coordinating body and pass-through mechanism for continuing field support begun as JSI subgrants to five NGOs working in six provinces to improve service delivery. In collaboration with provincial and district health authorities, the NGOs are supporting expanded community-based care to alleviate high rates of maternal and infant mortality through health committees and by building up staff capacity in FP/RH and primary health care at referral facilities. As part of its agenda of new (non-JSI carryover) initiatives, Advance Africa sent reproductive health assistants to support World Vision and Save the Children/United Kingdom health sector activities in the densely populated provinces of Zambezia and Nampula. The effectiveness of this targeted assistance in training and logistics remains in question, insofar as both Zambezia and Nampula have recently suffered from contraceptive stockouts (the only two provinces with this problem), and the MOH staff at the central level implied that communications with provincial Advance Africa have been problematic.

An Advance Africa initiative in Mozambique with clear potential to enhance the quality of care has been the standardization of NGO monitoring and evaluation data; institutionalization of quarterly coordination meetings of relevant stakeholders at the provincial and, more recently, district levels; and the development of *Intelligent Indicators*, a useful analytic tool for helping managers maximize the benefit of service delivery encounters. Unfortunately, the person responsible for these innovations recently left the project; it remains to be seen whether his successor will build on the momentum achieved thus far for the limited duration of the project.

In response to a strategic mapping exercise in Angola, with core funds and in collaboration with the MOH, Advance Africa developed and recently initiated an integrated FP/RH project (including HIV/AIDS) in the central province of Huambo, one of the poorest and most war-affected provinces in the country as well as one of the most populated. Although it is too early to gauge the overall impact of the project, it has opened hitherto unavailable health care options to the population, thereby significantly improving community access to better quality clinical and nonclinical services. The USAID Mission in Angola has been so pleased with Advance Africa's activities to date

that it has earmarked field support funds to ensure the project's continuation for the coming year.

Since late FY 2003, Advance Africa has been providing technical assistance to the SANRU III (Santé Rural) primary health care project in the DRC to increase the use of modern contraception in 13 health zones, 2 of which harbor mostly internally displaced populations. The principal input thus far has been supervision and the training of trainers through CAFS. According to USAID/DRC, Advance Africa has added "an element of professionalism" to an overextended project, ensuring that beneficiaries now have access to better supervised FP/RH services and more informed personnel.

In Senegal, Advance Africa's overhaul of the country's primary health care (PHC) performance monitoring system through CAFS included the addition of FP/RH indicators. This has enabled program managers in six USAID districts to assess the progress of five key PHC interventions (including FP and HIV/AIDS prevention activities) more closely and to respond accordingly to problems identified, thereby upgrading the quality of care. Advance Africa has been restricted from further involvement in this regard because the USAID Mission believed that another centrally managed project (MEASURE) could follow up. Advance Africa also endeavored to put female genital cutting (FGC) more prominently on the national health agenda by proposing that FAWE train secondary school teachers to discuss with students the deleterious health consequences of this practice. USAID/Senegal, however, decided not to move forward with this initiative.

In summary, in those countries where Advance Africa has or has had a field presence, its activities have contributed to improved service delivery through better trained personnel, more holistic programmatic approaches, and enhanced management tools. Initial staff turnover and management disruptions as well as marketing restrictions, however, greatly encumbered the project from having a greater global impact.

FINDINGS FOR CATALYST

CATALYST has two indicators to measure contributions to *increased access to and improved quality of FP/RH clinical and nonclinical programs*: the percentage/number of clients in service delivery points initiated and/or improved with CATALYST, and the percentage of clients in relevant program areas accepting the use of contraceptives. Tables 4 and 5 on the following page present the data that were available to the team on these indicators as well as the overall funding level in those countries. (The source is *CATALYST Consortium Integrated Results for Core, Regional and Mission Funded Activities*, December 2003, except as noted for Egypt and Bolivia.)

Table 4
Percentage and Number of Clients in Service Delivery Points
Initiated and/or Improved With CATALYST

Country	Activity and/or Indicator	Available Data
Egypt (\$14.5 million)	In Upper Egypt Ministry of Health and Population (MOHP) clinics: <ul style="list-style-type: none"> Percentage of FP/RH clients under 25 years Percentage of 0–2 parity clients receiving FP/RH services 	Data are available on five MOHP rural health units in Minia: ¹ <ul style="list-style-type: none"> Quarter 3, 2003: 14%; Quarter 4, 2003: 13%; Quarter 1, 2004: 11% Quarter 3, 2003: 25%; Quarter 4, 2004: 27%; Quarter 1, 2004: 24% Average daily number of clients seeking FP/RH services in these clinics: Quarter 3, 2003: 5.3 clients; Quarter 4, 2003: 5.1 clients; Quarter 1, 2004: 5.4 clients
	In Upper Egypt Clinical Services Improvement project (CSI) clinics: <ul style="list-style-type: none"> Percentage of FP/RH clients under 25 years Percentage of 0–2 parity clients receiving FP/RH services 	CATALYST presented no data to team.
Peru (\$12.1 million)	Total number of FP/RH consultations in RedPlan	29,401
	Total number of OBSI clients at Asociación para el Desarrollo Amazónico Rural (ADAR) clinics	3,555
	Total number of youth visiting supported kiosks or reached out to by those kiosks	90,231
	Clients for expanded method mix at emergency centers	2,264
Bolivia (\$1.7 million)	Total number of OBSI clients	1,120 ²
	Total number of PAC clients	19,629
	Total number of youth clients	12,423
India (\$1.7 million)	Number of CBD clients	An increase of over 600,000 clients from the point at which CATALYST assumed responsibility for program

Table 5
Percentage of Clients in Relevant Program Areas Accepting Use of Contraceptives

Country	Activity and/or Indicator	Available Data
Bolivia	Percentage of PAC clients	37% (7,207 clients)
Peru	Percentage of clients accepting FP in OBSI pilot in Amazon	34% (1,137 clients accepting)
	Percentage of youth accepting FP in two youth kiosks	11% and 12% (total: 2,253 youth)

¹ “Discussion, Outcome Indicator Results, January–March 2004,” CATALYST, undated.

² In May, CATALYST presented data to the team showing 1,120 OBSI clients; in September, CATALYST indicated the number was 4,834.

The following box presents CATALYST/Peru service statistics on FP/RH activities undertaken with Peruvian NGOs (ADAR, Apoyo a Programas de Población [APROPO], Flora Tristan, and the Instituto Peruano de Paternidad Responsable [INPPARES]), and with the commercial sector. No service statistics are available for the extensive PAC services, expanded with CATALYST's support, in the public sector.

CATALYST Data on Peruvian FP Clients, Commodities, and Couple Years of Protection (CYPs)

- RedPlan: 29,401 consultations, of which 8,646 were for family planning, with a contraceptive distribution equivalent to approximately 3,000 CYPs
- OBSI pilot project (with ADAR): 1,137 family planning clients, who were 34 percent of the clients counseled (CYP data not provided)
- Social marketing (with APROPO): 195,000 condoms distributed (CYP: 1,625)
- Expanding method mix in emergency centers (with Flora Tristan): 2,264 clients
- Yes! youth project in Lima (with INPPARES): total youth accepting FP: 2,253, averaging 11.5 percent of youth counseled (CYP: 11)
- Three other youth activities: 17,713 visitors (unknown number or percentage of youth accepting FP or contraceptives distributed)

Although in terms of the indicators in the cooperative agreement CATALYST documents relatively small scale and low volume activities, CATALYST has documented extensive inputs and process activities that should lead, in time, to increased access to and improved quality of FP/RH clinical and nonclinical programs. Details on these inputs and process activities are available in CATALYST's work plans and progress reports at both the global and country levels.

A major contribution using core funding that should lead to increased access to and improved quality of FP/RH clinical programs has been CATALYST's leadership role in launching OBSI, an initiative that presents a clear and compelling health basis for family planning and demonstrates that three to five-year birth intervals result in reduced morbidity and mortality for mothers and infants. CATALYST has aggregated medical research on the subject, overseen a literature review, disseminated findings among USAID CAs and donors, and built awareness among Missions, governments, host country institutions, donors, and pharmaceutical companies. CATALYST reports on OBSI focus groups in six countries (Bolivia, Egypt, India, Pakistan, Peru, and Romania) are valuable documents that illustrate the barriers women face in spacing pregnancies. Through these reports, CATALYST did an excellent job of integrating gender issues into the OBSI discussion and facilitating more effective programming in gender and male involvement.

The results of CATALYST's and USAID's efforts appear to be a greater consideration of spacing for health reasons and a willingness of countries wary of family planning to reconsider it on new repositioned grounds. Peru is an example. The May 2004 OBSI conference in Lima placed OBSI on the Peruvian public and private health agenda by providing evidenced-based data on the strong link between three to five-year birth

intervals and improved maternal and child health. Meetings in Bolivia are doing the same. However, to date, there is no evidence of countries responding to OBSI by revising national policies, revising medical standards or protocols, or working to ensure contraceptive supply in response to the knowledge that spacing births three-to-five years saves lives.

One extenuating factor limiting the effectiveness of the replication and expansion of OBSI programs at the field level as well as the ability of CATALYST to increase access to and improved quality of FP/RH clinical and nonclinical programs is a shortage of modern contraceptives in the public sector. Although CATALYST has ensured that the small OBSI pilot programs it has facilitated with NGOs have had contraceptives, CATALYST has had no responsibility or authority for assuring contraceptive supply in the public sector. Contraceptives are in short supply in three Latin American countries (Guatemala, Peru, and Bolivia) where CATALYST has made significant, successful efforts to introduce the OBSI agenda.

In Peru, a recent report³ confirms the anecdotal data that Peruvian managers and service providers related to the assessment team about the shortage of contraceptives in the public sector, which was responsible for 79 percent of contraceptive prevalence in 2000.

- While the number of women of reproductive age rose 2 percent annually from 2000 to 2003, the national budget (MOH or Ministerio de Salud [MINSA]) for contraceptives dropped from 8,889,714 to 1,600,000 soles. During that time, MINSA CYP reportedly dropped for modern methods as follows: intrauterine device (IUD): 28.6 percent; injectable contraceptives: 0.3 percent; female sterilization: 65.2 percent; and vasectomies: 0.5 percent.
- In 2003, the MINSA CYP was 5 percent less than four years previously (had it kept pace with the 2 percent annual growth in the number of women of reproductive age, it would have grown 8 percent).
- MINSA reported that the number of abortions treated in MINSA facilities over the period rose from 34,653 to 41,993.
- Although maternal mortality declined steadily from 1997 to 2003 and adolescents as a percentage of that mortality declined steadily from 1997 to 2001 (from 15.6 to 11.1 percent), in 2002, the adolescent percentage began to rise, and in 2003, it was approximately the same percentage (15.7 percent) as it was in 1997 (15.6 percent).

Improved PAC is the second area in which CATALYST has had an important global leadership role. CATALYST has clearly expanded access to and improved the quality of PAC services. Bolivia is an example of the success possible with PAC programming. In Bolivia, where abortion has been a leading cause of maternal mortality,⁴ CATALYST

³ Delicia Ferrando, *El Aborto Clandestino en el Peru, Nuevas Evidencias*, Pathfinder International and Flora Tristan, with the support of the Ford Foundation, May 28, 2004. Note: USAID funds were not used for this study.

⁴ In 1987, the ministry estimated that about 40,000 women annually suffered abortions. Of these, only about 30 percent reached hospitals for treatment of hemorrhage or infection. Abortion was the number one

trained 722 providers from 62 different hospitals in PAC. Service statistics indicate that over 19,000 clients have received PAC services at these facilities since program inception. CATALYST data⁵ indicate that women treated for PAC are electing to use family planning at rates considerably higher than the national contraceptive prevalence. Data for 12 months of 2003 (but incomplete for the month of December) from 22 hospitals in five urban and peri-urban areas indicate that 9,507 women received treatment in 2003. Of these, about 75 percent (7,140) received family planning counseling. Of these 7,140 women, 49 percent chose to leave with a modern method of contraception (Depo-Provera, condoms, oral contraceptives, or an IUD). Thirty-seven percent of all women treated choose to use modern contraception. In the 1998 Bolivian Demographic and Health Survey (DHS), modern method contraceptive prevalence was 25 percent (the 2003 Bolivia DHS is not yet available).

From a small start in a few hospitals, CATALYST, working with the Peruvian MOH, has expanded to seven departments through the Obstetric and Neonatal Emergencies program. CATALYST is training public sector doctors, nurses, and midwives in the five departments in new obstetric and neonatal emergency standards of care that include PAC. Additionally, CATALYST has been able to assess the capabilities of 843 facilities to provide emergency obstetric care, including PAC, and is in the process of developing institutional capabilities among these facilities to address PAC emergencies.

Building upon the successful programs in Bolivia and Peru, CATALYST has increased access to improved PAC services in Latin America. In 2002, it held a PAC conference attended by 110 participants from six countries in the region, leading to the initiation of PAC programs in three new countries at the initiative of public sector entities, without external financial support. Guatemala incorporated comprehensive PAC into its RH norms and protocols. Conference attendees from Nicaragua and the Dominican Republic have launched pilot programs in their countries.

CATALYST has made a real contribution in advancing PAC as a concept with multiple essential elements. PAC, as promoted by USAID and CATALYST, comprises three essential elements:

- emergency treatment for complications of spontaneous or induced abortion;
- family planning counseling, service provision, and referral for selected reproductive health services; and
- community awareness and mobilization.

However, in reality, the treatment of complications continues to be, by far, the strongest element in the model.⁶ Contraceptive shortages in Latin America impede family planning services in PAC just as they hinder OBSI. Referral for selected reproductive health services continues to be very weak, as it was during the USAID global PAC evaluation in

cause of maternal mortality (Ministerio de Previsión Social y Salud Pública, *Seminario Taller Lucha Contra El Aborto*, La Paz Bolivia, March 20–22, 1989, pp. 139–145).

⁵ Data provided to team leader by CATALYST in February 2004.

⁶ USAID and the CA community have defined the PAC model in various ways since the concept was developed in 1991. USAID developed the current model in April 2003.

2001, principally because reproductive and other health services are lacking in the public sector in most countries. Community awareness and mobilization are only at the preliminary, pilot stage in three countries (Bolivia, Peru, and Romania).

Although CATALYST defines its PAC activities as comprehensive, they are comprehensive more in theory than in practice, principally due to the lack of other reproductive health services in public sector facilities. For example, in Peru, where the 2000 Peruvian DHS reported that 25 percent of sexually active women indicated that in the previous 12 months they had had an STI, genital secretion, or ulcers, it seems essential that diagnosis and referral for STIs be part of comprehensive PAC. Given the high levels of gender violence reported in the CATALYST OBSI focus group reports and in DHSs around the world as well as the role of gender violence in unwanted pregnancy, referral for gender-related violence, detected during PAC treatment and counseling, should be part of comprehensive PAC services.⁷

Integration has been a key theme of the CATALYST project and the focus of two models. The first, developed in Laos, is the integration of FP into maternal and child health (MCH) programs. The second model, defined by CATALYST as more comprehensive, is that of Egypt, with the integration of FP not only into MCH but also into nonhealth programs, such as education, agriculture, and literacy. The discussion under IR 2 below presents ways CATALYST has begun to mobilize various segments of civil society (agricultural workers, religious leaders, university faculty) in Minia, Egypt, to advocate for improved FP/RH decision-making.

Integration of Egyptian public sector FP and MCH is a challenge. The assessment team observed CATALYST efforts at integration at the village level in the governorate of Minia, where it is working through rural health clinics that are used as springboards for community mobilization. To date, CATALYST has worked in five villages in rural Upper Egypt where the unmet need for FP/RH is greatest. CATALYST and USAID state that there is great MOHP interest in expansion to further villages in the governorate and in other governorates of Upper Egypt; CATALYST and USAID are planning expansion.

Whether the Minia model will achieve its objective of increased use of FP/RH services overall as well as by young and low-parity women remains to be seen. Reviewing the data for the first 9 months in light of outcome indicators for the project (presented in table 4 above for five rural health units which averaged five FP/RH clients a day), CATALYST wrote in an assessment of those activities that “Increases in total FP clients, youth clients and low-parity clients have not yet been seen in the five rural health units where TAHSEEN has renovated facilities and trained providers.” Exit interviews with female patients in three clinics indicate that the number of female clients seeking curative services, however, increased by 24.5 percent.

⁷ See Sunita Kishor and Kierston Johnson, *Profiling Domestic Violence, A Multi-country Study*, ORC Macro, June 2004. The study profiles violence against women by their intimate partners. The proportion of ever-married women reporting such violence ranged from highs of 48 percent in Zambia, 44 percent in Colombia, and 42 percent in Peru, to the lowest of 18 percent in Cambodia. The authors note that “domestic violence not only poses a direct threat to women’s health but also has adverse consequences for other aspects of women’s health and well-being and for the survival and well-being of children.” Further, in all nine countries examined except Haiti, “women who have ever experienced violence are less likely to have had a birth that was wanted at the time of conception than women who have never experienced violence.”

CATALYST notes that “continued and intensified activities are planned at both the health unit and the community level in these five sites over the next year, with another year of phase out as well. These activities are expected to contribute to an increased demand and use of reproductive health services in the communities.”^{8,9} (See appendix D for the Egypt country report.)

Efforts at the central level, with the potential for national impact, face entrenched political interests; however, USAID reports that there is government support at the highest levels for integration. The assessment team spoke with government leaders and staff from other cooperating agencies working on the same or allied agenda in Egypt. Their consensus was that dealing with the issues of differential financial incentives on a central level (a highly political subject) and collaboration between family planning and MCH were key to successfully integrating FP and MCH in Egypt.

CATALYST notes¹⁰ that it has undertaken an “enormous amount of national level work” to promote integration, including “updating and expanding training curriculums and materials, client/patient materials, standards of practice (SOPs), supervision systems and tools, performance bonus incentive system, etc.” The team did not meet with any national-level CATALYST counterparts on these activities or see any documents relevant to these activities and hence has not commented on them in this assessment.

CONCLUSIONS AND RECOMMENDATIONS ON IRI

Except for CATALYST’s work in PAC in Peru and Bolivia and its CBD work in India and Advance Africa’s CBD program in Zimbabwe, few quantifiable data are available to demonstrate that to date, these two projects have significantly increased access to and improved the quality of FP/RH programs, thereby leading to increased use. Advance Africa has few data on client use or contraceptive distribution/supply. CATALYST presented data on activities that to date, after three and a half years, are small scale and low volume. For example, in Peru, the total number of family planning clients reported by four activities is 14,300, while reported CYP is 4,500;¹¹ in Egypt, the only service delivery data that are available reports an average of five clients a day from each of five renovated rural health units. However, both projects have set in motion processes that should lead to more significant expanded access and improved quality.

Improved PAC services are safer for the woman, less costly for the woman and the health system, and offer the possibility of reducing repeat abortion and of detecting/preventing other illness and/or trauma.¹² USAID should continue to support the global expansion of

⁸ “Discussion, Outcome Indicator Results, January–March 2004,” CATALYST Consortium, undated.

⁹ In written comments to this report’s second draft, both CATALYST and USAID/Egypt indicated that the “original intention was to conduct a national mass media campaign beginning in November of 2003 and continuing for a year with focused messages for these women, including OBSI.” They indicated that the responsible project had yet to undertake the campaign. The team heard no discussion about such a national mass media campaign from CATALYST, USAID, or the other project while in Egypt and cannot comment on this issue.

¹⁰ In written comments to a review of the second draft of this report.

¹¹ “CATALYST Consortium Integrated Results for Core, Regional and Mission Funded Activities, December 2003.”

¹² Safer and less costly than traditional dilation and curettage (D&C).

PAC services. It is essential that program planners continue to examine ways to implement all three essential elements of PAC, as appropriate, in their respective countries.

Contraceptive supply and security are essential to improving maternal and child health as well as to ensuring the effectiveness of USAID efforts in OBSI and PAC.

Both the CATALYST and Advance Africa experiences demonstrate the critical importance of continued work on integrated RH care. The Egyptian program illustrates the challenges of integrating established vertical programs. As USAID phases out of contraceptive supply and issues of sustainability become paramount, it is essential in countries where USAID has long supported vertical programs that USAID support determined efforts to integrate the various components of RH. The Zimbabwe expanded CBD program has shown successful integration of HIV/AIDS awareness, dual protection, and referral for VCT into family planning; it should be documented and expanded when possible.

Recommendations on IR 1

USAID should continue to support, through a follow-on mechanism, USAID technical leadership in

- OBSI;
- PAC, stressing the importance of all three elements; and
- integration.

Advance Africa should document the lessons learned from the Zimbabwe expanded CBD program so that this successful program initiative can be resuscitated, replicated, and expanded once conditions improve.

USAID should intensify efforts to ensure contraceptive security.

III. IR 2: INCREASED CAPACITY FOR INFORMED FP/RH DECISION-MAKING AMONG CLIENTS AND COMMUNITIES

Advance Africa and CATALYST have specific indicators for measuring and evaluating the IR of *increased capacity for informed FP/RH decision-making among clients and communities* in their cooperative agreements with USAID. However, while Advance Africa’s indicators focus on FP/RH knowledge and attitude (aspiration), the lead indicator for CATALYST assesses changed practice among the population targeted by CATALYST. USAID and CATALYST documents specify that the programmatic areas in which FP/RH behavior change is to be achieved are family planning, postabortion care, and integration between health and nonhealth interventions. The two projects’ indicators for this IR are presented in the box. The source of data for both was to be surveys: additionally, CATALYST was to employ qualitative studies and program records.

Indicators for IR 2: Increased Capacity for Informed FP/RH Decision-Making Among Clients and Communities
<p>Advance Africa Indicators</p> <ul style="list-style-type: none"> ▪ Percentage of women of reproductive age in union with aspiration to space next child at least 36 months ▪ Percentage of men of reproductive age in union with aspiration to space next child at least 36 months ▪ Percentage of women of reproductive age in union reporting increased communication with partner over FP/RH issues ▪ Increase in proportion of underserved population aware of available FP services
<p>CATALYST Consortium Indicators</p> <ul style="list-style-type: none"> ▪ Percentage of targeted audience adopting behaviors supported by CATALYST (e.g., discussing/negotiating contraceptive use with partner, seeking support/assistance when facing gender-based violence, discussing care-seeking for emergency obstetric care/PAC patients with family members) ▪ Percentage of programs establishing links between FP and social programs in other sectors

Three critical factors constrain assessing Advance Africa and CATALYST’s achievements regarding more informed FP/RH decision-making. The first factor is that the source of data is primarily national surveys, the timing of which does not coincide with this assessment. A second constraint is the relatively short timeframe of project activities. A third is the fact that many USAID Missions have different indicators than those outlined in the USAID/Washington cooperative agreements.

FINDINGS FOR ADVANCE AFRICA

Advance Africa appears to be cultivating increased client and community capacity for informed FP/RH decision-making and demand for services through some of its country program initiatives. These include expanding community networks, targeting youth, enlisting increased male involvement, and integrating life skills education into school curricula. Key to this has been the buy-in of clinic and nonclinic providers who use positive peer pressure to disseminate appropriate messages and facilitate referrals. In Zimbabwe, according to a ZNFPC/Advance Africa monitoring report, client referrals from CBD agents to VCT centers increased 694 percent from October 2002 to September 2003, CBD referrals for family planning increased by 352 percent, and the distribution of oral contraceptives increased by 662 percent during this same period—testimony to the project’s effectiveness in creating a more informed clientele.

Promotion of (optimal) birthspacing as a health intervention and integrating it into prenatal (prevention of mother-to-child transmission [PMTCT]), postnatal, and VCT services in Zimbabwe, Angola, and Mozambique is helping to overcome inherent cultural beliefs and misinformation that are in opposition to family planning. The concept of spacing children for maternal and child health rather than messages about optimal family size generates a more acceptable context for encouraging contraceptive use in communities where fertility and large families are signs of status and HIV/AIDS is destroying the societal makeup.

Formation of community health committees in Mozambique has proven to be an effective means for marshaling increased local awareness of FP/RH issues. In rural Zambezia in northern Mozambique, both male and female local health committee members demonstrated a good understanding of the health benefits of birthspacing as well as knowledge of a number of contraceptive options and were aware of when pregnant mothers needed to seek assistance. In Angola, Advance Africa theater groups have reached over 1,000 people with reproductive health messages since the beginning of 2004. The audiences include many who might otherwise not be informed, such as adolescents and men.

Increasing male involvement is crucial for improving FP/RH decision-making capacity. Even though men acknowledge the economic and health benefits of family planning, entrenched attitudes regarding infertility, promiscuity, and masculinity abound. The basic belief that large families are inherently good makes it difficult for them to view limiting family size as positive. Advance Africa has been supporting a number of initiatives designed to encourage male motivation through expanded CBD program activities in Zimbabwe, mobilizing rural health committees in the DRC, and conducting IEC activities in Mozambique and Zimbabwe. In Zimbabwe, the ZNFPC has undertaken a campaign to encourage men to be nicer to their partners and to show love outside the bedroom (e.g., helping with child care or carrying heavy loads).

Anecdotal evidence suggests, however, that women are still taking primary responsibility for pregnancy prevention and yielding to their husbands' contraceptive preferences rather than exercising their own choice. The advantages of permanent contraception when ideal family size is achieved are not widely touted. When they are, tubal ligation is highlighted, even though a vasectomy is easier to perform and less invasive. Changing male attitudes can only be done over an extended period of time—merely that men are more involved than before (evidenced by reports in Zimbabwe and Mozambique of increasing numbers of couples seeking services together and their growing participation in community health activities) testifies to Advance Africa's efforts to foster increased male participation in FP/RH decision-making.

Advance Africa's collaboration with FAWE in Mozambique, Zimbabwe, and Senegal strives to promote life skills education for adolescents and thus enhance their decision-making capacity. In Senegal, FAWE proposed to highlight the risks of FGC in elementary and high schools in the hope of creating support among the young to eradicate the practice. Further work on this initiative has been suspended, however, on the direction of USAID/Senegal.

In Zimbabwe, Advance Africa is working with FAWE (FAWEZI) to integrate life skills education into primary and secondary schools with an emphasis on reaching adolescent girls. Interviews with FAWEZI staff suggest that the curricula, while providing some information on reproductive health/physiology, will emphasize abstinence and avoid direct reference to condom or contraceptive use. Also, it will not openly address the needs of adolescents who are already sexually active and at risk of STIs and unwanted pregnancies. This could be a counterproductive approach insofar as one of FAWE's stated objectives is to keep young girls in school, and unwanted pregnancies are one of the primary reasons they drop out. The project is still in its conceptual stage and may be of limited utility anyway because the United Nations Children's Fund (UNICEF) is already working with the Ministry of Education to integrate life skills education and reproductive health (including HIV/AIDS prevention and family planning) into school curricula. (Curiously, FAWE was not aware of this endeavor at the time of its discussions with the assessment team.) FAWE also plans to work with clubs in schools to promote career guidance and decision-making and to uphold moral values.

FAWE's effort to integrate life skills education into school curricula and to foster a cadre of young people capable of informed decision-making about reproductive health matters in Mozambique (core-funded) is just beginning. Its approach, however, looks more promising than in Zimbabwe. FAWE will work in partnership with three ministries (MOH, Ministry of Education [with which it is already reviewing curricula], and Ministry of Youth and Sports) and link existing youth centers (many of which are located at or near a health facility) with nearby schools.

Overall, it would seem that many of the youth-related interventions, especially in Zimbabwe, are giving precedence to advocating abstinence over providing service referrals or laying the groundwork for proper informed consent. CBD agents and depot holders in Zimbabwe provide condoms to young men, but refer young women under 16, even if they are already sexually active, to health centers for contraception. Transportation costs, the dire economic situation in Zimbabwe, and double standards and mixed messages regarding teenage sexuality may present barriers to effective follow up. (According to interviews, both young boys and young girls in rural Zimbabwe are encouraged to test their fertility early on to prove that they are capable of childbearing/producing once they are married. Also, young girls impregnated by their betrothed apparently fetch a higher bride price because their parents can claim that damage has been done to their daughter.) PSI has made inexpensive condoms and subsidized oral contraceptives widely available through its social marketing program. Thus, in spite of programmatic and societal sanctions against premarital sex, informed adolescents in Zimbabwe have easy access to STI and pregnancy prevention methods. Nevertheless, a greater effort needs to be made to juxtapose traditional values with an approach that recognizes that adolescents tend to be sexually active regardless of societal mores.

Mozambique appears to be less conservative than Zimbabwe regarding adolescent sexual and reproductive health needs. Teenage pregnancy and high maternal mortality rates prevail in both countries. (The latter is much higher in Mozambique.) Adolescents in Mozambique face fewer barriers in accessing contraceptive services through the health system, with condoms and birthspacing counseling available through Advance Africa and

United Nations Population Fund (UNFPA)–supported centers that are specifically designed to meet youth needs.

FINDINGS FOR CATALYST

CATALYST as a global project has two indicators for measuring *increased capacity for informed FP/RH decision-making among clients and communities*: percentage of targeted audience adopting behaviors supported by CATALYST (e.g., discussing/negotiating contraceptive use with partner, seeking support/assistance when facing gender-based violence, discussing care seeking for emergency obstetric care/PAC patients with family members) and number of programs establishing links between FP and social programs in other sectors. USAID and CATALYST documents indicate that the programmatic areas in which progress is to be achieved are family planning, postabortion care, and integration between health and nonhealth interventions. At the field level, Missions have identified additional behavior change indicators. This section discusses CATALYST achievement as measured by global indicators as well as field-level indicators.

Table 6
Data Showing the Targeted Audience Adopting Behaviors Supported by CATALYST

Country	Activity and Indicators	Available Data
Egypt	<ul style="list-style-type: none"> ▪ Family planning: three indicators (husbands approving, FP use, obtaining permission to go to health services as a barrier)¹³ ▪ Integration: two indicators on postnatal care ▪ Youth: seven indicators related to age of marriage and FP 	<p>Baseline data are from 2000 DHS (a comprehensive DHS).</p> <p>The Egypt Interim 2003 DHS does not break out data for Upper Egypt, the area of CATALYST focus, to enable comparison.</p>
India	<ul style="list-style-type: none"> ▪ Family planning: one contraceptive prevalence indicator 	Baseline data are from 2002 USAID survey; no additional data are yet available.
Peru	<ul style="list-style-type: none"> ▪ Family planning (OBSI): one indicator on contraceptive prevalence in the region of an OBSI grant ▪ One RH indicator (percentage obtaining Pap smear) for activities in one health center in peri-urban area of Huanacayo (COOPERANDES) 	<p>Baseline data came from a 2003 household survey; end-of-project data are expected.</p> <p>The number of women is not stated; the percentage increased from 9 to 20% in 2003 to 31% in 2004.</p>

Additionally, the CATALYST report on results presents a number of indicators for assessing increased FP/RH knowledge that would theoretically lead to an increased capacity for informed decision-making on FP/RH.

¹³ Secondary analysis of the Egypt 2000 DHS concludes, “There is not a strong relationship between perceptions that a specific barrier is a ‘big’ problem and use of family planning. Women who cite ‘knowing where to go’ and ‘not wanting to go alone’ as big problems are somewhat less likely to be using family planning than the population as a whole, but the differences are not large.” *Perspectives on Women’s and Children’s Health in Egypt, Results of Further Analysis of the 2000 Egypt and Demographic Health Survey*, MEASURE DHS, April 2003.

Table 7
Percentage of Targeted Audience With Increased FP/RH Knowledge

Country	Activity	Available Data
Peru	<ul style="list-style-type: none"> ▪ Youth kiosk activity (YES!): indicators on knowledge on correct FP use 	Based on 723 exit interviews in 2003, compared with baseline: <ul style="list-style-type: none"> ▪ Knowledge of different methods increased ▪ Knowledge of fertile period decreased slightly from 42 to 38% ▪ Knowledge that condoms can be used only once increased from 81 to 87% ▪ Correct knowledge of putting on condom increased from 81 to 87%
	<ul style="list-style-type: none"> ▪ ADAR birthspacing grant: one indicator on risks and one on optimal spacing 	Baseline data from household survey with 716 respondents in 20 communities in grant area
	<ul style="list-style-type: none"> ▪ RH activities in one health center in peri-urban area of Huanacayo (COOPERANDES): two indicators 	Baseline data from health center
Bolivia	PROCOSI birthspacing grant: five indicators on the knowledge of relationships between spacing and health	Baseline data available on 1,120 clients

The two INPPARES youth kiosks that provide outreach services to adolescents, cited above, are supported in part by CATALYST/Peru. It is a small activity, but has the potential for future expansion if additional funding is identified.¹⁴ CATALYST data indicate that the Yes! activity has had almost 13,000 visitors and that it has distributed 866 condoms and 62 cycles of oral contraceptives, for a total CYP of 11.

CATALYST produced three training manuals based upon PROFAMILIA’s documents and CEDPA’s training methodology and expertise. These include

- a manual for training managers of youth programs that addresses adolescent sexual and reproductive health issues; it is used in Egypt in sessions with young married couples and in Latin America to train program managers;
- a manual on gender and rights for service providers that was piloted by PROFAMILIA in Colombia and built a momentum, among the Bolivian participants, to integrate a gender and rights perspective into the 2003–07 Bolivia national strategy for adolescents and school-based youth; and
- a manual for advocacy intended for providers, used to train Latin American participants and to develop IEC messages in Bolivia.

¹⁴ CATALYST has documented two successful youth programs, one with PROFAMILIA in Colombia and one in Mexico with the Mexican Federation of Private Associations for Health and Community (FEMAP). Findings of these programs, which are highly sustainable, were disseminated at the USAID Bureau for Asia and the Near East conference in Cairo, March 2000, and have been replicated by CATALYST in Peru and elsewhere.

Table 8 presents data on CATALYST’s linkages with other programs.

Table 8
Number of Programs Establishing Linkages Among
FP and Social Programs in Other Sectors

Country	Activity	Process Outputs
Egypt	<ul style="list-style-type: none"> ▪ Training of opinion leaders and community leaders on FP/RH/MCH issues for BCC with newlyweds and engaged couples 	35 religious leaders, 25 community leaders
	<ul style="list-style-type: none"> ▪ Number of attendees at BCC events (play and puppet shows) in Upper Egypt 	8,650 people
	<ul style="list-style-type: none"> ▪ Training of agricultural workers 	In development
India	Cross-training with dairy cooperative staff and workers	5,100 staff and workers trained in 2003–04

In addition, at the field level, Missions have indicators for *increased capacity for informed FP/RH decision-making among clients and communities*. USAID/Peru stated that for FP/RH, it holds CATALYST responsible in two areas, both relying on periodic DHS for assessment: women’s knowledge of their fertile period and percentage of institutional births. The draft CATALYST Egypt monitoring and evaluation plan has many indicators for assessing FP/RH behavior change, ranging from the DHS–based impact indicator, percentage of women whose age at first marriage is before legal age, to the CATALYST training report indicator, number of BCC materials distributed to service delivery points in Upper Egypt. Any BCC data available to the team on these indicators are presented in the tables above.

Together with USAID/Peru and the Peruvian MOH, CATALYST organized an OBSI conference, held in Lima, Peru, on May 19–20, 2004. The purpose of the conference was to place OBSI on the Peruvian public and private health agendas by providing evidence-based data—at the global and country levels—on the strong link between three to five-year birth intervals and improved maternal and child health. The 2-day conference, which was opened by the USAID health officer in Peru and the deputy health minister, included presenters from UNICEF, the MOH, Peruvian NGOs, and CATALYST staff from headquarters and Peru. Over 350 participants from key health organizations in the public and private sectors attended the successful conference.

CATALYST’s project in Egypt, a large buy-in from the USAID Mission, provides a unique model promoting FP/RH behavior change in rural Upper Egypt at the village level.^{15,16} Technical components include targeting women and young people in a comprehensive approach to development that focuses on behavior change, quality improvement of services (renovation of clinics and capacity training of staff), community involvement, linkages to other sectors (such as agricultural workers), and engagement of

¹⁵ Although dramatic behavior change has occurred in rural Upper Egypt over the last 10 years (contraceptive prevalence has increased from 24 percent in 1995 to 45 percent in 2003), contraceptive prevalence is still significantly behind the national average of 60 percent.

¹⁶ CATALYST/Egypt received \$9,000 in core funding during an initial phase, but quickly received field support funds in the amount of \$2 million for the transition period following the previous bilateral population project.

local health authorities and religious leaders (Muslim and Coptic leaders). It includes an innovative coeducational peer education activity at Minia University, in which 21 male and female students were trained to be educators on such themes as premarital counseling, delaying age of first marriage, and the harmful effects of FGC. A critical first step was obtaining the support of the president of the university for the program, after he reviewed all the modules of the CATALYST program. Most participants, male and female, described the training as being life changing and related to the team many stories of using their training with peers and family members.

CATALYST's BCC program in Minia includes radio and television programming, newspaper articles, plays, and puppet shows to promote key FP/RH messages. It has also established links between FP/RH professionals and other sectors to diffuse FP/RH messages. The participation of the religious leaders in project activities, such as meeting with the students at Minia University to dispel myths about the contents of the Koran in terms of reproductive health and in community activities, which on a regular basis disseminate health messages and use of family planning for spacing, bodes well for overcoming local cultural misconceptions about FP/RH and gender issues. The CATALYST project began in Minia in 2003, and there are plans to replicate the activities in the additional seven governorates of Upper Egypt by March 2005.

CATALYST has conducted and disseminated some valuable research on male involvement, OBSI, and gender-based violence. (See section VII on gender for additional information.) Additionally, CATALYST is implementing pilot projects in gender-based violence in Peru and Bolivia and plans to initiate activities in Egypt through the National Council for Women.

While the preceding indicators measure and report on CATALYST contributions that can be directly related to the CATALYST Intermediate Result of *increased capacity for informed FP/RH decision-making among clients and communities*, CATALYST has implemented a number of other activities that do not fit into this classification.

USAID/Peru, in its health strategy to improve the quality of health care, identified the need for greater communication of health information and development of supportive community structures. Thus, as part of a large buy-in to the consortium (\$12.1 million obligated as of February 2004), the Mission asked CATALYST/Peru to support a number of education and communication activities to change health behaviors associated with preventable health risks. These activities are being carried out in the regions of Huanuco, Junin, Pasco, San Martin, Ucayali, Ayacucho, and Cusco, the seven coca-growing regions of Peru that are USAID's focus in that country. The Promotion of Healthy Behaviors and Healthy Environments is being implemented in extremely poor regions of rural Peru. The project includes making regional and local authorities as well as community leaders aware of the health situations of their populations to gain support for promoting preventive health interventions; working with community representatives and local NGOs to develop orderly health plans of action at provincial, district, community, and school levels; and educating media professionals on health issues. The assessment team was able to visit the Huanuco region, which was the first implementation site and served as the model for replication to the other regions, such as Ayacucho, Junin, and Ucayali—regions in which project staff is actively engaged at different levels of implementation.

In Huanuco, these efforts have generated concrete achievements. In 2003, with technical assistance and capacity-building support from CATALYST, the district-level health authorities and local leaders of Huanuco's civil society developed and published a regional health plan, which includes a strategy to achieve strategic health objectives by 2006 and a plan to monitor and evaluate results. Currently, 75 percent of the districts (of a total of 76 districts) have identified and begun to implement culturally appropriate health interventions, working with schools, markets, and families. The long-term objectives are to promote healthy behaviors as social norms (e.g., institutional childbirth, handwashing, preparing nutritionally balanced food, and changing environmental conditions that facilitate the spread of mosquito-borne diseases and other illnesses). Ongoing and future work in five of the seven regions will reach a population of over 3 million, where 32 percent suffer from chronic malnutrition and 25 percent of the women receive no prenatal care. (See appendix D for the Peru country report.)

CONCLUSIONS AND RECOMMENDATIONS

Advance Africa's most notable programmatic gaps in addressing IR 2 are

- the short-lived nature of most of its interventions as a consequence of staff turnover and management-related implementation delays at the central, regional, and country levels; and
- the tendency of some of its country programs to give precedence to IEC over actual service delivery for adolescents at risk.

Specifically, community-based distributors in Zimbabwe are counseled against supplying first-time adolescent contraceptive users, and FAWE's conservative approach may stunt the effectiveness of its life skills education initiatives.

As with Advance Africa interventions, it is not possible to measure the effect of CATALYST interventions to increase capacity for informed FP/RH decision-making because the activities are so recent and Missions are using different indicators than CATALYST headquarters to measure achievement. However, CATALYST has worked strongly in the last year to identify and target both those who make FP/RH decisions for themselves and those who can enable behavior change for others. Its work with civil society and community leaders, reaching out to men, identification of gender-based violence and gender and rights, linkages to social programs (nonhealth activities), and youth-related programs (service delivery as well as gender violence) potentially hold many models for replication.

Recommendation

Before phaseout, CATALYST should evaluate, as rigorously as possible, document, and disseminate the process and results of its behavior change work to reduce gender-based violence in the models cited in this report.¹⁷

¹⁷ In written comments from a review of the second draft of this report, CATALYST wrote, “Because of the limited timeframe for the implementation of gender-based violence activities in the LAC region and in Egypt, it would be unrealistic to expect CATALYST to evaluate behavior changes, i.e. a reduction in the prevalence of gender-based violence among the beneficiaries of the gender-based violence projects. At this stage of our work, our activities focus on increasing the communities’ awareness about gender-based violence, and involving the community in designing community-based projects that will address gender-based violence.”

IV. IR 3: INCREASED CAPACITY OF PUBLIC AND PRIVATE SECTORS TO SUSTAIN QUALITY FP/RH SERVICE DELIVERY PROGRAMS: CATALYST CONSORTIUM

The hypothesis behind this IR, for which only CATALYST was responsible, is that all three sectors—public, private, and commercial—have a vital role in a sustainable FP/RH program. As USAID has phased down and or out of contraceptive supply and phased down other support for public sector FP service delivery in countries in which CATALYST has been working, the need for sustainable contributions and roles of each sector is apparent. USAID and CATALYST have set two indicators to assess accomplishments under this IR: percentage of program costs covered by income generated by the program (institutions in Egypt, India, and Peru) and number of partnerships established with/or between commercial NGO/public sector entities. CATALYST does not yet have data on progress made to enable targeted institutions to cover more of their program costs. Moreover, as the Egypt country report indicates, many key factors that affect the performance of a family planning NGO are beyond CATALYST's control. This section therefore covers CATALYST's work to develop partnerships with the commercial sector to enable both national and regional programs. Corporate social responsibility is one area in which CATALYST believes it has made a unique and new contribution to FP/RH service delivery.

With core funds, CATALYST has worked with three major contraceptive manufacturers (Wyeth, Schering, and HRA Pharma) with positive results. These corporations have helped disseminate OBSI research at conferences in Chile and Berlin, and these findings were further highlighted in a public relations article on OBSI in the Wall Street Journal. Schering has been a particularly supportive partner at the field level.

In Peru, in a national and donor environment wary of FP and in which there are reported severe shortages of contraceptives in the public sector, CATALYST is working with INPPARES, Schering, and APROPO in two relatively small ways to expand the role of the commercial sector in reproductive health. Through RedPlan, approximately 471 midwives in Lima's peri-urban slums are providing contraceptives at low prices, enabled by Schering's social marketing products. These midwives have provided approximately 3,000 couple years of protection (1,711 condoms, 9,562 cycles of oral contraceptives, 1,421 IUDs, 7,729 Depo-Provera, and 834 foaming tablets).

With CATALYST support, APROPO, Schering, and Cayetano Heredia University are working together with a network of pharmacists, physicians, and midwives to improve access to and increase the use of contraceptives and treatment products for STIs and increase knowledge and promote healthy behaviors and practices regarding STI prevention and contraceptive methods (MS PREVEV project). The group has trained 381 physicians and midwives in 10 cities in syndromic management of STIs, and is ensuring that providers will have supplies (including emergency contraception) as well as the skills to provide reproductive health care. Agreements have been signed with radio stations in the 10 cities; the radio stations will participate in a communication strategy and broadcast radio spots (developed in collaboration with Johns Hopkins University). Additionally, Schering is working with its distributors to expand low-price commodities to pharmacies beyond these first cities. An APROPO telephone hotline service records 3,716 calls

received; the APROPO web site has had 19,435 visits. CATALYST data indicate that APROPO has sold 195,000 condoms.¹⁸

In the Dominican Republic, CATALYST was a partner with HRA Pharma, the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), Sued Pharmaceuticals, and PROFAMILIA/Dominican Republic to expand the method mix by introducing a dedicated emergency contraceptive pill. CATALYST indicates that 20,000 units have been made available through this partnership. Data are not available on the number of women who have used this method from this source.

To build support for corporate social responsibility in Latin America, CATALYST held a well-attended corporate social responsibility conference in Bogotá, which led to partnership agreements with Peru 2021, an association of private companies operating in Peru. CATALYST and Peru 2021 collaboratively conducted a study of work-based health programs and employee health and lifestyle habits in 30 companies in Lima and published their studies on employee health conditions and benefits. During the assessment, CATALYST provided no data that this work had led to increased access to FP/RH services.

With core funds, CATALYST has developed a corporate social responsibility toolkit for USAID health and population officers and other managers who might be interested in initiating corporate social responsibility programs. The toolkit is valuable in that it presents a variety of tools: a compendium of activities worldwide (with emphasis on Asia and the Near East region), resources, a casebook, and methodology for corporate social responsibility.

One advantage of the flexibility of CATALYST has been its ability to respond to individual opportunities in countries in which it does not support a field program. This flexibility has been particularly useful in the case of commercial partnerships. One example was the introduction of the emergency oral contraceptive in the Dominican Republic. Another was in Bangladesh, where CATALYST held a regional corporate social responsibility conference in collaboration with Deloitte Touche Tohmatsu, who is working on NGO sustainability in Bangladesh, that led to the NGO sale of products for income generation and cross-subsidization.

CONCLUSIONS AND RECOMMENDATIONS

In a world of declining resources and growing needs for FP/RH, building the capacity of the NGO and commercial sectors to provide services for those with the ability to pay for those services, at least in part, is vital. Inasmuch as the role of the three sectors in any national program is a result of political factors as well as organizational efforts and foreign technical support, the ability of a project to move quickly to seize targets of opportunity is a great asset. USAID and CATALYST are to be commended for the agility with which CATALYST has functioned in this respect.

¹⁸ “CATALYST Consortium Integrated Results for Core, Regional and Mission Funded Activities, December 2003”: data presented to the team during the assessment.

Recommendation

A follow-on activity should have a strong component strengthening the capacity of the NGO and commercial sectors.

V. IR 3: IMPROVED AWARENESS OF THE IMPORTANCE OF THE HEALTH BENEFITS OF FP AMONG AFRICAN POLICYMAKERS: ADVANCE AFRICA

REPOSITIONING FAMILY PLANNING

Advance Africa has succeeded in bringing family planning back for discussion under its strategic collaboration with the World Health Organization/Africa Regional Office (WHO/AFRO) in repositioning family planning in Africa. Efforts began with Advance Africa's participation in the first WHO task force meeting in Nairobi/Kenya in October 2002 and a subsequent meeting in Dakar/Senegal in October 2003. Advance Africa has contributed to presenting and widely distributing the data that came from the October meeting on the status and trends of FP in Sub-Saharan Africa held in Arlington, Virginia, and attended by 73 representatives of 23 CAs, USAID, and donors. The meetings discussed issues and trends of family planning in Sub-Saharan Africa given the context of the HIV/AIDS epidemic. The Arlington meeting provided Advance Africa with strong and convincing data to advocate for repositioning FP, which was losing support in Africa because of the growing emerging and reemerging epidemics, including HIV/AIDS, malaria, and tuberculosis. The data were shared widely with all partners, members of the WHO task force, and particularly with the division of family and reproductive health at WHO/AFRO, which led the elaboration of the repositioning FP framework for the African region. The collaborative work with WHO/AFRO in developing the framework included sharing the documents that came out of the Arlington meeting and participating in drafting and correcting the framework. The elaboration process involved all partners of the reproductive health task force to ensure consensus on its content and real commitment to its promotion once it was endorsed by the member states. The framework will constitute a guideline for countries on how to revitalize family planning programs and ensure a comprehensive approach to maternal and child health. The framework will be reviewed and it is hoped that it will be adopted at the 54th session of the WHO Regional Committee for Africa, August 30–September 3 in Brazzaville, Democratic Republic of Congo, by the 46 ministers of health of the member states. Advance Africa will continue to have a key role in the framework's implementation, specifically through a group meeting of experts held in Arlington, and at the first launch of a regional advocacy conference in Accra, Ghana, both later in 2004.

National repositioning workshops have been held in Mozambique and the DRC, with one tentatively scheduled for Angola later this year. Through strategic mapping exercises in Benin and Madagascar, Advance Africa has helped highlight the critical role of FP/RH.

In Zimbabwe, a 1–day meeting on integrating family planning and HIV/AIDS activities was held in September 2003 that brought together a wide array of policymakers and stakeholders. Subsequently, an integration working group, coordinated by Advance Africa, was formed among the MOH, donors, CAs, and NGOs in Zimbabwe to continue work on raising the profile of FP and integrating it into HIV/AIDS, MCH, and RH activities. Given that repositioning family planning is very much in the interests of Advance Africa's principal partner ZNFPC, the strategy has generated much momentum in Zimbabwe. Advance Africa has also trained Zimbabwean journalists and ZNFPC IEC officers to write persuasive human interest stories about FP/RH and destigmatizing

HIV/AIDS to raise greater awareness of these issues among policymakers and the general public.

Following a birthspacing/repositioning family planning workshop held in Mozambique in December 2003, the Advance Africa deputy director from headquarters held advocacy meetings with MOH officials and other concerned stakeholders at central and regional levels. Interviews with several MOH informants and NGO partners indicate that Advance Africa's dissemination of the latest data on the health benefits of longer birth intervals is convincing policymakers, program managers, and clients alike to take (optimal) birthspacing more seriously. Of considerable use in raising awareness of policymakers and program managers has been Advance Africa's development of a unique service triangle monitoring tool, which consists of a graph to help visualize the magnitude of missed opportunities for providing integrated services, including family planning.

Advance Africa is also providing technical assistance to the MOH in Mozambique to elaborate a family planning strategy that will be incorporated into a broader maternal mortality reduction strategy, thereby codifying family planning and longer birth intervals as health interventions. This will be one of the first instances around the world of countries moving on a national level to change policies in light of the new evidence on the benefits of three to five-year birth intervals.

As noted in the IR 2 section, FAWA is marshaling a multisectoral initiative to integrate FP/RH/HIV/AIDS messages into school curricula. In addition to the advocacy initiatives, Advance Africa, Save the Children/United Kingdom, and the MOH are finalizing the protocol for an OBSI operations research project in Zambezia and Nampula. Of concern for the integrity of the data and continuity of the project is that Advance Africa's presence in Mozambique will end in September 2004, although Save the Children will remain.

A national conference on repositioning family planning was planned in Dakar, Senegal, but was canceled due to the Mission's reluctance to host it. Advance Africa's success, however, in integrating family planning into Senegal's existing performance monitoring and improvement system serves as an ongoing reminder to policymakers and program managers of the importance of the birthspacing agenda. Advance Africa also tried to marshal a policy initiative to eradicate FGC, but was not able to obtain the Mission's support.

As noted above, Advance Africa recently hosted a national repositioning family planning conference in the DRC. The MOH in the DRC has already embraced the birthspacing message to some degree in that the concept of *naissance desirables* (desired births) is used in place of family planning to imply an integrated and voluntary approach to promoting modern contraceptive use. Several of the districts where Advance Africa is working in the DRC are home to displaced populations, thereby helping to put their FP/RH needs on the national agenda.

Through its demonstration project in Huambo and a national conference on repositioning family planning scheduled for later this year, Advance Africa has a pivotal role in raising awareness of family planning and optimal birthspacing in Angola. Given that Angola has exceptionally low contraceptive prevalence, a history that shattered and scattered

families, and high rates of maternal mortality, advocating (optimal) birthspacing and family planning as health interventions rather than as birth control appeals to policymakers and program managers as well as to the client population.

CONCLUSIONS AND RECOMMENDATIONS

Repositioning family planning and advocating for more integrated FP/RH programs represents one of Advance Africa's hallmark initiatives. As discussed with USAID and Mission staff in Mozambique and Zimbabwe, because of weak linkages between FP policy, contraceptive procurement, and logistics (at least in those countries), successful birthspacing advocacy faces the risk of increasing demand for family planning in the absence of contraceptive security.

Recommendations

Insofar as possible, USAID Missions should ensure that contraceptive supply can meet increased demand arising from successful repositioning family planning strategies.

In addition to underscoring the health and social benefits of longer birth intervals, repositioning family planning strategies should more prominently address gender mainstreaming and women's empowerment issues.

VI. IR 4: SCALED-UP AND IMPROVED FP/RH SERVICE DELIVERY PROGRAMS THROUGH TECHNICAL COLLABORATION WITH OTHER AGENCY/DONOR/FOUNDATION PROGRAMS: CATALYST

SCALING UP PROGRAMS

USAID/Washington measures the results of activities addressing this IR by the percentage of programs scaling-up effective interventions and the number of collaborative project/activities undertaken with other USAID CAs to implement evidence-based practices. CATALYST, in its self-assessment, perceives its major accomplishments under this IR as the dissemination of best practices; the replication and expansion of mature country programs in Peru, Bolivia, and India, and later on this year, Egypt; and its collaboration with other CAs and partners.

CATALYST is able to demonstrate the expansion of programs through providing additional services, increasing coverage of target groups, and replicating interventions. In Peru, for example, CATALYST has expanded emergency obstetric care capacity within health institutions on a nationwide basis to reduce maternal mortality (rate of 185 per 100,000 live births as per DHS 2000) and to improve the quality and availability of treatment of complications of incomplete abortions—the fourth leading cause of maternal mortality in Peru. To date, CATALYST has trained over 1,000 health professionals in 50 hospitals. In addition, the project pursued the development of a software program, initiated in an earlier Pathfinder project in Peru, which allows a health institution to self-assess the quality of its emergency obstetric care services. CATALYST has expanded the installation/implementation of this tool from 26 to 843 facilities and trained staff to use it. The team learned that the MOH in Peru is interested in expanding this, and other Latin American countries are looking to replicate the tool.

In India, data provided by CATALYST indicate that during the period 2002–03, CBD programs have expanded in 16 new districts. CBD outlets increased by over 9,000 for a total of 25,372 outlets; CBD clients increased from 691,000 to 1.33 million and an additional 14,825 pradhans (village level workers) have been trained, for a total of 26,075.

However, the India Mission, in its written reply to the assessment's questionnaire (see appendix E) stated that it perceived these results as the outcome of an earlier project (ENABLE) in India, that was carried out by one of the CATALYST Consortium members (CEDPA) and not as the result of CATALYST's interventions. The India program became part of the CATALYST field program at the beginning of 2003, with a buy-in from the India Mission (total of \$1.7 million as of February 2004). Nevertheless, CATALYST should be recognized as a flexible mechanism that allowed the continuation of an important CBD program of one of its consortium members. CATALYST is expanding the project to two other states and is planning to evaluate the impact of the training of the pradhans, who have been empowered not only to distribute contraceptive services, but also to have a more active role in social issues affecting the communities and who have been actively participating in conferences.

As indicated, the team believes that CATALYST has been effective in building consensus for optimal birthspacing. The May 2004 Lima OBSI conference illustrates CATALYST's ability to expand the dissemination of best practices at high-level forums. In addition, CATALYST held a conference in April of this year in Cairo, "Scaling Up for Success." This conference, attended by 150 participants from 18 countries, strongly pertains to this IR because the conference themes addressed issues relevant to best practices in FP/RH, including OBSI, integrated services, community postpartum care and prevention of hemorrhage, reaching men, and other service delivery health themes. The results of the emergency obstetric care program in Peru were also highlighted at the conference. CATALYST is currently disseminating the final report, which shares the best practices and contributes to the global field of FP/RH.

EXPANSION THROUGH NETWORKING

Other examples of CATALYST's successful expansion—through networking among similar organizations to mobilize resources to expand coverage and by linking to smaller projects that implement different components of reproductive health—include using USAID/Bolivia funds to expand youth services to 13 new facilities and creating a network of midwives in the city of Lima's RedPlan Salud, which began in 5 districts in Lima and is currently serving 21 districts (a joint effort of CATALYST, INPPARES, a local NGO, and a pharmaceutical company [Schering]). In its self assessment, CATALYST identified over 17 instances in which it has cooperated with other CAs, foundations, bilateral and multilateral donors, and government agencies in such topics as cosponsoring conferences, holding joint training sessions, designing strategies in a participatory manner, and joint review of research protocols.

While CATALYST has successfully expanded activities as discussed above, many FP/RH field activities have been pilot or small-scale programs, or programs that have been initiated only in the last year. These include the peer education activity in Minia University; the community mobilization of civil society, including religious leaders, in five Egyptian villages/clinics; and the pilot OBSI activities with NGOs in Peru and Bolivia. However, these activities do present valuable models and contributions that could be replicated or expanded at a future time.

CONCLUSIONS AND RECOMMENDATIONS

CATALYST has been successful in collaborating with other organizations to expand awareness of such global issues as OBSI and PAC. CATALYST has successfully replicated and expanded some important programs, the predecessors of which were begun in previous projects. Other field activities, begun anew with CATALYST, in gender, with youth, with religious leaders, and for field-level OBSI, remain small, pilot activities. Expansion for impact or sustainability takes time.

Expansion of OBSI policies and programs, given the potential impact of such expansion on maternal and child health, is the priority. As the recent global review of OBSI¹⁹ indicates, "the majority of nonfirst births in developing countries occur after too short an interval. Data from 55 developing countries show that 57 percent of women have spaced

¹⁹ William H. Jansen and Laurel Cobb, *USAID Birthspacing Programmatic Review*, 2004.

nonfirst births shorter than three years, and 26 percent have spaced births less than two years apart. In five Latin American countries, among adolescent girls with more than one birth, approximately 95–97 percent of those aged 15–19 have birth intervals of less than three years.” (See Jansen and Cobb 2004 for the essential components of a country OBSI program and more detailed recommendations for replication and expansion.)

Recommendation

USAID should pursue, on a priority basis, efforts to replicate and expand programs that

- create a favorable policy environment for effective birthspacing and
- incorporate quality-of-care factors that enable women to space their children as they wish.

VII. CROSSCUTTING ISSUES

BEST PRACTICES

The WHO initiative, Implementing Best Practices Consortium and USAID's Maximizing Access and Quality (MAQ) initiative, have greatly contributed to the existing, large body of knowledge on FP/RH best practices. Both Advance Africa and CATALYST have given priority to identifying, documenting, and promoting FP/RH best practices. These efforts have contributed to improved definitions of best practices, the development of practical tools for the implementation of best practices, and in some cases, particularly with CATALYST, the expansion of best practices in country programs.

Advance Africa

Because Advance Africa was delayed in launching its country programs and the demand for its technical assistance was less than anticipated, the project has had limited opportunity as well as time and conditions for replicating and expanding promising practices. Its measured success in this respect is not so much a function of shortcomings in project models as it is a consequence of challenges encountered in the implementing arena.

Senegal represents one example of expansion, where Advance Africa has provided technical assistance to upgrade the performance monitoring and improvement system for the PHC system. The activities began small (\$100,000 the first year and \$150,000 the second year) and focused on improving the performance monitoring and improvement training materials and revising the PHC monitoring system to include family planning indicators. The project helped to produce guides that have been widely distributed and used. The MOH and other CAs are so pleased with the pilot results, based on implementation of the revised performance monitoring and improvement in all health centers of the USAID intervention districts, that plans are underway to adopt it nationally.

Advance Africa also has had relative success in expanding (albeit on a small scale) its initiatives to strengthen the rural health (SANRU III) program in the DRC. USAID/DRC initially commissioned the project to provide technical assistance (in the form of social mobilization, training, and IEC) to 11 health zones in the country, 3 of which are home to internally displaced populations. The project has since expanded to cover 22 health zones, and USAID/DRC plans to expand to the remaining 28 health zones under its assistance umbrella.

The integrated supervision model, developed in Mozambique by Advance Africa and the MOH, was tested first at the central level and then at the provincial level in Nampula and Zambezia. The pilot project proved so successful that the MOH is now in the process of expanding it to other provinces. Given that the MOH has taken full ownership of this initiative, the momentum for replication and expansion is likely to continue even after Advance Africa phases out in a few months.

Advance Africa has also developed some monitoring and evaluation models that have been modestly expanded from their initial implementation and have significant potential for further expansion—specifically, reinforcement of quarterly coordination meetings among CAs, NGOs, and government counterparts, and the elaboration of two useful analytical tools, Smart Indicators and Value-Added Analysis (which are discussed in greater detail elsewhere in the report). However, the staff member who developed the analytical tools has since left the project, and it remains unclear whether Advance Africa/Mozambique is committed to replicating and expanding them.

In Angola, Advance Africa's project activities are still too nascent for replication. In fact, the project has barely been in operation long enough to generate monitoring information. Nevertheless, the model of providing integrated FP/RH health services, with a significant community component in a post-conflict environment, looks promising for replication in other war-ravaged regions of the country. The project also represents one of the few opportunities that Advance Africa has had to undertake a comprehensive strategic mapping process and to incorporate the findings into the project design.

Advance Africa's expanded CBD program in Zimbabwe represents an outstanding candidate for replication and expansion, were the country's political and economic climate more hospitable. The model has been extended from an initial 8 to 16 districts under the aegis of Advance Africa. Sadly, however, further expansion is unlikely in the near future. Zimbabwe's current dire economic and political situation has so financially undermined management capacity of the Zimbabwe National Family Planning Council that it is barely able to implement the project efficiently, much less attract the requisite resources needed to expand it nationally.

Advance Africa has focused most of its attention on implementing its USAID Mission-driven country programs and testing project models in Zimbabwe, DRC, Senegal, Angola, and Mozambique. Due to competing demands, it has therefore had neither the time nor resources to produce nor disseminate a wide array of technical documents. The Best Practices Compendium is perhaps the most widely known and disseminated of the technical materials that the project has generated. Developed for use by the entire population/reproductive health community, the compendium is a potentially valuable resource for project managers. Whether as a CD or a web-based document, it is easy to use, comprehensive in its coverage, and artfully prepared. Its presentation of 1-page distillations of successful projects enables users to quickly scan dozens of potentially relevant examples across a broad array of population/reproductive health interventions. Advance Africa's own survey of current users indicates, however, that users in developed countries are responsible for most of the visits to the compendium's web site. Moreover, Advance Africa staff members responsible for Advance Africa country programs rarely use the compendium themselves, nor do they regularly distribute the CD to host country partners and counterparts (Advance Africa/Zimbabwe informed the assessment team that it was not familiar with the CD).

Advance Africa headquarters staff points out that the Advance Africa project was directed/funded by USAID to develop the compendium, but that no project funds have been made available to promote or market the tool. (Advance Africa has received core funding, however, to sponsor a conference on best practices in Uganda in June of this year.) Moreover, without instruction from USAID, other CAs feel no obligation to use

the tool as a resource to inform their own project design and development efforts. Advance Africa noted that an evaluation of the compendium is scheduled to begin within a month.

CATALYST Consortium

The project has endeavored to analyze lessons learned to close the gap in knowledge in behavior change leading to improved practices in the FP/RH area. The result is a decision to pioneer best practices that integrate crosscutting themes—leading to changes in behavior of FP/RH clients, service providers, families, and communities. This strategy/approach, developed with input from AED behavior change specialists as well as other staff, is described in the CATALYST behavior change diagnostic framework. The framework discusses behavior change and BCC in theory, CATALYST’s approach, its application to OBSI, and steps in using the framework. It would appear to be an effective BCC tool, particularly for OBSI; CATALYST did not supply data on any evaluation of its use.

Most of CATALYST’s strategies and activities are related to best practices in themselves, such as the promotion of optimal birthspacing intervals, PAC, FP/RH integration and linkages to other health and nonhealth sectors, sustainability programs, adolescent programs, gender integration, community mobilization, commercial partnerships, and technical cooperation among less developed countries. However, it appears that the project has not developed a synthesis of the key best practices within the theme areas, which have allowed the activities to be replicated to other settings. For example, in the overview of best practices in the 2003–04 work plan (recently updated for the assessment team), the only OBSI best practices highlighted are the following:

- promoting optimal processes in client–provider interactions, such as treating the client respectfully, providing information on the clients’ preferred method, tailoring counseling to the individual, promoting interactive counseling, and avoiding information overload; and
- providing essential information when counseling about a contraceptive method, including effectiveness, side effects, advantages and disadvantages, correct use, follow up, potential complications, and STI/HIV prevention.

The above are key best practices but they are too general and do not reflect CATALYST’S solid experience in helping women achieve the birth intervals they want throughout many settings and cultures.

The project’s “Scaling Up for Success” conference, held in Egypt on March 29, 2004, included a wealth of case studies of best practices that highlighted CATALYST’s work on the subject. Additionally, CATALYST has worked very closely with Advance Africa in developing the Best Practices Compendium and serves as a member of the advisory group in developing criteria for assessing best practices that include evidence of success and transferability. The team reviewed the case studies and project data and was able to identify two global initiatives—OBSI and PAC—that CATALYST has begun to replicate and expand successfully.

OBSI activities began as early as 2002, when CATALYST began the dissemination, on a global scale, of new evidence-based research on the association of longer birth intervals with improved maternal and child health. During October 2002, the project held a workshop in Washington, D.C., to review the evidence that longer birth intervals (three-to-five years) saved lives. An outcome of the workshop, which was attended by participants from 16 countries from Asia, Latin America, Eastern Europe, Africa, and the Near East, was the decision to support the three to five-year interval as the global norm for optimal birthspacing. Early efforts also included facilitating the development of a birthspacing working group, known as Champions, with representatives from USAID, UNICEF, other CAs, NGOs, and individual researchers. CATALYST became the secretariat for the initiative and worked closely with USAID, WHO, and UNICEF to carry out an intensive literature review during 2003.

As part of its research to gain a better understanding about attitudes, beliefs, and practices related to fertility and birthspacing behavior, CATALYST conducted focus group research in six countries. The outcomes of this excellent, qualitative research helped the project in formulating policy dialogue strategies as well as training and counseling modules. CATALYST also developed a small grants program in Bolivia, Peru, and Romania—a program that is providing valuable lessons learned in field-tested OBSI interventions, including one in 50 communities of the Loreto region (Amazon) of Peru. Details of the current solicitation, with emphasis on integrating OBSI messages into nonhealth programs, are posted on its web site.

All of the above activities, coupled with intensive collaboration with other partners (CAs and international organizations, including UNICEF, WHO, and USAID Missions, as reflected in CATALYST's work plans and project documents) have allowed CATALYST to make important contributions to reviews of programmatic birthspacing activities in several countries. Moreover, regular Champions meetings and international conferences on OBSI are contributing to place OBSI on the countries and global health agenda. In its self-assessment, CATALYST identified three countries in which it is integrating OBSI into the CATALYST programs: Egypt, Guatemala, and Laos. In addition, an OBSI program has been initiated in Pakistan.

Information provided by CATALYST demonstrates that the dissemination of OBSI research findings has been impressive. The project has successfully repackaged OBSI data into easy-to-use formats that are informative and useful to international donors and health service providers. For example, an OBSI overview was distributed to 660 UNICEF field offices around the world. Other OBSI publications have been produced in collaboration with other CAs, such as the Johns Hopkins University and ORC MACRO. OBSI has also been the subject at Global Health Council and American Public Health Association (APHA) conferences. CATALYST's efforts to disseminate OBSI findings to a broader audience have also resulted in numerous media articles in the United States and overseas.

CATALYST identifies the following PAC best practices that the project has highlighted:

- promoting the use of manual vacuum aspiration equipment for treatment of complications resulting from unsafe abortions, particularly in low resource settings;

- introducing the essential elements of postabortion care in PAC programming;
- promoting the optimal use of methods of pain management during PAC procedures, including the use of Para cervical block and verbal anesthesia;
- provide family planning counseling at the point of service or during household follow up in countries where this does not represent a problem; and
- use of PERU 2000 facility audit checklist adapted to emergency obstetric care and neonatal care.

To illustrate the replication and expansion of best practices, the Peruvian emergency obstetric care/PAC model is important because the program

- is innovative from the point of community involvement in early diagnosis of pregnancy complications,
- offers an example of integration achieved between PAC and FP services; and
- introduces an approach wherein less developed countries help each other (e.g., Peruvian staff working with Egyptian staff) to disseminate results.

Current Peruvian data show that more than 350,000 induced abortions are performed annually. Of these, 30 percent usually result in complications, with incomplete abortion the most frequent. Because 50 percent of those women never reach a hospital, CATALYST has begun not only to reinforce emergency obstetric care at all levels of the Peruvian health care system but also to promote institutional childbirth at the community level. For example, in Huanuco, the region with the highest mortality rate in Peru, the project is training midwives and health promoters to promote institutional delivery because home delivery in rural Peru is the cultural norm. Moreover, in this region, CATALYST, jointly with USAID and UNICEF, is supporting an MOH district-level initiative to transfer pregnant women 2 weeks before delivery from areas where access to health facilities is nonexistent to *casas de espera* (community waiting homes), supported mainly by civil society to ensure institutional childbirth. Currently, there are 18 *casas de espera* in Huanuco, and CATALYST plans to replicate this initiative in other regions.

Data from the Peru PAC program, which began in 1997 under Pathfinder and was expanded to seven regions, show that between 1997 and 2002 there has been

- an increase in postabortion family planning use from 29 to 57 percent,
- an increase in the use of manual vacuum aspirators (facilitated but not paid for by the project) to treat abortion complications from 6 to 51 percent, and
- a decrease in the use of D&C (a more invasive intervention) from 94 to 49 percent.

CATALYST has also had a significant role in disseminating the findings of its PAC experience. The project has held large conferences in Bolivia and Peru; helped the PAC Consortium in its dissemination efforts and web site; furthered the PAC model in Egypt; continued PAC work with other CAs, continued to train providers, such as 722 PAC providers in Bolivia; and succeeded in having the MOH in Guatemala incorporate CATALYST's PAC model into its norms and protocols in 2003.

In conclusion, CATALYST has effectively responded to GH's core-funded mandate to advance the global health agenda by generating knowledge of best practices that have broad application across multiple country programs.

Recommendations

- The lessons learned from Advance Africa's expanded CBD experience in Zimbabwe should be documented and highlighted as a best practice to facilitate a revival and expansion of the program when circumstances are more favorable.
- If warranted by the findings of the upcoming evaluation of the Best Practices Compendium, USAID should plan to locate for the compendium in another CA or to include continued responsibility for its development and dissemination in the scope of work of a follow-on activity to the Advance Africa/CATALYST projects.
- USAID should promote broader use of the compendium—and broader reference to best practices in general—by requiring that all project proposals and responses to RFAs/RFPs and task orders demonstrate the submitters' due diligence in researching best practices that might be relevant to the proposal. Proposals for USAID funding should identify specific best practices considered by the submitter, describe how those best practices are reflected in the proposal, and/or explain why the relevant best practices were considered but rejected.
- CATALYST should produce a comprehensive summary of the best practices that are currently being implemented. Such a summary, succinctly packaged as a list of best practices in order of priority, would greatly enhance the project's legacy.

GENDER

Enhancing gender awareness and making it a crosscutting issue are stated or inherent objectives in both CATALYST and Advance Africa activities. Overall, CATALYST appears to have taken on gender more vigorously and integrated it more prominently into country programming than Advance Africa. That the USAID Missions visited in Africa did not seem to assign especially high priority to gender issues could explain this discrepancy.

CATALYST Consortium

CATALYST activities strive to engender greater women's empowerment and male participation (and cooperation) in sexual and reproductive health decision-making. In the absence of an enabling environment for women to seek or access services, issues related to service availability and quality are rendered irrelevant. Male participation promotes women's equality in RH decision-making by increasing support and understanding of women's sexual and reproductive health and children's well-being as well as by improving their well-being. Until recently, most FP/RH interventions gave only peripheral attention to male sexual and reproductive health needs.

CATALYST has produced and disseminated a number of documents specifically highlighting gender concerns. These include qualitative studies on birthspacing in Pakistan, Bolivia, Egypt, India, and Peru, and on more comprehensive research on male sexual and reproductive health behavior (including HIV/AIDS) in Bangladesh and Nepal. According to some of the findings, women across all levels of society still face formidable challenges in controlling and negotiating their sexual and reproductive behavior, especially regarding condom use. Violence against women remains prevalent and renders them impotent in making decisions concerning their own or their children's best interests. Fertility is often considered so sacred that the responsibility for it is taken entirely out of women's hands. While men were found to be increasingly receptive to family planning and birthspacing, they still often take the lead in making these decisions. In general, open discussion of sexual and reproductive matters between partners and within families is still not commonplace. The comprehensive CATALYST paper on HIV/AIDS and reproductive health of men in Nepal, which is facing the rapid and widespread transmission of HIV/AIDS from high-risk populations to the general public, demonstrates how sexual behavior between men can have an impact on the health of their female partners and suggests policy and programmatic options to address the problem.

In the field, the team observed pioneering efforts in Egypt to bring male and female students at Minia University together to discuss issues including sexual and reproductive health (including female genital mutilation), hitherto considered generally taboo to address outside of a family nucleus or in mixed gender settings. In addition to training student leaders, this initiative also involves the participation of Coptic and Muslim religious leaders, thereby further breaking down social and cultural resistance to the dissemination of sexual and reproductive health information. While the existence of this one subproject does not attest to widespread attitudinal changes about sexual and reproductive behavior in Egypt, it nevertheless represents an extremely promising initiative that warrants replication and expansion.

Advance Africa

Advance Africa's proposal recognizes that the status of women is a fundamental determinant of use levels for FP/RH services. It points out the success of creative initiatives to marshal eradication of FGC and to demonstrate that harmful practices can change without compromising values. The inclusion of FAWE in the Advance Africa consortium, with its focus on life skills education to raise young women's self-esteem and encourage them to stay in school along with FAWE's efforts to abolish FGC, is evidence of Advance Africa's intent to enhance women's decision-making leverage in

Africa. However, Advance Africa has enjoyed limited opportunity to highlight gender or formally integrate it into most of its country programs because none of the USAID Missions requested any specific technical assistance in this area. Also, long-term gender interventions do not feature at the top of most African political agendas.

Despite these caveats, a number of Advance Africa projects have served directly and indirectly to raise awareness of gender issues, promote gender equilibration, and involve men more actively in reproductive health responsibilities. FAWÉ's advocacy efforts in Senegal, Mozambique, and Zimbabwe on behalf of young girls' welfare address some of the factors contributing to girls' and women's subjugation, such as lack of education, FGC, and premature assumption of family responsibilities. In addition, Advance Africa is strengthening the FAWÉ chapters themselves through capacity building in organizational management and development of counseling and teaching skills in adolescent reproductive health.

Staff training for ZNFPC's expanded CBD program as well as FP training for Mozambique's health staff both highlight gender issues, albeit cursorily, in their curriculum. ZNFPC has found that extending its community-based network, simply by bringing additional services closer to the community, has helped give both men and women increased access to gender-sensitive FP/RH services. That female condoms are being made more readily available through both CBD and commercial channels in Zimbabwe means that women are better able to protect themselves against unwanted pregnancy and disease. However, this protection is not heavily promoted, and CBD agents and depot holders do not seem fully comfortable discussing or demonstrating female condoms. ZNFPC referral sites in Zimbabwe are increasingly integrating FP services with VCT and curative services for STIs. This provides a good opportunity to reach men and encourage them to take increased responsibility for family planning and sexual health.

Globally, between one fifth and one half of women report that their first sexual experience was forced, making abstinence or insisting on condom use impractical. Marriage is not a reliable means of preventing HIV/AIDS, as infection rates are higher among married women in developing countries—where most women marry by the age of 20—than among unmarried sexually active females. Furthermore, due to the patriarchal nature of many countries, including Peru, Egypt, Zimbabwe, and Mozambique, women must overcome entrenched taboos to negotiate condom use in marital relations.

As Advance Africa itself points out in its self-assessment, even with the best of intentions, gender issues regarding women's rights require political, structural, and social developments that cannot be achieved through the health system alone.

CONCLUSIONS AND RECOMMENDATIONS

Without commitment to gender awareness and integration from USAID country Missions, centrally funded projects, such as Advance Africa, face difficulties in fulfilling their centrally mandated gender programming objectives.

Recommendations

- In view of reluctance or indifference of some Missions to pursuing gender as a priority objective, USAID/Washington should exercise more technical leadership in promoting the adoption of this Agency priority by USAID Missions.
- Given the high levels of gender violence documented through CATALYST reports and in demographic and health surveys around the world as well as the role of gender violence in unwanted pregnancy, USAID should not only ensure that referral for gender-related violence, detected during PAC treatment and counseling, should be part of comprehensive PAC services, but also that all CA reproductive health projects raise awareness of and address gender-based violence in its different ramifications.

VIII. SYSTEMS AND MANAGEMENT

HUMAN RESOURCE MANAGEMENT

Advance Africa

The Advance Africa project experienced several disruptions and changes to its staffing structure since the project's launch in 2001. These included the departure of several key staff members (project director, deputy director, and monitoring and evaluation director) within the first year of the project; the release of personnel originally recruited to staff Advance Africa regional offices; and project management's decision to implement the remainder of the project in a skeletal mode.

The project's release of personnel recruited to staff regional offices was an especially wrenching, albeit necessary, task for the members of the Advance Africa consortium. When the Advance Africa project was designed in 1999, USAID expected that it would attract up to \$72 million in field support funding from 15 countries. By mid-2003, however, it had become clear to Agency managers that funding generated by the project was falling far short of those expectations—to the extent that Advance Africa regional offices established in Harare, Dakar, and Nairobi had become costly, nonproductive drains on project resources.²⁰ Before that realization, Advance Africa had recruited professional staff—mostly African nationals—to manage those offices. USAID's instruction to close the regional offices was inevitably disruptive to regional staff on a personal level and produced some internal tensions within the Advance Africa consortium.

An immediate consequence of the decision was the project's loss of some very talented professionals. The somewhat more protracted result was the consortium's effort to readjust the project's staffing profile following the departure of field staff who had been employed mostly by consortium members CAFS, FHI, and DTT. Predictably, perhaps, this produced some strain within the consortium, as members sought to preserve their proportional representation in the project's reduced manpower level. Consortium leader MSH eventually brought these discussions to a close by making some definitive staffing decisions, which generally preserved the same proportions as had existed before the staff reduction.

These events—the project's disappointing level of field support, the release of field staff, and a growing perception within the consortium that USAID was itself disenchanted with the project—produced a sense of detachment from the project for several members of the consortium. Specifically, some member organizations came to view the project as a second or third-tier activity that did not warrant their close participation or the

²⁰ By the end of May 2004, the project had received \$13 million from five countries, and expects to receive only modest additional funding over the project's remaining 16 months. Reasons for this funding shortfall suggested by USAID managers and Advance Africa consortium staff include a USAID prohibition on marketing the project, leaving Missions uninformed regarding the activity's prospective value to country programs; USAID procurement lags (i.e., between the end of the predecessor Pathfinder and SEATS projects and the launch of the new project), which left Missions little choice but to pursue bilateral solutions to their development requirements; Mission efforts to pare down the number of CAs working in-country; a shortage of population funds; and early leadership and management problems at Advance Africa.

assignment of their best staff members. For example, such key positions as deputy director remained unfilled until late 2003; the monitoring and evaluation position was occupied for a year and then the deputy director assumed this role after his departure. Tellingly, only one other member of the consortium aside from MSH responded to the self-assessment instrument distributed by USAID in preparation for this assessment, and that response addressed only the consortium management question posed by USAID.

Consortium leader MSH has managed this situation relatively well. Over the past year, it has looked to its consortium partners to address the project's staffing requirements on a short-term, case-by-case basis rather than via the appointment of full-time personnel. Advance Africa management is not filling some vacancies with senior-level personnel, but is relying instead on more junior, but talented, high-energy younger staff who stretch into their roles. In consequence, salary costs at Advance Africa headquarters are relatively low, and staff morale is generally high. It should be noted, however, that this mode of operation would probably not be appropriate in the context of a growing project. It works at Advance Africa because project leaders there have concluded that the activity is on a downward path over the next 16 months; that they intend to start no new country programs (aside from those currently in operation) over the life of the project; and that their task now is to provide support for those four country programs while organizing themselves for an orderly and methodical termination of the project.

Advance Africa's commitment to a lean staffing profile is reflected at the country level as well. The five-person Mozambique office is headed by one expatriate (an AED employee), two host country field supervisors (MSH), one resident hire coordinator (MSH), and a resident hire administration and finance officer (MSH) who not only manage Advance Africa's \$6 million project, but who also provide overall logistic, administrative, and coordination services for other CAs in the country. Advance Africa's Zimbabwe office is similarly headed by an expatriate, with four other positions staffed by host country nationals. There is no resident staff in the DRC, and only one expatriate (MSH) program manager in Angola. Importantly, all of these country programs have relied heavily on African—mostly host country—sources to meet their short-term technical assistance needs.

Advance Africa country-level managers in Zimbabwe and Mozambique advise that they receive generally good support from Advance Africa headquarters, mostly in the areas of administrative and financial support. Both report that MSH handles all of their financial transactions and budget requests very quickly and efficiently. The FHI-managed Advance Africa/Zimbabwe office has sought technical guidance more often from the FHI regional office in Nairobi than from Advance Africa/Arlington. The Advance Africa/Mozambique office has never had any substantive contact with AED, but does rely on MSH for financial management services.

Advance Africa country directors in Zimbabwe and Mozambique as well as USAID staff in both countries remarked on a valuable aspect of Advance Africa/headquarters' support. In both countries, a variety of factors had contributed to long delays in project implementation (e.g., communication problems between Advance Africa/Mozambique and the regional Advance Africa office in Harare, Advance Africa country office inaction on some new initiatives, indecision on the part of local USAID Missions). On three occasions since January 2004, the new Advance Africa deputy project director visited

these countries and, to paraphrase the comments of several observers in Advance Africa and USAID, made things happen. She also provided the project with valuable technical input regarding ways to advocate in support of the repositioning family planning initiative, helped identify and resolve obstacles, and worked with various parties to reach hitherto elusive agreements. Her work in these areas deserves special mention as a factor in promoting Advance Africa success in its country programs.

CATALYST Consortium

CATALYST also experienced major, disruptive senior staff turnover during the first three years of the project. The current project director, who assumed the position in October 2003, is the fourth director (including one acting director for several months) since CATALYST began. Directors appeared to have resigned for both personal and professional reasons. The current deputy director is the third one. Senior staff acknowledges that there were difficult times during these periods of conflict. According to USAID/Pakistan (with whom the team had a telephone interview), major difficulties with that important Mission were not reported to Pathfinder/Boston, which therefore did not intervene in a timely way, as it would have if it had known.

Senior staff members believe that they have moved beyond those difficult early years, in which CATALYST was implementing inherited programs. The current leadership has worked strongly to strengthen field programs, build morale, resolve problems, and improve expenditures. CATALYST has recently begun new initiatives in Laos and Yemen, is expanding its geographic coverage in Egypt, and was requesting a project extension at the time of this assessment; there was no evidence of planning for closure of the project.

In both Egypt and Peru, with large buy-ins, CATALYST has large offices. The Egypt office currently has 45 people on staff, with plans to hire another 15 by the end of the year; the Peru office also has 45 people, with additional contracts with Peruvian firms for specialized activities, such as the accreditation of health facilities, the healthy schools, and the healthy municipalities activities.

MANAGEMENT SYSTEMS AND TOOLS

Advance Africa

Advance Africa relies on a number of management systems and tools to facilitate the design of project activities; to direct and monitor the use of project resources (funds, people, supplies, and equipment); and to monitor and report on project performance.

Two tools that Advance Africa identifies as central to its project design and development process are strategic mapping and the Best Practices Compendium. At its basic, conceptual level, strategic mapping is a largely intuitive process whereby the managers of a prospective project seek to engage all or most stakeholders to work in a participatory manner to identify goals and objectives, routes to achieve them, and gaps that need to be addressed. Responsible project managers generally take steps to ensure that such a process takes place, although the specific venue, timeframe, and politics of the process might vary considerably from one country/project to another. The special contribution of the Advance Africa project has been to organize and package this process into a

comprehensive, methodical presentation (i.e., a strategic mapping manual, which is currently in draft). Once published and distributed, the manual has the potential to serve as a valuable aid to project design specialists and managers who might welcome the opportunity to apply a more rigorous, disciplined approach to the project design and negotiation process. Ironically, Advance Africa itself has had little opportunity to apply its own strategic mapping tool in practice—largely because most of Advance Africa’s larger projects (Zimbabwe, Mozambique, and Senegal) were presented to them by the three USAID Missions as very precise scopes of work. Advance Africa did have more leeway to apply the tool in Angola and to some extent in Benin, but in neither instance was the tool employed rigorously or methodically. Perhaps more importantly, however, assessment team observation of Advance Africa programs in Zimbabwe and Mozambique and discussions with USAID health, population, and nutrition officers in Senegal, Angola, and the DRC indicate that Advance Africa staff observes and applies the *essence* of strategic mapping, namely, that they make a sincere effort to engage as many stakeholders as possible in project discussions/brainstorming and strategic planning, and to strengthen these stakeholders’ sense of ownership in Advance Africa–assisted activities.

Similar to strategic mapping, Advance Africa’s Best Practices Compendium is a potentially valuable contribution that has had limited application in practice. (See section VII, Best Practices, for a discussion of this tool as well as some recommended steps for maximizing its value.)

Advance Africa exercises very thorough oversight of project funds. The assessment team reviewed project financial records and concluded that Advance Africa has accounting systems in place that can provide accurate, timely financial information to Advance Africa and USAID managers. As noted earlier, Advance Africa country offices consistently recognized Advance Africa headquarters’ responsiveness in providing project funds quickly.

A brief analysis of project expenditures indicated that the rate of project expenditures has increased considerably. This increase is due partly to Advance Africa’s role as a pass-through mechanism for five private voluntary organizations (PVOs) in Mozambique, and partly to Advance Africa project management’s decision to freeze the project portfolio (i.e., to not take on any new commitments beyond the existing programs in four countries [Angola, Zimbabwe, Mozambique, and the DRC]).

The Advance Africa project uses cost-coding procedures to track the amount of time each project employee spends on any given activity. MSH, which manages the system, uses it for payroll purposes for MSH staff as well as for overall activity tracking purposes for all staff. MSH states that its analysis of data from this tracking system supports its assertion that per person salary costs have declined over the past year.

Advance Africa’s performance in the use of monitoring and evaluation tools is mixed, both at the country level and at Advance Africa headquarters. Advance Africa/Zimbabwe has developed a very extensive set of monitoring and evaluation instruments. It has also helped streamline the ZNFPC management information system (MIS), trained ZNFPC provincial-level staff in the use of new data collection/reporting instruments, and helped ZNFPC managers use the data generated by the refined MIS for project oversight

purposes. Meanwhile, however, the overall management capacity of ZNFPC continues to deteriorate (see the Zimbabwe country report, appendix D), calling into doubt the sustainability of Advance Africa's innovations after the country program ends in 2005.

In Mozambique, Advance Africa has only recently recruited (April 2004) a monitoring and evaluation specialist, who faces a daunting set of tasks that must be completed within the country program's four remaining months. These include the

- organization and completion of an endline survey that will track changes in key outcomes since the predecessor JSI project conducted a baseline survey in late 2000,
- launching of an operations research activity (core-funded research on optimal birthspacing), and
- development of a monitoring and evaluation plan for the country program—a document that USAID/Mozambique has been demanding for several months (a draft plan has been prepared by Advance Africa/Arlington).

Delays in beginning these activities jeopardize their prospects for completion by the end of the project.

Advance Africa/Mozambique has developed some very useful and innovative performance tracking tools that can serve as models for other programs and CAs. These include a Microsoft program manager–based quarterly performance report that Advance Africa/Mozambique has used to consolidate and present data submitted by all of the USAID–funded CAs and PVOs currently working on FP/RH in Mozambique as well as two qualitative assessment tools (smart indicators and a value-added measurement tool) that could, if more widely disseminated, become standard practice worldwide. All of these innovations were originally developed by an Advance Africa project coordinator (who has since resigned) while he worked for the predecessor JSI/HSDS project. Perhaps because they were developed under the JSI project, these tools do not seem to have gained unqualified ownership within Advance Africa/Mozambique. During its visit to Mozambique, the assessment team urged USAID/Mozambique to ensure that these tools and analytical approaches are examined, and if possible, adopted, by the new contractor(s) that will continue FP/RH activities in Mozambique when the Advance Africa/Mozambique project ends later this year.

Advance Africa headquarters is generally responsive to USAID's reporting requirements. The project's quarterly reports to USAID focus on country-level achievements and do not include much analytical content. Reasons include a separation between the project's cooperative agreement–level indicators and indicators established by the USAID Missions, which are paying for Advance Africa's country-level programs, and the project's continuing lack of monitoring and evaluation personnel. In the assessment team's judgment, this lack of analytic content is not necessarily a shortcoming to the extent that the USAID Missions themselves feel that they are receiving the information they need to exercise meaningful oversight of their Advance Africa country programs. USAID Missions in Zimbabwe, Angola, and the DRC appear to be satisfied with Advance Africa reporting. USAID/Mozambique (and the MOH) effectively use Advance

Africa-prepared quarterly coordination reports, but as noted earlier, USAID/Mozambique has not been satisfied with Advance Africa's tardiness in developing a monitoring and evaluation plan for the country program.

CATALYST Consortium

By the end of February 2004, USAID's total obligations, under the CATALYST project, amounted to \$57,137,897. The project has received \$17,733,000 in core funds and \$39,404,897 in field support funds (the Egypt and Peru buy-ins amount are close to 68 percent of total field support). Projected core expenditure rates, currently on target, indicate that the project is on track to expend all of its remaining funds by the end of the project, September 2005. CATALYST's analysis of project field support expenditure rates for Bolivia, Egypt, India, Laos, Nepal, Pakistan, and Peru indicate that there are no anticipated problems in funds being spent by the closing of the project.

Earlier in the project, CATALYST had low expenditure rates. In October 2003, CATALYST made systemic changes to improve performance. There is now an expenditure tracking system that allows CATALYST to monitor expenditures by subactivity (in contrast to the previous IR basis) on a monthly basis. Consortium members have been asked to quickly process invoices. All team members at the central level now have agreed upon budgets.

The CATALYST cooperative agreement includes eight indicators for contribution toward four IRs (see scope of work, appendix A). CATALYST classifies these indicators as central and presents another 12, which together comprise the essential 20 indicators.²¹ CATALYST presents progress on these 20 in the "CATALYST Consortium Integrated Results for Core, Regional and Mission Funded Activities." Additionally, there is another category of indicators that CATALYST classifies as program management indicators. They are presented in the "Annual Work Plan, July 1, 2003 to June 30, 2004," in CATALYST country program monitoring and evaluation indicators and plans, and as USAID Mission indicators for CATALYST country programs.

These various categories include indicators that would present valuable information to managers and decision-makers on different aspects of CATALYST's activities. Unfortunately, there are two main problems with the system:

- To date, CATALYST data on the essential indicators is minimal relative to total funding, and comes mainly from several small activities, such as the five clinics in Egypt and Yes!, OBSI, and RedPlan activities in Peru. An exception is the Indian program.
- Missions have bought into CATALYST because they have welcomed the one stop shopping they believe it enabled and have entrusted CATALYST with a wide variety of important activities with significant budgets for which these essential indicators are not relevant or feasible, given the nature or scale of the activity. In the case of the two major buy-ins, Peru and Egypt, the essential indicators are not relevant, feasible, or important to the Missions. These

²¹ "Essential Indicators: A Guide to Monitoring and Evaluating Programs."

Missions have identified other indicators, principally linked to national demographic and health surveys, for CATALYST in-country programs. DHS data to assess progress toward Mission objectives will not be available for several years.

Summary on Management

Advance Africa

The Advance Africa project did not evolve as originally planned. The project generated far less field support funding than anticipated; it worked through an inevitable but painful staff reduction process; and it struggled to maintain the commitment of consortium members that felt that their association with a somewhat marginalized project might not serve their long-term interests with USAID. For the most part, however, Advance Africa's country-level programs—whose orientation has been to the local USAID Mission and to host country partners—have not reflected these dislocations. Indeed, most of Advance Africa's country programs appear to be producing good results, although conclusive data are not yet available for recently launched programs in Mozambique, Angola, and the DRC. Moreover, some of the problems being faced by country programs are due more to local conditions (economic crisis in Zimbabwe, communication lapses between Advance Africa country staff and USAID Mission personnel in Senegal, USAID/Mozambique dissatisfaction with the pace of Advance Africa activities) than with any management shortcomings at the overall project level. As noted previously, Advance Africa headquarters (represented by the Advance Africa deputy director) has been very effective in helping remove impediments and stimulating rapid action during her occasional visits (since January 2004) to Mozambique.

The project is very capably led. The project director is a highly respected African professional, and MSH is represented onsite by a USAID-experienced senior officer who understands the Agency's requirements. Indeed, it is tempting to imagine what the project's appeal and coverage might have been if the current leadership had been in place at the beginning and if the current project director had had the opportunity to market the activity with other technical leaders in Africa.

Conjecture aside, the project is clearly in a phase-down mode. Advance Africa staffing decisions, project promotion activities, and work assignments all reflect management's determination to bring the project to an orderly close by September 2005. Without contrary instructions from USAID, Advance Africa will not initiate any new field support-funded programs during the remainder of the project. In a few months, staff tasks will shift increasingly toward functions associated with project closeout (e.g., preparation of final reports and equipment inventories) and efforts to place staff. MSH's forward planning for this final phase of the project is minimizing the likelihood of any management problems over the next 16 months.

CATALYST Consortium

The most significant management issue for CATALYST will be the timely and responsible phaseout of project activities before the anticipated end of the project in

September 2005. CATALYST has been hoping for a project extension and, in contrast to Advance Africa, is expanding its activities in a number of countries.

- Bolivia is expecting to receive an additional \$450,000 for activities in FY 2005.²²
- The Egypt program is rapidly expanding; there are plans to hire new staff, including 10 field officers for Minia, Beni Suef, Fayoum, Assuit, and Sohag, and to establish two regional field officers. Whereas CATALYST has implemented its community mobilization model in five rural communities in Minia to date, plans are for implementation in 80 communities in Upper Egypt, including those in four additional governorates and in three urban slums of Cairo.
- There are new programs in Laos and Nepal.
- A recent buy-in for Yemen has led CATALYST to recently visit Yemen and begin plans for a country program.

Conclusions and Recommendations

Although both projects experienced disruptive changes in their leadership and management team, both have been able to surmount these problems and are currently providing effective oversight and management of their respective programs.

The two projects' performance indicators have little relevance to USAID Missions and do not reflect most of the work (i.e., at the country program level) being carried out by the two projects.

The Advance Africa project is moving methodically toward an anticipated project close out at the end of September 2005. CATALYST, however, is in the process of expanding some of its larger country programs, to an extent that may not be consistent with an orderly close out of the project.

Recommendations

- USAID/Washington, CATALYST, and specific USAID Missions should establish clear understandings regarding the likelihood of a project extension beyond September 30, 2005.
- Prior to launching a follow-on activity, USAID/Washington should attempt to establish, via enquiries to USAID Missions, the extent of market demand for a follow-on project, and to determine the approximate levels of field support funding that Missions might be prepared to make available for the new project.
- Immediately after launching a follow-on activity (should USAID/Washington decide to do so), the Agency should support the implementing agency(s)

²² "CATALYST Pipeline Analysis Through April 2004."

efforts to inform USAID Missions regarding the new project's objectives, its usefulness to the Missions, and the means by which Missions could access the project's services.

THE CONSORTIUM APPROACH

Advance Africa

The Advance Africa consortium includes MSH, FHI, AED, DTT, CAFS, and FAWE. Each member organization possesses extensive technical depth and operational experience in fields of activity relevant to Advance Africa's design and objectives.

In practice, Advance Africa has not been able to fully capitalize on many of these institutional skills, primarily because the project never attained the breadth of engagement anticipated when the activity was being designed. Moreover, programs that Advance Africa did support were generally assigned to them by USAID Missions that had already determined the strategies and approaches they expected Advance Africa to follow—leaving little room for the exercise of creative thinking by consortium members. As noted above, the interest of some consortium members began to fade as the project failed to attract significant amounts of field support funds, and as it emerged from the consequent reductions in field staff.

This is not to suggest that the project does not reflect the technical expertise and experience of some of its various members. CAFS, for example, had an important role in the design of training materials for the expanded CBD program in Zimbabwe as well as in conducting training of trainers and supervisors in the DRC; FHI provided valuable technical assistance in support of MIS development and related research in that country. MSH's management skills are helping Advance Africa/Mozambique assure good oversight of a complicated (informal) partnership among several USAID-funded CAs and NGOs involved in the country program. FAWE has a somewhat specialized role in the project (i.e., working with its affiliates in countries where Advance Africa has a presence in order to develop and introduce life skills education content into school curricula). FAWE's proposal to promote broader awareness of FGC in Senegal was rejected by USAID/Senegal as nonsustainable and not reflective of the Mission's priorities in that country. Various consortium members are also represented at the country level: FHI manages the Zimbabwe program, the country director in Mozambique is an AED employee (other staff work for MSH), and CAFS had the lead responsibility in Senegal.

On one hand, the consortium appears to have allocated tasks and resources in a manner consistent with its members' strengths: CAFS' role in Senegal and Zimbabwe drew on its regional presence in French-speaking West Africa (Togo) and East Africa (Kenya); the FHI regional office in Nairobi was able to provide sound logistic, technical, and research support to the Zimbabwe program. On the other hand, staff and resource allocations appear to be guided by other considerations. Advance Africa/Zimbabwe staff had no prior affiliation with FHI, and had been recruited by FHI because FHI had the administrative lead in Zimbabwe. In Mozambique, the country director learned after she was recruited from the predecessor JSI/Mozambique project that her employer would be AED. FAWE's very limited role in support of life skills education appears to reflect that

organization's expectations as a member of the consortium—although the conservative nature of its approach and limited experience in the area of adolescent reproductive health do little to expand young adults' access to quality FP/RH information and services.

In summary, Advance Africa's consortium approach to project management has its advantages and disadvantages, neither of which makes a compelling case for or against the consortium model as USAID considers options for future project(s). Tilting the argument somewhat in favor of a nonconsortium structure, perhaps, are the downsides of managing a consortium itself. This can be a time-consuming and distracting process for the consortium leader and members, and while it is largely hidden from USAID's view, can divert staff time and energies more usefully focused on the support of project programs.

CATALYST Consortium

The CATALYST Consortium consists of Pathfinder International (prime), AED, CEDPA, Meridian Group International, Inc, and PROFAMILIA/Colombia. CATALYST indicates that the consortium model as it has implemented it has worked very well and that the model has the following strengths:

- it offers a broader spectrum of technical expertise than a single contractor could offer;
- it fits Mission interests because often Missions want single source contracting, yet with a broad range of skills; and
- Pathfinder was egalitarian and transparent as the prime. (Rather than the activity director reporting to Pathfinder, the position has reported to a consortium management committee.)

CATALYST acknowledges that at the field level the success of the model has not been so obvious. One Mission with whom the team talked indicated that it bought into CATALYST simply to access one particular partner and they were not interested in the rest of the project. Another Mission indicated that it expected that in-country staff hired by certain partners would come with greater institutional memory and technical expertise, in line with the partner member of the consortium. The major problems with another Mission might have been resolved more quickly if the activity director reported directly to Pathfinder and Pathfinder/Boston had known about the situation earlier and responded forcefully sooner.

One particular and unique strength of this consortium has been PROFAMILIA/Colombia, which has contributed at the headquarters level and has also been able to offer technical assistance to several developing countries. PROFAMILIA/Colombia is a unique institution that was itself the recipient for many years of very major USAID support. It would be a mistake to generalize from the success of PROFAMILIA/Colombia's role as partner to all developing institutions.

Conclusions and Recommendations

The consortium approach has been more successful under the CATALYST project than under the Advance Africa project. In neither instance, however, did the consortium model fully deliver on its theoretical advantage (i.e., to help ensure that USAID/Washington and Missions have access to the full range of technical skills and experience represented by the various members of the consortia).

Recommendation

When USAID prepares its solicitation for a follow-on project, it should make clear to prospective bidders that the Agency does not assume that larger groupings of prospective implementing partners (organized, for example, as consortia or as prime contractor plus multiple subcontractors) have any intrinsic advantage over smaller groupings (e.g., of one to three implementing agencies). Rather, the essential criterion to be addressed by offerors would be to demonstrate that they either have available or can quickly access the technical and managerial skills required to implement the follow-on project. (Offerors would still be required to demonstrate, as called for by Agency policy, an appropriate level of participation in the project by minority-owned and/or small and disadvantaged organizations.)

IX. U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID MISSION PERSPECTIVE

Advance Africa

Most of the USAID Mission staff interviewed by the assessment team were pleased with the responsiveness and technical quality of the Advance Africa project.

In the DRC, USAID is attempting to extend primary health care services to 50 of the country's 500 zones (the SANRU III project), and asked Advance Africa to help integrate FP/RH into 22 of those zones, including three sites for internally displaced persons. Advance Africa's initial proposals (in 2003) to the USAID Mission were declined, but the Mission advised the assessment team that Advance Africa has more recently "bent over backwards" to demonstrate its responsiveness to Mission requirements. The Mission added that it has been very pleased with the technical caliber of Advance Africa technical consultants, and that it intends to provide an additional \$300,000 in field support to ensure continued Advance Africa participation in the project over the next year.

Advance Africa has been heavily involved in planning for a repositioning of family planning conference scheduled to take place in Kinshasa in May 2004 (core funded, \$400,000). USAID/DRC reported that Advance Africa consultants have been very effective in organizing the conference with host country partners, and noted that the conference will be "a great boost for FP in a country where malaria and HIV/AIDS get all the attention..."

USAID/Angola looked to Advance Africa to help integrate family planning information and services into the MOH's MCH program in Huambo province. The core-funded program (\$728,000) serves as the USAID Mission's entire FP program (the Mission has not been successful in attracting bilateral population funds from USAID/Washington). Although the activity has been underway for only 4 months, the USAID Mission acknowledges Advance Africa success in forging good partnerships with USAID, the MOH, UNFPA, and local communities in Huambo province. Advance Africa's extremely positive working relationship with the MOH has helped to secure the ministry's support for a repositioning family planning advocacy meeting, tentatively scheduled to take place in the near future. USAID/Angola is optimistic regarding its ability to provide some of its own field support funding to the Advance Africa project later this year.

USAID/Senegal advised the assessment team that Advance Africa was very successful in responding to the Mission's request that it strengthen the FP/RH content of the MOH's semiannual performance monitoring process. According to the Mission, Advance Africa significantly improved that community-based system, which is now used in virtually all of the country's health posts. The Mission did note, however, that Advance Africa engaged in pursuing uninvited initiatives in FGC and promotion of a national FP repositioning conference in Senegal that were not consistent with the Mission's priorities.

USAID/Zimbabwe invited Advance Africa to implement one of the Mission's priority interventions in the FP/RH sector—the development of a new model for the delivery of

integrated FP/RH and HIV/AIDS services in mostly rural parts of the country (the expanded CBD program with the Zimbabwe National Family Planning Council). Mission staff reported that Advance Africa was exceptionally responsive to the Mission's instructions. It further observed that the model launched with Advance Africa support would be appropriate for a nationwide expansion by ZNFPC, were it not for the country's economic crisis and the related deterioration in ZNFPC's management capacity. USAID/Zimbabwe also reported its satisfaction with Advance Africa's role in helping to integrate FP/RH into two other Mission interventions (HIV/AIDS services at Mission hospitals and HIV/AIDS support for orphans and vulnerable children).

USAID/Mozambique was more ambivalent in its view of Advance Africa responsiveness. On one hand, it acknowledged that Advance Africa is addressing the Mission's priority requirements—continuation of tasks begun, but not completed, under a predecessor project with JSI; introducing FP/RH into MOH activities; coordinating reporting from several CAs and NGOs funded by USAID; and serving as a pass-through mechanism for USAID funding allotted to NGOs working in six provinces. On the other hand, the Mission voiced its concern with the slow pace of Advance Africa's work in these areas as well as the project's delay in meeting some of its principal commitments, including preparation of a monitoring and evaluation plan.

CATALYST Consortium

Most USAID Mission health officers interviewed by the assessment team were pleased with the responsiveness and technical quality of the CATALYST project, and most expressed a high degree of satisfaction with the project and its management. The team interviewed the USAID Mission health officers in Egypt and Peru; contacted by telephone Mission health staff in Bolivia, India, and Pakistan; and obtained information on the Nepal and Laos programs through the Bureau for Asia and the Near East health staff. Written responses to the Mission's survey on CATALYST activities were received from India, Yemen, and Peru (see appendix E).

CATALYST has a central role in the USAID health programs of Egypt and Peru (with sizeable buy-ins of \$14.5 and \$12.1 million, respectively, as of February 2004). Neither Mission has a bilateral health program with their respective governments and chose CATALYST to replace previously existing bilateral projects. Thus, CATALYST became the lead partner in the implementation of most FP service delivery activities. Both Mission health officers perceive CATALYST as a flexible, multipurpose, centrally funded mechanism and are pleased with the technical quality of the project and its management. The range of activities carried out in both countries has been described in earlier sections of this report (see also appendix D for reports on both countries).

In India (buy-in of \$1.7 million as of February 2004), CATALYST has a unique role in the Mission's bilateral health program. As previously discussed, CATALYST in 2003 took over a large CBD project, previously managed by one of the members of the CATALYST consortium. Although the Mission attributes the successes of this large program (which operates in the state of Uttar Pradesh and covers a population of 21 million) to the earlier project, the Mission found the CATALYST mechanism to be flexible and responsive.

In Bolivia (buy-in of \$1.7 million as of February 2004), CATALYST is actively supporting the bilateral health program in the areas of adolescent programs and PAC.²³ Mission staff found CATALYST to be a good fit with its bilateral program and its work in PAC to be very good. In Pakistan (buy-in of \$2.8 million as of February 2004), where CATALYST faced many challenges and where Mission dissatisfaction had been high, concerns appear to have been addressed; a small OBSI program has begun. Yemen (buy-in of \$3.1 million as of February 2004) and Nepal (\$300,000 as of February 2004) are also programs that are just beginning, but the Bureau for Asia and the Near East is pleased with CATALYST's work and complimented them, particularly on the Laos program (buy-in of \$329,000 as of February 2004), which seeks to integrate family planning into maternal health care programs.

ADVANTAGES AND DISADVANTAGES OF TWO ACTIVITIES

Any single project requires a major investment in time, energy, and resources to organize and maintain itself so that it can successfully address its mission. USAID has noted its concern over some of these maintenance costs and seeks to keep these expenses (and certainly the core-funded portion of these costs) to a minimum.

From that perspective, the decision to award two separate activities—CATALYST and Advance Africa—needs to be assessed on the basis of the two projects' efficiency as assistance mechanisms. For example, are, the additional maintenance costs of two projects warranted by the size of their respective portfolios?

Technical skills and regional competence are additional criteria. Do the two projects possess special skills and/or region-based experience that are especially pertinent to their respective technical and/or geographic areas of involvement?

With some qualifications, the answer to both questions would appear to be “no.” Neither project has been able to attract a significant number of clients (i.e., USAID Missions/countries [the large Egypt and Peru programs under CATALYST skews that project's field support account]) and—with the exception of CAFS and FAWE (Advance Africa) and PROFAMILIA (CATALYST), the members of the two consortia all have extensive worldwide experience in FP/RH. In brief—and with the advantage of hindsight—it would not appear that the demand for these two projects has been sufficient to justify two separate awards; nor does either consortium seem to demonstrate a unique capability in a limited geographic area.

As a qualification to the foregoing observation regarding insufficient demand, it must be recalled that the two projects were launched several months after the predecessor Pathfinder and SEATS projects ended. It is not possible to determine with any certainty what effect this delay had on prospective buy-ins from USAID Missions. Anecdotal reports suggest that many Missions that might have bought into the projects had little choice but to use bilateral mechanisms to continue their programs. Moreover, these Missions were making their decisions during a time (ongoing) when the overall trend in the Agency was/is toward greater bilateralization of USAID–assistance programs.

²³ Early this year, the Mission transferred CATALYST's early work in OBSI to another CA, which is responsible for family planning in the country.

For USAID, the two projects' history would appear to serve as a caution against awarding multiple successor projects, should the Agency decide to proceed with a follow-on activity. (See section IX, Future Strategic Directions, for the assessment team's recommendations.)

USAID MANAGEMENT

Advance Africa

USAID/Washington has had a very active role in its management of the Advance Africa project. In the project's early phase, Agency management was assertive, which is not unusual for a new project. And, as noted previously in this report, the Agency's ban on Advance Africa marketing efforts may have hindered the project's ability to attract USAID clients.

More recently, the Agency has had an especially constructive role in its management of the project. This included a readiness to pursue difficult decisions—most notably the elimination of regional offices—that, while painful, maintained the project's financial viability. In addition, the USAID project manager's efforts to re-cast Advance Africa as a major participant in the Agency's new repositioning family planning strategy gave a *raison d'être* and a coherent vision to a project that was in search of a clear mission. Advance Africa staff indicates that USAID's current management team has been especially supportive of the project.

CATALYST Consortium

USAID/Washington management of the CATALYST Consortium has been excellent. Since its inception, the project has had the same CTO, who has had a central role in

- helping market the project in the early stages to the USAID Missions, at a time when marketing of centrally funded missions was problematic;
- resolving issues surrounding the early challenges faced by the project, including changes in project management;
- providing overall technical guidance and opening new avenues of program development, such as the OBSI initiative;
- maintaining close contact with Missions to ensure successful implementation of buy-ins; and
- communicating and disseminating results of the CATALYST program.

CATALYST senior management and staff are grateful for USAID/Washington's support.

FUTURE STRATEGIC DIRECTIONS

The two projects, while not as broad in their coverage or impact as originally anticipated, do address some of the Agency's highest priority development objectives. Moreover, centrally managed projects, such as CATALYST and Advance Africa, often serve as invaluable assistance mechanisms for USAID Missions that are not prepared or able to implement all elements of their country programs through wholly bilateral assistance programs. An examination of the continuing gaps in—and future opportunities for—the Agency's exercise of its global technical leadership role points to a continuing need for a centrally managed assistance mechanism suited to address these gaps and opportunities. That examination also indicates that even if Mission demand for such a mechanism does not increase substantially, it will still be of sufficient scope and importance to warrant the continuation of a centrally managed assistance project.

Gaps

Both projects were reasonably successful in responding to the priorities identified in their cooperative agreements. However, a number of challenges remain—the unfinished work of USAID's technical leadership role—that can be productively addressed by a centrally managed project. Some of these key challenges include OBSI and repositioning of family planning, meeting the needs of youth, PAC, FP and HIV/AIDS linkages, gender, and replicating and expanding best practices.

OBSI and Repositioning of Family Planning

USAID and WHO have identified a critically important new strategic approach that has the potential to reinvigorate and rescue moribund efforts in the FP/RH sector—especially in Africa. Now that OBSI has established an extensive and credible foundation in research, USAID should move vigorously to promote broader integration of OBSI into additional country programs. USAID efforts in this area should include a special focus on measures to reach and work with African leaders at the country level as well as through such regional organizations as the West African Health Organization (WAHO) and WHO/AFRO.

Meeting the Needs of Youth

CATALYST has been successful in developing some innovative youth-oriented interventions, especially in Egypt. Advance Africa encountered significant obstacles, however, perhaps reflecting the more problematic cultural obstacles facing such efforts in Africa. Given the age structures in most developing countries as well as the special vulnerabilities faced by young adults, Agency efforts to successfully address the needs of youth will continue to be one of USAID's primary pieces of unfinished work in the foreseeable future.

PAC

Although PAC is an essential component of safe motherhood programs, it has only infrequently been replicated and expanded in country programs. This is largely due to regulatory and/or cultural barriers to PAC. USAID should support policy and advocacy

efforts to address these constraints, and take steps to replicate and expand PAC programs in countries prepared to commit to it.

FP and HIV/AIDS Linkages

Both projects demonstrated innovative ways to link FP and HIV/AIDS programs, including integration of FP and HIV information and services in outreach programs for at-risk and vulnerable population groups, through PMTCT programs, and through advocacy efforts directed toward policymakers. An expanding HIV/AIDS epidemic, especially in the context of declining population assistance resources, places a special burden on USAID to develop effective, cost-efficient approaches to broader integration in the years ahead.

Gender

Both projects encountered significant indifference to gender concerns at the USAID Mission level. USAID/Washington can exercise more technical leadership in this area by using a centrally managed project(s) to promote and facilitate greater Mission attentiveness to this Agency priority.

Replicating and Expanding Best Practices

Centrally managed projects are not the most appropriate mechanism for replicating and expanding smaller but demonstrably viable activities. Such central projects are well positioned, however, to identify and disseminate information regarding best practices to USAID/Washington, Missions, and partners worldwide.

Adequate Contraceptive Supplies

In three of the four countries visited by the assessment team (Zimbabwe, Mozambique, and Peru), contraceptives were in short supply—leading to occasional stockouts in areas served by CATALYST and Advance Africa. In the case of Peru, stockouts in the public sector (the source of supply for 79 percent of users) were reportedly nationwide. Such shortages/stockouts call into question the purpose and value of projects designed to promote demand for FP/RH services, expand FP/RH services, or to effect qualitative improvements in FP/RH service delivery programs. USAID/Washington and the Missions need to ensure that this fundamental enabling factor—adequate contraceptive supplies—is addressed or is being addressed before requesting or approving new initiatives to be implemented under centrally managed projects.

Mission Demand for Centrally Funded Activities

The exercise of technical leadership is a primary responsibility of USAID/Washington, and one of the core reasons for USAID/Washington sponsorship of centrally managed projects. Ultimately, however, the essential, overriding purpose of these projects is to serve the needs of country programs, and in doing so, contribute to the attainment of global development goals. The experience of CATALYST and Advance Africa in responding to Mission requests for assistance illustrates some trends for USAID to consider as it determines whether and how to structure a follow-on project. These trends include the following:

- **Declining demand for the services of centrally managed FP programs:** Neither CATALYST nor Advance Africa met Agency expectations in terms of their ability to attract field support funding from USAID Missions.²⁴ Some of the reasons for that disappointing response have been cited herein. While the delayed launch of the two projects' and restrictions on marketing were certainly factors, other Agency-wide trends were at least as important. These include an increasing preference at the Mission level for bilateral assistance mechanisms and, notably, declines in population assistance resources. In short, Missions have fewer field support funds available to buy into centrally managed projects.
- **Missions continue to resist a plethora of CAs:** Related to the above factor (declining demand), Mission directors are (still) instructing population, health and nutrition officers to cull the number of CAs working in host countries. There is no evidence of a change for this trend.
- However, it appears that several **USAID Missions will continue to depend on centrally managed projects to address critical, high-priority components of their assistance strategies:** USAID Missions in Egypt, Peru, Angola, the DRC, Zimbabwe, and Mozambique depended heavily on CATALYST and Advance Africa to help implement key elements of their programs. The inability to access the two assistance mechanisms would have, to varying degrees, seriously impeded the Missions' capacity to achieve their development objectives.

In addition, **new types of Mission-level requirements appear to be emerging.** USAID's mission is changing. While the U.S. government has always been sensitive to the risks posed by political and/or social upheaval in other countries, recent events have underscored the potential for disruptions in conflict-prone and fragile states that threaten vital U.S. interests at home and abroad. Increasingly, USAID is being incorporated into a broad U.S. government strategy to anticipate and address the root causes of these threats. Moreover, the emergence of the Millennium Challenge Account (MCA) is throwing into stark relief USAID's institutional responsibilities in this area. While the MCA will advance important U.S. government policy objectives in the developing world, it will also result in devolution of the more difficult countries, including a significant number of failed, failing, and fragile states to USAID's institutional scope of work.

The implications of this trend are already visible in the country foci of the CATALYST and Advance Africa projects: all four countries that Advance Africa is currently assisting fall into the Agency's failing/fragile (Zimbabwe, the DRC) or recovering (Angola, Mozambique) categories. Much of the CATALYST program in Peru is targeted on drug-producing areas where the reach of the national government is limited at best.

Looking to the future, USAID/Washington might want to structure its centrally managed projects to more directly support the Agency's growing responsibility to address FP/RH

²⁴ Recent buy-ins to CATALYST (which, in contrast to Advance Africa, has continued to market itself) from the Nepal, Yemen, and Pakistan Missions demonstrate Mission demand for some form of central project and for the services CATALYST has offered.

needs in conflict-prone, transitional, and fragile/failing states. Some specific roles for centrally managed grantees or contractors would include the following:

- Help host country governments become reengaged in geographic areas where government services have broken down or disappeared during periods of conflict.
- Support new or newly returned USAID Missions that are not yet ready to develop bilateral solutions to development problems.
- Few USAID population, health, and nutrition officers have experience in failed states, whereas some CAs and contractors have specialized experience working in such areas. CAs can apply this experience to supplement or reinforce the capacities of USAID Missions requiring such assistance.
- Host country ministries in some recovering states might be too fragile to work with multiple cooperating agencies and contractors. In such instances, a multipurpose, USAID/Washington–managed project could serve as a type of general contractor for FP/RH assistance.
- Alternatively, such a multipurpose CA/contractor could help relieve the management burden on USAID Missions and host country partners by acting as a broker regarding the work of other CAs and contractors, coordinating reporting to USAID and partners, and facilitating the development of joint work plans.

Centrally managed projects can also be an important component of some USAID Missions' phaseout or program graduation strategies. The flexibility of such projects makes them ideal for filling in gaps as well as for addressing short to mid-term requirements that supplement and/or complement a Mission's graduation plan.

USAID Missions in a number of countries advise that important initiatives launched by CATALYST and Advance Africa will continue to require support after September 30, 2005. If USAID undertakes procurement for a follow-on project in a timely manner, the follow-on project would be able to address the needs of these otherwise orphaned activities with a minimum of disruption.

USAID and CA Management

The leadership of both projects examined in the course of this assessment noted their satisfaction with the tone and substance of USAID/Washington management of their respective cooperative agreements. USAID/Washington, meanwhile, has successfully managed scores of cooperative agreements, grants, and contracts in the population and reproductive health sector over the past three decades and has accumulated a body of knowledge regarding CA management that this assessment is unlikely to enhance. However, on several occasions, the assessment team did encounter a USAID management practice that has been of little utility to the Agency but which has represented a significant burden to the CAs.

Earlier in this report, the lack of a connection between the two grantees' monitoring and evaluation plans, indicators, and reporting responsibilities to USAID/Washington on one hand and to USAID Missions on the other was noted. Specifically, the grant-level performance indicators jointly established by the grantees and USAID/Washington have little relevance to the Mission-funded programs, which represent the bulk of work under the two projects. Both CATALYST and Advance Africa project teams, however, struggle to force their country program data into grant-level performance indicators in their quarterly, semiannual, and annual reports to USAID/Washington. The resultant data do not serve as meaningful measures of grantee performance for USAID/Washington project managers.

A more useful approach would be for USAID/Washington managers to work with the grantees to establish one set of indicators that directly reflect the grantees' work in furtherance of but limited to the core-funded activities implemented under the grants. Those core-funded activities would not represent the totality of the grants' work in support of USAID/Washington technical leadership—some of those initiatives would be Mission-funded—but they would represent the totality of activities for which the grantee has a direct responsibility to USAID/Washington. Specific core-related indicators and grantee reporting responsibilities would be proposed annually in the grantee's work plan and would be tied specifically to core-funded activities proposed for the period covered by that work plan. USAID/Washington would defer to the grantee(s)—or contractor(s)—to develop their own monitoring and evaluation plans with sponsoring USAID Missions, and would significantly reduce grantee/contractor reporting requirements to USAID/Washington regarding field support-funded programs.

USAID/Washington should consider whether this reduced reporting commitment on the part of the grantees/contractors would warrant their continued submission of quarterly, semiannual, and annual reports. USAID might find that less frequent submissions are adequate to monitor implementation of the core-funded components of the program.

Options for Implementation Mechanisms

Based on the implications of the foregoing observations, it is apparent that a flexible, multipurpose, centrally managed project will continue to be needed by USAID—especially by USAID Missions—into the foreseeable future, and these needs can be met most efficiently by one global project.

Such a follow-on project(s) could be implemented under a variety of assistance mechanisms (i.e., cooperative agreement, leader plus associate award, contract, or indefinite quantity contract [IQC]). A specific procurement mechanism is not being recommended, but the following observations are for USAID's consideration.

- Cooperative agreements offer considerable flexibility to both USAID and the participating grantee(s). However, they lock the Agency into one vendor (or internally contracted group of vendors).
- A contract would ensure close compliance with Agency direction, but would be an unwieldy vehicle for Mission buy-ins and would require relatively high management intensity on the part of both the contractor and the Agency.

- Leader plus associate awards can assure closer Mission control over grantee operations, and they offer Missions greater flexibility in establishing the timeframe of associate awards (i.e., associate awards can continue after completion of the leader award). Similar to the foregoing mechanisms, however, leader plus associate awards provided limited choice of vendors to Missions. Moreover, Missions have yet to demonstrate any significant interest in this mechanism.
- An IQC would provide more vendor choice to the Agency (typically, IQCs are awarded to more than one contract holder), and, like leader plus associate awards, allow Agency users to tailor their timeframes more closely to their needs. The disadvantage of IQCs is that they bring limited standing capacity to a project, as technical/consultant assistance is essentially purchased by the Agency on an as-needed basis.

Experience with the current two projects—especially in the case of Advance Africa—suggests that the cooperative agreement/consortium approach delivered few real advantages to the Agency, while it burdened the consortium members with the distracting need to manage the consortium itself. Contracts are labor intensive for all parties; leader plus associate awards still seem to confound many Missions (and Mission procurement officers). The IQC mechanism thus appears to offer the greatest flexibility to the Agency and would probably minimize core-funded maintenance costs for a centrally managed response mechanism.

RECOMMENDATIONS FOR THE FUTURE

Summarizing the above, the assessment team proposes the following recommendations for consideration by USAID.

- USAID should develop one follow-on project to the current CATALYST and Advance Africa projects. The project should be global, multipurpose, flexible, and structured to facilitate access by its primary users—USAID Missions.
- The project design should take into account, inter alia;
 - the Agency’s unfinished work;
 - the changing mission of the Agency—to address the special requirements of conflict-prone, fragile, and failing states; and
 - the needs of Missions in the process of developing or implementing phaseout or graduation strategies.
- USAID/Washington should poll the Missions where CATALYST and Advance Africa–supported projects are currently underway to identify activities that will require continued support (i.e., from a centrally managed project) after September 30, 2005. USAID/Washington should identify these activities in its RFA/RFP as first-response tasks for the successful bidder(s).

- Grantee/contractor monitoring and evaluation responsibilities to USAID/Washington should be streamlined to reflect only those core-funded/technical leadership activities directly sponsored by USAID/Washington. The frequency of grantee/contractor reports to USAID/Washington might also be reduced.
- USAID/Washington and USAID Missions should ensure that a fundamental enabling factor—adequate contraceptive supplies—is addressed or is being addressed before requesting or approving new initiatives to be implemented under centrally managed FP/RH projects.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. SCHEDULES

D. COUNTRY REPORTS

E. MISSION SURVEY RESPONSES

**F ADVANCE AFRICA AND CATALYST MONITORING
AND EVALUATION PLANS**

G REFERENCES

APPENDIX A

SCOPE OF WORK
(from USAID)

ASSESSMENT of ADVANCE AFRICA and CATALYST CONSORTIUM

SCOPE OF WORK

March 23, 2004

I. PROGRAM INFORMATION

Project Name:	Advance Africa	CATALYST
Cooperative	HRN-A-00-00-00002-00	HRN-A-00-00-00003-00
Agreement No:		
Agreement Value:	\$92,062,892	\$92,199,828
Obligation Date:	10/29/00	10/29/00

II. BACKGROUND

A) Project Overview

Advance Africa and the **CATALYST Consortium** are two USAID Global Health (GH) Bureau activities funded through cooperative agreements, and managed by the Service Delivery Improvement (SDI) Division of the Office of Population and Reproductive Health (PRH). While these activities have the same mandate -- to increase the use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and non-clinical programs -- they are focused in different regions. Thus, they have fundamentally different sub-activities and programs.

Advance Africa is a consortium of six organizations (Management Sciences for Health (MSH) – lead; the Academy for Education Development (AED); Family Health International (FHI); the Centre for African Family Studies (CAFS); the Forum for African Women Educationalists (FAWE); and Deloitte Touche Tohmatsu (DTT)). It works with clinical and non-clinical programs, particularly in the context of high HIV/AIDS prevalence in Sub-Saharan Africa, and focuses on five countries: Mozambique, Angola, Democratic Republic of Congo, Senegal and Zimbabwe.

The **CATALYST Consortium** is a partnership of five organizations: Pathfinder International – lead; Academy for Educational Development (AED); Centre for Development and Population Activities (CEDPA); Meridian Group International Inc.; and PROFAMILIA/Colombia. As a multi-regional initiative, it supports country programs in Bolivia, Egypt, India, Pakistan, Yemen, Nepal, Laos and Peru.

While the strategic objective and the intermediate results for both cooperative agreements are the same (see below), both programs have evolved independently and autonomously, with their own unique opportunities and challenges largely based on their regional focus.

B) USAID’s Bureau for Global Health Strategic Objectives

The Bureau for Global Health has five Strategic Objectives:

- SO1: Advance and support voluntary family planning and reproductive health programs worldwide;
- SO2: Increased use of key maternal health and nutrition interventions;
- SO3: Increased use of key child health and nutrition interventions;
- SO4: Increased use of improved, effective and sustainable responses to reduce HIV transmission and mitigate the impact of the HIV/AIDS pandemic; and
- SO5: Increased use of effective interventions to reduce the threat of infectious diseases of major public health importance.

Advance Africa and CATALYST’s programs contribute directly to the achievement of SO1 and SO2. Advance Africa also contributes to the achievement of SO4.

C) Objective and Intermediate Results

The **Objective** for Advance Africa and CATALYST is:

Increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and non-clinical programs.

The Intermediate Results (IRs) are:

- IR 1: **Increased access to and improved quality of FP/RH clinical and non-clinical programs;**
- IR 2: **Increased capacity for informed FP/RH decision-making among clients and communities;**
- IR 3: **Increased capacity of public and private sectors to sustain quality FP/RH service delivery programs; and**
- IR 4: **Scaled-up and improved FP/RH service delivery programs through technical collaboration with other agency/donor/foundation programs.**

Key Indicators

The indicators for Advance Africa and CATALYST are attached (Annex A). These indicators were submitted to the Office of Procurement for modification to each cooperative agreement and have been approved. For both projects the revised indicators more accurately reflect the nature of the CATALYST and Advance Africa portfolios after field support allocations have been made and country programs are being implemented. As a result, they reflect the interests of USAID/W and Missions as well as funding allocations made available for evaluation purposes at the country level. Along with the change in essential indicators, Advance Africa has also made a change to the Intermediate Result 3 which reads “**Improved awareness of the importance of the health benefits of FP among African policy-makers**”.

III. Purpose of Assignment

The purpose of this assignment is to assess the extent to which Advance Africa and CATALYST have achieved the results described in their cooperative agreements. Although the programs of Advance Africa and CATALYST are distinctly different in technical and regional focus, it is hoped that through one assessment, relevant lessons can be shared and documented that reflect both activities.

Accordingly, the objectives are to:

- 1. Assess the extent to which Advance Africa and CATALYST have achieved the objectives of their respective cooperative agreements;**
- 2. Document relevant lessons, given the two activities' differences in technical and regional focus; and**
- 3. Make recommendations about future strategic directions for FP/RH service delivery field support.**

IV. Questions to be Addressed

The following is a list of priority questions that the assessment team should address. In preparing the assessment, the team should take into account that it is being conducted in year four of both activities, with over one year remaining for implementation.

A) Results and Accomplishments

1. For each Intermediate Result, what are the major technical accomplishments of Advance Africa and CATALYST, and how has their programming advanced state-of-the-art FP/RH service delivery? To what extent are data available, or will data be available, that provide evidence of changes in knowledge, behavior and service use in field programs, as a result of CATALYST and Advance Africa activities? For each IR, to what extent are there gaps in achievements with respect to activities planned in annual workplans? What are the principal reasons for any gaps in performance?
2. Have Advance Africa and CATALYST taken any best practices to scale in any of the countries in which they work? Describe the activities and strategies used to apply and scale-up best practices in country programs. Are they effective? What additional steps should be taken?
3. What steps have been taken to move the best practices that have been applied in the country programs toward sustainability?
4. In the activity design, "Gender" was intended to be a cross-cutting issue, yet full integration into programming has proved challenging. What were the specific issues that impeded the mainstreaming of gender in the activities? Are there lessons that could be learned from this experience and what could be done differently in the future?

5. To what extent are Advance Africa and CATALYST technical documents requested/used by other organizations in their programs? Please describe the documents used by other organizations in their programs.
6. How effectively have Advance Africa and CATALYST collaborated with other cooperating agencies and USAID contractors? Have they sought to apply the tools, research findings and evidence-based best practices of other organizations in Advance Africa and CATALYST field programs? What could be done to enhance use of other organization's tools and best practices?

B) Systems and Management

7. Are the number of staff and areas of expertise appropriate/adequate, given field support levels and field/Washington headquarter requests? Are they overstaffed/understaffed?
8. What has the role of headquarters of the prime CA been, and how has it supported Advance Africa and CATALYST, especially with respect to management, technical needs and implementation? How could this role be strengthened in the future?
9. To what extent did Advance Africa and CATALYST effectively use modern management tools – for example financial management (i.e. tracking burn rates and pipeline) and programmatic tracking tools and electronic databases? What impact did use or non-use of these tools have on effective management of these activities? How could use of such tools and effective management practices be improved in future activities? What key management tools, if any, should be used?
10. What are the strengths and weaknesses of Advance Africa's and CATALYST's monitoring and evaluation systems? What are the team's recommendations for strengthening M & E systems for FP/RH service delivery activities in the future?
11. In light of the team's review of accomplishments and gaps, have Advance Africa and CATALYST been effectively managed?

C) The Consortium Approach

12. One of the advantages of the consortium model is having the specific expertise of different organizations in one entity. How effectively did the prime cooperating agencies in each consortium provide technical and management support to Advance Africa and CATALYST over the life of these activities? What are the strengths and weaknesses of the consortium approach? How can technical and management support under the consortium model or similar mechanisms be strengthened in the future?
13. How effectively were the comparative technical strengths of all of the consortium partners used in each activity, especially to support field programs? Describe the effectiveness of the program management structure in providing support to the field. How efficiently have resources been allocated? Should they have been allocated differently to maximize results at the field level?

D) USAID

14. How do USAID Missions view Advance Africa and CATALYST with respect to responsiveness, technical quality, management, and implementation? Do they believe Advance Africa and CATALYST are contributing to mission SOs and IRs? What are the major activities or inputs Missions thought were most valuable?
15. What were the advantages and disadvantages of Advance Africa and CATALYST being awarded as two separate activities given that they have a different geographical focus but share a similar strategic framework?
16. How did the gap between the end of the prior global service delivery project and the initiation of the Advance Africa and CATALYST activities affect Missions' decisions about whether to put field support funds into the Advance Africa and CATALYST mechanisms?
17. What were the strengths and weaknesses of USAID management of Advance Africa and CATALYST?

E) Future Strategic Directions

18. What are the gaps in and future opportunities for global technical leadership and field activities in FP/RH service delivery? How can these gaps and opportunities be best addressed?
19. What are the technical gaps, if any, in the Advance Africa and CATALYST activities and if there were to be a future activity, how might these gaps be addressed?
20. Considering that there has been a relative decline in the use of centrally funded family planning programs, what is the nature of mission demand for centrally funded activities? How can GH best respond to current demand?
21. How can management (i.e., tracking of activities, pipelines, expenditures, internal monitoring and evaluation systems) within USAID-supported activities be strengthened in the future? What lessons can be learned from Advance Africa and CATALYST activity management? How can the management burden be reduced for both USAID and the Cooperating Agencies? Please provide specific recommendations.
22. What strategies appear to be the most effective for applying and scaling-up evidence-based best practices? What strategies should PRH consider in future activities?

V. Resources and Methodology

A) Data Sources

The assessment team will review all project documentation, including, but not limited to the following: the Advance Africa and CATALYST Cooperative Agreements; Advance

Africa and CATALYST Self-Assessment reports; annual workplans and budgets; Management Results Review documents; research and technical reports; quarterly and progress reports (not including financial information) and other relevant correspondence.

B) Self-Assessments

Prior to the assessment, USAID will ask Advance Africa and CATALYST to conduct self-assessments (Annex B), and these self-assessments will be sent to POPTECH to serve as a data source for the team.

C) Mission Surveys

In addition, USAID/W will send surveys to Missions prior to the assessment team's arrival in Washington, and the submitted responses will be sent to POPTECH to share with the team.

D) Background Materials/Documents

- Self-assessments prepared by consortium partners
- Mission surveys
- Cooperative agreements
- Annual workplans and budgets
- Quarterly and progress reports
- Management Review reports
- Research and technical reports

E) Team Planning Meeting

A Team Planning Meeting will be held for USAID and POPTECH staff and the Assessment Team to ensure that team members understand the assessment's objectives. The Assessment Team will be briefed by the CTO and POPTECH on the purpose, strategy and current status of the activities. Background materials and other data sources will be provided, the timeline will be finalized and team member responsibilities will be assigned. Report preparation guidelines will be provided and discussed. The Team will review the Table of Contents and outline for an Executive Summary before departure and suggest any revisions that might be needed to the CTO.

F) Interviews

The team will conduct interviews with USAID Mission and Washington staff, Advance Africa and CATALYST staff members and staff from consortium member agencies. In addition, a select number of CAs that work directly with the two organizations will be contacted. The team will also conduct a number of key informant interviews with

USAID Washington staff within the Office of Population and Reproductive Health, and with CATALYST and Advance Africa staff.

While in Washington, the assessment team will conduct phone interviews with a select number of Mission staff (further to survey responses) and other key stakeholders.

List of Interviewees is found in Annex C.

G) Field Visits

To assess activities in greater depth, the assessment team will conduct field visits in four countries. It is unlikely that all team members will travel to all countries. Site visits will be decided in conjunction with USAID staff. Potential field sites under discussion are Peru and Egypt (for CATALYST) and Zimbabwe and Mozambique (for Advance Africa).

VI. Proposed Level of Effort

It is estimated that up to eight weeks of effort will be required for each of the POPTECH consultants, and possibly an additional two weeks for the team leader. The consultants will perform some of the work at home prior to the team's arrival in Washington, D.C. and after the country site visits are completed. The consultants are authorized to work a six-day week when in the field.

The assessment will begin in mid April. A total of six weeks will be needed for data collection, and approximately 15 weeks to complete the entire assignment.

VII. Deliverables

A) Debriefings

The Assessment Team will conduct separate debriefings for USAID, Advance Africa and CATALYST to discuss preliminary findings.

B) Draft Assessment Report

The draft Assessment Report will be submitted to the CTO, to be shared with TAs and Cooperating Agencies for corrections and comments. The draft assessment report will follow the Report preparation guidelines, contain clear findings, conclusions and recommendations, and address the priority questions above. The draft will be submitted in pdf format via email and, if so requested, in hard copy.

C) Final Assessment Report

The final Assessment Report will be no longer than 40 pages total excluding Annexes (Times New Roman font 12 pitch). The report will follow the attached outline (see Annex D). Any modifications to the outline should be discussed with USAID. POPTECH will edit the final report. Approximately 20 hard copies will be distributed.

VIII. Team Composition

The Assessment Team will consist of four members with the following areas of technical/management expertise.

A) Team Leader

1. A team leader with extensive experience in FP/RH service delivery programming and management, with excellent evaluation, interpersonal, writing and facilitation skills.

B) Other Team Members

2. A senior program management specialist who is familiar with GH programs and has experience in management, implementation and evaluation of FP/RH service delivery programs, ideally in both the public and private sectors. This individual should have extensive developing country field experience and knowledge of USAID results programming.

3. A senior FP/RH technical expert, with extensive developing country service delivery experience, particularly with community-based and integrated quality programming.

4. A senior FP/RH technical expert, with extensive developing country service delivery experience, particularly with the private and commercial sector.

Portuguese and Spanish language capability is highly desirable.

IX. Funding, Scheduling and Logistics

All funding and logistical support will be provided through POPTECH. POPTECH activities will include recruiting and supporting the assessment team (including travel, per diem and related team expenses), compiling Mission responses, providing logistical support including setting up meetings in Washington and the countries visited, possible translation and secretarial support, and producing and distributing draft and final reports. Advance Africa and CATALYST will assist POPTECH in making arrangements for the country site visits regarding logistics, scheduling of meetings and, if necessary, in-country travel.

Week	Activity
Week 1 (April 19-23)	<ul style="list-style-type: none"> a. Preparation on April 19 & 20 b. Travel to DC on April 21 c. Team planning meeting/meetings with USAID
Week 2 (April 26-30)	<ul style="list-style-type: none"> a. Interviews with USAID, Advance Africa, CATALYST and others (partners/stakeholders) b. Phone interviews with Missions c. Travel to home evening of April 30
Week 3-5 (May 3-21)	<ul style="list-style-type: none"> a. Field visits b. Return home by May 21
Week 6 (May 24-28)	<ul style="list-style-type: none"> a. Travel to DC on May 25 b. Team conducts post-field-visit review c. Travel to home evening of May 27
Weeks 7-8 (May 31-June 11)	<ul style="list-style-type: none"> a. Team works at home b. Team members submit draft to TL on June 8 c. TL consolidates draft report
Week 9 (June 14-18)	<ul style="list-style-type: none"> a. TL sends draft to team on June 14 b. Travel to DC on June 15 c. Draft report submitted to USAID CTO on June 16 d. Debriefings on June 17 and 18 e. Travel to home evening of June 18
Week 10 (June 21-25)	<ul style="list-style-type: none"> a. USAID CTO sends consolidated comments to TL by June 23 b. TL revises draft report
Week 11 (June 28-30)	<ul style="list-style-type: none"> a. TL submits final draft report to POPTECH by June 30
Week 11-14 (July 1-22)	<ul style="list-style-type: none"> a. POPTECH edits report b. POPTECH sends clearance copy to USAID CTO by July 22
Week 15 (July 26-30)	<ul style="list-style-type: none"> a. POPTECH prints and distributes Final Report within 3 days of clearance by USAID

Annex A-1

Advance Africa Key Indicators

Strategic Objective: Increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and non-clinical programs

Indicator	Source	Notes
Couple years of protection (CYP), by method	Service statistics	W/Trends
Modern method contraceptive prevalence rate (CPR), by method, for various targeted sub-populations	Surveys, Service statistics	Not nationwide
% of Advance Africa FP programs with at least 4 of 5 birth spacing program operational elements	Documentation	Operational elements to be agreed to w/AID

Intermediate Result 1: Increased access to and quality of FP/RH clinical and non-clinical programs

Indicator	Source	Notes
# of fully functioning FP/RH SDPs accredited according to local standards	Service statistics, SDP assessments & inventory	
# of MTCT sites where more than 75% of clients receive FP counseling and services	Service statistics	
% of HIV/AIDS clients receiving FP at MTCT sites	Service statistics, Exit interviews	
% of FP clients whose cases are managed in compliance with the local quality standards	SDP assessments	Through direct observation

Intermediate Result 2: Increased capacity for informed FP/RH decision-making by clients and communities

Indicator	Source	Notes
% women of reproductive age in union with aspiration to space next child at least 36 months	Surveys	
% men of reproductive age in union with aspiration to space next child at least 36 months	Surveys	
% of women of reproductive age in union reporting increased communication w/partner over FP/RH issues	Surveys	
Increase in proportion of underserved population aware of available FP services	Surveys	Youth, IDPs

Intermediate Result 3: Improved awareness of the importance of the health benefits of FP among African policy-makers

Indicator	Source	Notes
# of countries using Advance Africa tools and materials to advocate for FP programs and elements of repositioning agenda	Documentation	
# of advocacy tools developed by Advance Africa and used by Advance Africa partners	Documentation	

Annex A-2

CATALYST Key Indicators

Strategic Objective: Increased use of sustainable, quality family planning and reproductive health services and healthy practices through clinical and non-clinical programs.

INDICATORS	DATA SOURCES
CPR in CATALYST activity areas	Project baseline and follow-up surveys; Program service statistics

POTENTIAL PROGRAMMATIC AREAS	INDICATORS	DATA SOURCE
Intermediate Result 1: Increased access to and improved quality of FP/RH clinical and non-clinical programs		
<ul style="list-style-type: none"> • Family planning • Optimal Birth Spacing Initiative (OBSI) • Emergency obstetric complications (EOC) • Postabortion care (PAC) • Integration of FP at the clinical level with MCH • Integration between clinical and non-clinical programs • Expanded method mix (EMM) • Adolescent reproductive health/family planning 	<ol style="list-style-type: none"> 1. #/% of clients in service delivery points initiated/improved with CATALYST assistance by program area (e.g., FP, OBSI grants, EOC, PAC, integration, EMM, adolescent RH/FP) and demographic characteristics (e.g., sex, age) 2. % of clients in relevant program areas (e.g., FP, OBSI grants, EOC, PAC, integration, EMM) accepting the use of using contraceptives 	<ol style="list-style-type: none"> 1. Program records and facility audits, as appropriate 2. Service statistics
Intermediate Result 2: Increased capacity for informed FP/RH decision-making among clients and communities		
<ul style="list-style-type: none"> • Family planning (FP) • Postabortion care (PAC) • Integration between health and non-health interventions 	<ol style="list-style-type: none"> 3. % of targeted audience adopting behaviors supported by CATALYST (e.g., discussing/negotiating contraceptive use with partner, seeking support/assistance when facing GBV, discussing care-seeking for EOC/PAC patients with family members) 4. # of programs establishing links between FP and social programs in other sectors 	<ol style="list-style-type: none"> 3. Surveys, qualitative studies 4. Program records

Intermediate Result 3: Increased capacity of public and private sectors to sustain quality FP/RH programs		
<ul style="list-style-type: none"> • Family planning (FP) • Optimal Birth Spacing Initiative (OBSI) • Expanded method mix (EMM) • Adolescent reproductive health/family planning 	<p>5. % of program costs covered by income generated by program</p> <p>6. # of partnerships established with/or between commercial/ NGO/public sector entities</p>	<p>5. Financial records</p> <p>6. Program records</p>
Intermediate Result 4: Scaled-up and improved FP/SD through TA to other agency/donor/foundation programs		
<ul style="list-style-type: none"> • Family planning (FP) • Optimal Birth Spacing Interval (OBSI) • Emergency obstetric complications (EOC) • Postabortion care (PAC) • Integration of FP at the clinical level with MCH • Integration between clinical and non-clinical programs • Integration between health and non-health interventions • Expanded method mix (EMM) • Adolescent reproductive health/family planning 	<p>7. # of programs scaling-up effective interventions</p> <p>8. # of collaborative projects/ activities undertaken with CAs to implement evidence-based practices</p>	<p>7. Program records</p> <p>8. Program records</p>

Annex B

Self-Assessment Questionnaire

As part of the end of activity evaluation process, organizations are asked to conduct a programmatic and organizational self-assessment. This is an opportunity for agencies to concisely highlight key accomplishments, challenges and lessons learned for the evaluation team and USAID. This self-assessment, as only one part of the evaluation, will contribute to the overall understanding of the activities by the team. As such, please limit responses to the questions below to no more than 15 pages. To the extent possible, refer the team to existing documents such as Results Reports and Quarterly Reports.

1. Please describe, by intermediate result, the major accomplishments of the Advance Africa and CATALYST activities, and how programming has advanced the state-of-the-art in family planning/reproductive health service delivery? Please separate core and field support funded activities.
2. What areas of particular promise or key evidence-based approaches could be further developed? What is the unfinished agenda?
3. Which activities or interventions required greatest effort and proved most difficult to implement? What were the specific obstacles to achieving results and what lessons have been learned in the process?
4. In the activity design, “Gender” was intended to be a cross-cutting issue, yet full integration into programming has proved challenging. What were the specific issues that impeded the mainstreaming of gender in the activities? Are there lessons that could be learned from this experience and what could be done differently in the future?
5. One of the potential advantages of the consortium model is having the specific expertise of different organizations under one organizational entity. How well did the consortium model work for each organization? What are the strengths and weaknesses of the consortium approach?
6. What role has the headquarters organization played in activity support, management and leadership? Should anything have been done differently?
7. Your activity experienced changes of key personnel over the past three years. How did this affect implementation and morale?
8. Given that your activity must respond to both USAID/W and USAID’s field missions, how have you managed these relationships? Do you have suggestions for the future?
9. Please comment on any other factors that the Evaluation Team should take into account when assessing Advance Africa and CATALYST results, management, leadership and implementation.

Annex C

List of interviewees:

CATALYST:

Brenda Doe, USAID/Egypt
Chris McDermott, USAID/Egypt
Richard Martin, USAID/Peru
Ahmed Attieg, USAID/Yemen
Samia Altaf, USAID/Pakistan
Elizabeth Drabant, USAID/Bolivia
Sheila Lutjens, USAID/Nepal
Robert Clay, USAID/India
Randy Kolstad, USAID/India
Susan Brems, USAID/Nicaragua
Billy Pick, USAID/ANE
Linda Hiebert, World Vision
David Weiler, CSR/Dhaka
Lily Kak, USAID/GH/HIDN/MCH

Advance Africa:

Suzanne Jessop, USAID/DRC
Cathy Bowes, USAID/Angola
Abuchahama Saifodine, USAID/Mozambique
Joan La Rosa, USAID/Mozambique
Brad Barker, USAID/Senegal
Peter Halpert, USAID/Zimbabwe

USAID/W:

Maureen Norton, CTO, CATALYST and Advance Africa
Kellie Stewart, TA, CATALYST
Caitlin Auld, Acting TA Advance Africa
Dana Vogel, SDI Division Chief
Pam Mandel, SDI Service Delivery Team Leader
Jim Shelton, Senior Medical Scientist
Margaret Neuse, Director PRH
Jeff Spieler, RTU Division Chief
Gary Cook, Health Advisor, ANE
Khadijat Mojidi, NEP

Other:

Suzanne Prysor Jones, SARA Project (for Advance Africa)

Annex D

Outline for Final Assessment Report

- I. Table of Contents**
- II. Executive Summary** (3 pages) – The Executive Summary should convey the important points of the report clearly and concisely. Because it may be distributed to a wider audience, it should be written as a stand-alone document which contains findings, conclusions and recommendations related to all priority questions listed in the scope of work.
- III. Background**
- IV. Methodology**
- V. Program description**
- VI. Summary of Findings, Conclusions and Recommendations**

Annexes

- A. Scope of Work**
- B. List of Contacts**
- C. Responses to Self-Assessment Questions**
- D. Schedule**
- E. Country Summaries (substantive and analytical)**
- F. Mission Responses**
- G. Summary of Advance Africa and CATALYST Funding to Date**
- H. Advance Africa and CATALYST Monitoring and Evaluation Plans**
- I. References**

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

WASHINGTON, D.C.

U.S. Agency for International Development (USAID)

Bureau for Global Health, Office of Population and Reproductive Health (GH/PRH)

Margaret Neuse, Director

James Shelton, Senior Technical Advisor

Scott Radloff, Deputy Director

Dana Vogel, Division Chief, Service Delivery Improvement Division (SDI)

Maureen Norton, Program Manager, SDI

Kellie Stewart, Technical Advisor, SDI

Jeff Spieler, Division Chief, Research, Technology, and Utilization Division

Lily Kak, Office of Health, Infectious Diseases, and Nutrition, Maternal and Child Health Division

Brad Barker, Population, Health and Nutrition Officer, USAID/Senegal

Telephone Interviews (USAID /Washington and Mission Personnel)

Gary Cook, Senior Health Advisor, Bureau for Asia and the Near East, Office of Strategic Planning, Operations, and Technical Support (ANE/SPOTS)

Billy Pick, ANE/SPOTS

Rocio Lara, Population, Health, and Nutrition Officer, USAID/Bolivia

Samia Altaf, Senior Health Advisor, USAID/Pakistan

Lina Piri Piri, Population, Health, and Nutrition Program Manager, USAID/DR Congo

Zipporah Wanjohi, Population, Health, and Nutrition Officer, USAID/Angola

Randy Kolstad, Population, Health, and Nutrition Officer, USAID/India

Advance Africa, Arlington, VA

Issakha Diallo, Project Director

Jack LeSar, Management Sciences for Health Representative

Bruce Gatti, Director of Finance and Administration

Elvira Beracochea, Deputy Director

Berengere de Negri, Lead Technical Advisor for Strategy and Implementation

Kwaku Yeboah, Senior Technical Advisor, Clinical Services

Yousouf Quedraogo, Monitoring and Evaluation Specialist

Bernardo Uribe, Public Health Logistics Officer

ZIMBABWE

Advance Africa

Premila Bartlett, Country Director

Thoko Maposa, Program Manager

Tendai Mwotowanyuka, Monitoring and Evaluation Specialist

Ityai Muvandi, Program Consultant

USAID/Zimbabwe

Peter Halpert, Team Leader

Tonya Himelfarb, HIV/AIDS Program Specialist

Zimbabwe National Family Planning Council (ZNFPC)

Godfrey Tinarwo, Executive Director
Mathew Zharare, Director, Administration and Finance
Warren Kufandarerwa, Acting Project Accountant
Davidson Mambudzu, Senior Training Officer
Cosmas Chitauru, Production Manager (IEC Unit)
Ronica Nyakauru, Program Manager, Research
Margaret Butau, Assistant Director, Service Delivery
Thembi Dube, Secretary, Service Delivery Unit

Ministry of Health and Child Welfare (MOH&CW)

Margaret Nyandoro, Reproductive Health Coordinator
Felicity Hatendi (Integration Working Group)

Population Services International (PSI)

Andrew Boner, Country Director
Miriam Mhazo, Voluntary Counseling and Testing Program Manager
Noah Taruberekera, Monitoring and Evaluation

ZNFPC/Mazowe District

Esnath T. Chimanikir, Group Leader

Bindura District, Mashonaland Central Province

Perpetua Canisius, Community-Based Distribution Agent
Rowesayi Negtharwasha, Depot Holder

Howard Mission Hospital, Mazowe District, Mashonaland Central Province

Paul Thistle, Medical Superintendent

Bulawayo and Matabeleland South Province

Godfrey Nhivativa, Acting Provincial Manager
Juliana Jubane, Sister-in-charge
Molly Maphosa, Group Leader
Sithandekile Nwbe, Health Promotion Officer

Tshelanyemba Mission Hospital, Bulawayo

Dawn Howse, Medical Superintendent

Catholic Relief Services (CRS) STRIVE Program

Choice Makufa, Head of Project

Forum for African Women Educationalists, Zimbabwe (FAWEZI)

Irene Mukondo, Chairperson
Susan Guwuro, Coordinator

Advance Africa Orphans and Vulnerable Children Program Partners
Phanuel Mandebvu, Executive Director, Diocese of Mutare Community Care
Program (DOMCCP)
Francis Tembo, Director, Batsiranai

World Health Organization/Africa Regional Office (WHO/AFRO)
Modibo Dicko, Technical Officer

MOZAMBIQUE

Advance Africa

Etheline M.L. Enoch, Country Director
Jorge Bardalez, NGO Coordinator
Arturo Sanabria, Former NGO Coordinator

Ministry of Health

Martinho Dgedge, Head, Community Health Department
Atalia Macome, Director of School Health
Cassimo Bique, Reproductive Health Officer
Della Mercedes Correia, Head, School and Adolescent Health Unit
Maria Teresa Vitorino, Director of Family Planning
Abdul Alberto, Chief Nurse, Gurue District, Zambezia Province
Cardoso Herculano, Health Officer, Gurue District, Zambezia Province
Eduardo Arame, District Health Director, Zambezia Province
Jose Chiruquefwha, District Administrator, Gurue District, Zambezia
Antonio Mussa, Provincial Health Director, Zambezia

USAID/Mozambique

Abuchahama Saifodene, PHN Officer
Titus Angi, Health Officer

World Vision

Joao Ausse, Project Coordinator
Estela Consula, District Coordinator, Gurue District, Zambezia Province

PERU

USAID/Peru

Dick Martin, Health and Family Planning Division Chief
Susan Thollaugh, Health Officer
Lucy Lopez, Project Coordinator

CATALYST Consortium

Milka Dinev, CATALYST Country Representative
Miguel Gutierrez, Medical Director
Johny Juarez
Dorina Vereau

Carlos Sanchez
Beatriz Huaman
Raul Suarez
Elizabeth Acevedo
Mariel Leon
Cesar Arroyo

Ministry of Health

Lucy del Carpio, Quality Health Care Area
Jorge Medrano, Vaccination Area
Dr. Arellanos, Huanuco Regional Division

Peruvian Association of Physicians (Colegio Médico del Perú)

Isaias Penalosa

Association of Faculties and Schools of Medicine (ASPEFAM)

Jesus Fernandez
Manuel Nunez

Instituto Peruano de Paternidad Responsable (INPPARES) (International Planned Parenthood Affiliate in Peru)

Daniel Aspilcueta

Schering

Alvaro Angel

Apoyo a Programas de Población (APROPO)

Carola de Luque

Partners For Health Reform*plus* (PHR*plus*) Project

Midori de Habich

EGYPT

USAID/Egypt

Brenda Doe, Family Planning/Reproductive Health (FP/RH) Team Leader
Kathryn Panther, Team Leader, Population and Health Division
Shadia Saad Attia, Monitoring and Research Advisor

CATALYST Consortium

Damianos Odeh, Country Representative
Linda Casey, Deputy Country Representative
Mohamed Abou Nar, Deputy Country Representative
Ton van der Velden, Quality Improvement Specialist
Nagwa Samir, Youth Specialist
Mawaheb El Mouelhy, NGO Sector Specialist
Hossam Hammad, Implementation and Planning Specialist
Gamal Elkhatab, Management and Sustainability Specialist
Rania Moustafa, Implementation Specialist

Ministry of Health and Population (MOHP)

Yahia S. El Hadidi, General Director, Family Planning and Population Sector

Population Council

Nahla Abdel Tawab

Healthy Mother/Healthy Child

Reginald Gipson, Chief of Party

Health Communication Partnership

Ron Hess, Chief of Party

PHR*plus*

Nadwa Rafeh

National Council for Childhood and Motherhood

Manal Shaheen

Clinical Services Improvement Project (CSI)

Mohamed Edrees and staff

Governorate of Minia

His Excellency, Major General Hassan Hemida

Ahmed El Husseiny, Management Information Systems

Atef Ezzat, Directorate of FP

Marcel Labib, Directorate of FP

Minia University

Abd El Moneim, President

Hanaa Hamdy, General Director, Youth Care Department

APPENDIX C

SCHEDULES

(prepared by Advance Africa and CATALYST Consortium)

ADVANCE AFRICA

Mozambique Visit to World Vision (Zambézia) and MCDI (Cuamba, Niassa) May 16–19, 2004 (prepared by Advance Africa)

<p style="text-align: center;">05/12/04 (Wednesday) Arrival to Moazambique</p>	<p>3:00 p.m.: Arrival to Maputo</p> <p>The team will be met at the airport and will be taken to Polana Hotel by Advance Africa’s driver.</p> <p>4:30 p.m.: Brief visit to MSH/Advance Africa Office to meet Advance Africa staff.</p>
<p style="text-align: center;">05/13/04 (Thursday) Meeting USAID, MOH, and MOH Partners</p>	<p>9:00 to 12:30: Meeting with relevant Advance Africa and MOH partners (Planning is in progress; names and times to be confirmed).</p> <p>14:00 to 17:00: Meeting with Advance Africa staff: Presentation of progress report and answering questions posed by the assessment team.</p>
<p style="text-align: center;">05/14/04 (Friday) Meeting MOH Partners</p>	<p>9:00 to 15:30: Meeting with relevant Advance Africa and MOH partners (Planning is in progress; names and times to be confirmed).</p>
<p style="text-align: center;">05/15/04 (Saturday)</p>	<p>Free</p>
<p style="text-align: center;">05/16/04 (Sunday)</p>	<p>Departure from Maputo (15:00)</p> <p>Arrival to Quelimane Airport (17:30) To be met at airport by Mrs. Gregória Mavundla, Advance Africa Provincial Reproductive Health Assistant.</p>
<p style="text-align: center;">05/17/04 (Monday) World Vision (Zambézia)</p>	<p>8:00 to 9:30 am. Meeting with:</p> <ul style="list-style-type: none"> ▪ Director da DPS: Dr. Antonio Mussa ▪ Head of Community Health Department: Sr. Titus Guamba ▪ World Vision Coordinator: Mr. João Ausse ▪ Advance Africa Provincial Reproductive Health Assistant: Mrs. Gregória Mavundla <p>Objectives</p> <ol style="list-style-type: none"> 1. Introduction of members of the assessment team to the DPS and NGO coordinator and vice versa (by Advance Africa Provincial Reproductive Health Assistant) 2. Assessment team informs the purpose of their visit <p style="text-align: center;">Presentation of the coordination system between the Provincial Health Directorate, World Vision, and Advance Africa by DPS</p>

	<p>10:30 a.m. Departure from Quelimane to visit the District of Gurue (1 hour trip by Air Serv)</p> <p>Team</p> <ul style="list-style-type: none"> ▪ Head of Community Health, Dire: Sr. Titus Guambe ▪ Chefe de Saúde Materna e Infantil: Sra. Francisca Bacião ▪ Coordenador da Visão Mundial: Sr. João Ausse ▪ Provincial Reproductive Health Assistant: Mrs. Gregoria Mavundla <p>Objectives</p> <ol style="list-style-type: none"> 1. Visit the District Health Directorate (DDS), meet and talk to the staff. 2. Visit a Community Health Council of this DDS and see how they liaise with the DDS 3. Household visits to see how the trained reproductive health community workers carry out their activities in the community.
<p>05/18/04 (Tuesday) MCDI Lichinga</p>	<p>8.00 a.m.: Departure from Gurue to Lichinga</p> <ol style="list-style-type: none"> 1. Visit the District Health Directorate (DDS), meet and talk to the staff. 2. Visit a community health council of this DDS and see: <ul style="list-style-type: none"> A) How they liaise with the DDS B) The use of ambulance bicycles for patients' transportation C) The community's perceptions in relation to the introduction and use of bicycle ambulances in their community 3. Household visits to see how the trained reproductive health community workers carry out their activities in the community. <p>Sleep in Lichinga</p>
<p>05/19/04 (Wednesday) Return to Maputo via Beira</p>	<ul style="list-style-type: none"> ▪ 7:00 a.m.: Departure from Lichinga to Beira (Air Serv) ▪ 09:45 a.m.: Arrival to Beira ▪ 12:00 a.m.: Departure from Beira to Maputo <p>Sleep in Maputo at Polana Hotel</p>
<p>05/20/04 (Thursday) Return home</p>	<p>9:00 to 10:00 a.m.: Visit to World Vision Central Office (the agenda for this meeting is still being planned).</p> <p>4:00 p.m.: Departure from Maputo</p>

CATALYST CONSORTIUM

Egypt Schedule of Meetings USAID/POPTECH Evaluation of TAHSEEN/CATALYST May 4–11, 2004 (prepared by CATALYST Consortium)

Monday, May 3

3:00 p.m. Laurie Cobb pick-up from airport and transfer to Semiramis.
Confirmation # 434831

Tuesday, May 4

8:30 a.m. Checkout from Semiramis Hotel and transfer to TAHSEEN office
9:00 to 10:30 a.m. TAHSEEN Presentation and group discussion with staff
10:30 to 11:30 a.m. Dr. Damianos Odeh, Country Representative, TAHSEEN/CATALYST
11:30 a.m. Transfer to MOHP
12:00 p.m. Dr. Yahia El Hadidi, Undersecretary for Population, MOHP
2:00 p.m. Lunch
4:00 p.m. Travel to Minia by train
7:30 p.m. Arrival and check-in at Aton Hotel, Minia
8:00 p.m. Dr. Abd El Moneim, President and Mrs. Hanaa Hamdy, General
Director, Youth Care Department, Minia University (Mrs. Hanaa
coordinates the peer educator program.)

Wednesday, May 5

9:30 a.m. Meeting with Peer Educators, Minia University
11:00 a.m. Visit a pre-renovation clinic
12:00 p.m. Opening Ceremony, Edmo Rural Health Unit*
1:00 p.m. Meeting with representatives of the Minia BCC Media Group
2:30 p.m. Lunch/break
5:00 p.m. Meeting with Mr. Raif Hennawi and field workers of St. Mark NGO at
Sawada Rural Health Unit
7:30 p.m. Meeting with Governor or Secretary General¹ of Minia

Thursday, May 6

9:30 to 10:30 a.m. Meeting with PAC trainees
11:00 to 11:45 a.m. Religious leaders training*
11:45 a.m. to 12:30 p.m. Meeting with religious leaders
1:00 p.m. Agricultural extension workers session*
2:30 p.m. Lunch

¹ Top governorate officials have been involved in and very supportive of TAHSEEN, such that we suggest this meeting with the Governor or his Secretary General.

4:30 p.m. Meeting with doctors and nurses of five clinics where TAHSEEN has renovated facilities and trained providers

6:00 p.m. PAC/Community Participation

*denotes previously scheduled activities, as opposed to meetings/interviews that have been arranged for the evaluation.

Friday, May 7

10:00 a.m. Drs. Atef Ezzat and Marcel Labib, MOHP/Minia and Mr. Ahmed El Husseiny

12:00 p.m. Visit to Jebel El Ter Church

2:00 p.m. Return to Cairo by car

5:30 p.m. Check in at Semiramis, Confirmation #437614 Laurie Cobb and #437615 Maria Mamlouk

Saturday, May 8

Day off, TAHSEEN office working space available.

Sunday, May 9

9:00 a.m. Ms. Kathryn Panther, Director, Health and Population, and Ms. Brenda Doe, FP/RH Team Leader, USAID

2:00 p.m. Ms. Manal Shaheen, NCCM

3:30 p.m. Dr. Mohamed Edrees, Executive Director, Clinical Services Improvement Project

Monday, May 10

9:00 to 10:00 a.m. Dr. Reginald Gipson, COP, JSI/Healthy Mother/Healthy Child

10:30 to 11:30 a.m. Dr. Nahla Abdel Tawab, Egypt Country Representative, the Population Council

12:00 to 1:00 p.m. Mr. Ron Hess, COP, JHU Communications for Healthy Living Project

1:00 to 4:00 p.m. Time open for work at TAHSEEN office, TAHSEEN team interviews as necessary or other appointments

4:00 to 5:00 p.m. Dr. Hussein Abdel Aziz, Country Representative, TAHSEEN/POLICY II Project

Tuesday, May 11

8:30 to 9:30 a.m. Dr. Nadwa Rafeh, COP, PHR+

9:00 a.m. to 2:00 p.m. Time open for work at TAHSEEN office, TAHSEEN team interviews as necessary or other appointments

2:00 to 3:00 p.m. Wrap up with TAHSEEN management

Wednesday, May 12

2:00 a.m. Check out from Semiramis and transfer to airport

FINAL AGENDA, PERU

CATALYST Evaluation

Laurel Cobb, Maria Mamlouk

(prepared by CATALYST Consortium)

Wednesday, May 12

21:12

Arrival, AA F/917

The Doubletree El Pardo Hotel's driver will meet you at the airport after passing the Immigration Control. The driver will hold a board with your names.

Thursday, May 13

16:00

Transfer from hotel to USAID's office

17:00 to 18:00

Meeting with Dr. Lucy López, Project Coordinator, USAID Perú

Friday, May 14

05:00

Transfer from hotel to airport

08:50 – 10:05

Fly to Pucallpa – accompanied by Lic. Dorina Vereau and Dr. Johnny Juárez

Saturday, May 15

09:00

Transfer from hotel to airport

11:05 – 12:20

Fly to Lima

Monday, May 17

08:15

Victor Ventocilla will pick up from hotel

08:30

Briefing Meeting with CATALYST Country Representative, Mrs. Milka Dinev and Medical Director, Dr. Miguel Gutiérrez

10:30

Transfer from Pathfinder's office to airport

13:15 to 14:15

Fly to Huánuco – accompanied by Dr. Hector Pereyra, Dr. Carlos Sánchez, Lic. Beatriz Huamán and Dr. Raúl Suárez

Wednesday, May 19

12:00

Transfer from hotel to airport

14:45 – 15:45

Fly to Lima

16:00

Attend OBSI Conference at Prince Hotel

17:00

Meet at OBSI Conference with Lucy del Carpio, from the Ministry of Health

18:30

Cocktail party with counterparts at Pathfinder's office

Thursday, May 20

09:00 to 11:00

Visit San Juan de Miraflores: Gender Based Violence accompanied by Mrs. Elizabeth Acevedo

Centro Emergencia Muer

12:00 to 13:00 ASPEFEEN (Asociación Peruana de Facultades y Escuelas de Enfermería): Mg. Margot Zárate

13:30 Lunch

15:00 to 15:45 Meeting with Mr. Richard Martin, Chief of Health, USAID

16:00 to 16:45 ASPEFAM (Asociación Peruana de Facultades de Medicina): Jesús Fernández Urday / Manuel Núñez

16:45 to 17:30 COLEGIO MEDICO DEL PERU: Dr. Isaías Peñalosa / Dr. Agustín Iza

17:45 to 18:30 MINED: Maria Teresa Ramos

Friday, May 21

10:00 to 10:45 INPPARES: Dr. Daniel Aspilcueta

11:00 to 11:45 MINSA (Ministry of Health): Mr. Jorge Medrano (Vaccination Area)

13:00 Lunch

14:30 to 17:15 LAB. SCHERING: Alvaro Angel/Miriam Vidurrizaga

15:30 to 16:45 PHR*plus* (Partners for Health Reform*plus*): Midori de Habich/Ada Pastor

16:30 to 17:15 Meeting with Milka Dinev

Saturday, May 22

04:00 Transfer from hotel to airport

07:30 Fly to USA

APPENDIX D

COUNTRY REPORTS

COUNTRY REPORTS

PREFACE

The four-person assessment team divided into two groups to visit two country programs of each CA, each for 1 week. One team visited Egypt and Peru (CATALYST), and the other team visited Mozambique and Zimbabwe (Advance Africa).

These visits were not evaluations of those country programs. As discussed with both POPTECH and USAID/Washington, 7 working days of interviews in each country is not sufficient to evaluate such major USAID programs as those in Egypt and Peru. The team was not to conduct an indepth evaluation of country programs, nor was there time or level of effort for an evaluation. Moreover, as table D-1 makes clear, the funding levels for the four countries is very different. Funding for CATALYST/Egypt (and presumably its size) is over 10 times that of the Advance Africa program in Zimbabwe. Per USAID design of this assessment, the level of effort for each country was the same; the objective was to become acquainted with the program as an example in order to jointly evaluate the global programs of Advance Africa and CATALYST.

Table D-1
Country Visits

CA and Country	Level of USAID Funding
Advance Africa/Zimbabwe	\$ 1,361,688
Advance Africa/Mozambique	\$ 6,613,700
CATALYST/Peru	\$12,114,417
CATALYST/Egypt	\$18,046,480 (includes \$3.5 million added in April 2004)

Given that the level of effort was equal for both projects, it was a challenge to fairly balance the reporting (in a brief report) on two service delivery projects implemented by two different CAs, when the size of their programs is very different.

EGYPT COUNTRY REPORT

PROGRAM DATA

Country Program Objective(s): “To provide the kind of assistance that will solidify USAID’s family planning/reproductive health investments of the last three decades, leave a sustainable FP/RH program that provides quality services to all who want and need them, and help Egypt take its final steps in reaching replacement level fertility by 2015.”

Program Components (Four themes; 10 results to be achieved):

Theme 1: Focused attention on priority groups

1. Youth better informed and use of services increased
2. Underserved and unempowered women better informed and use of services increased
3. Postpartum/postabortion women and those medically qualified for tubal ligation better informed and use of services increased

Theme 2: Improved quality for the customer

4. Quality of FP/RH services improved
5. Integration of FP/RH/maternal and child health (MCH) services within Strategic Objective (SO) 20 strengthened

Theme 3: Stronger institutional capacity and systems

6. Policies identified and implemented to support a sustainable FP/RH program (principally the responsibility of the POLICY II Project; the only CATALYST responsibility will be assistance to the Demographic and Health Survey (DHS) in 2005)
7. FP/RH management and leadership systems strengthened
8. Contraceptive security ensured (principally the responsibility of POLICY II)

Theme 4: Achieving sustainable sectoral shares

9. NGO sector’s role in FP/RH expanded
10. Commercial sector’s role in FP/RH expanded

Cost: \$18 million (core: \$9,000; field support: \$14.5 million plus \$3.5 million added in April 2004)

Key USAID Partners

- POLICY II Project
- Central Contraceptive Procurement
- MEASURE DHS
- Communications for Healthy Living
- Mothercare Healthy Mother/Healthy Child

Key Egyptian Partners

- Ministry of Health and Population (MOHP)
- National Population Council

- Regional Center for Training (USAID project)
- Clinical Services Improvement Project (USAID project)

BACKGROUND

The following information on the background of CATALYST in Egypt is from the document “CATALYST Scope of Work 2002–2009.doc” dated December 2003.

USAID has provided assistance to the Egyptian family planning program since 1978. Over more than two decades, support has been aimed at enabling the GOE to increase demand for and utilization of family planning (FP) services by:

- Improving access to FP services and information;
- Improving the quality of clinical FP services;
- Ensuring adequate supplies of contraceptives and other commodities;
- Establishing effective population policies and management and support systems.

Support has been provided in many forms to a wide range of public, commercial and NGO sector organizations. The depth, quality and success of these efforts over 23 years are illustrated by a range of impressive outcomes:

- Universal knowledge of FP;
- Contraceptive prevalence more than doubled;
- Total fertility rate cut by over a third;
- Very high levels of access through dense coverage by clinical facilities;
- Reliable supplies of contraceptive commodities to the program;
- Affordable services available from public, NGO and commercial providers;
- Strong and continuing commitment to the program from the highest levels of government.

Unfortunately, obstacles and challenges remain, including major disparities in health status, especially among vulnerable groups; inadequate systems to ensure effective operation of health care management and services; limited institutional capacity to implement and improve programs and services; and the sustainability of improvements, programs, institutions and health care services. Through September 2009, USAID/Egypt will provide support to the PH sector under the strategic objective “Healthier, Planned Families” (SO 20). SO 20 was approved as part of the Mission Strategic Plan by USAID/W in January 2000. SO 20 is the last planned health and population activity for USAID/Egypt and, consequently, has an obligation to make sustainability a prime focus.

In April 2001, a team was contracted to prepare proposals, ideas and options regarding the design of the final family planning/reproductive health (FP/RH) program for Egypt from 2002–2009. That program design was ultimately named “Tahseen Sihatna bi Tanzeem Usritna” or TAHSEEN (previously known as the TAHSEEN Project). Four partners will work together to implement TAHSEEN via buy-ins to central agreements: CATALYST, Central Contraceptive Procurement (CCP), MEASURE DHS, and POLICY II. However, because the POLICY, CCP and MEASURE activities are relatively discrete and feed into the broader CATALYST program, CATALYST will function as the largest activity under TAHSEEN. As such, it will play a leadership and coordination role among all of the partners in-country.

TAHSEEN's goal is to provide the kind of assistance that will solidify USAID's family planning and reproductive health (FP/RH) investments of the last three decades, leave a sustainable FP/RH program that provides quality services to all who want and need them, and help Egypt move towards its ambitious goal of replacement level fertility by 2017. To achieve this goal, the project will have to address and resolve four challenges which remain after the enormous progress of the last 20+ years:

- To focus its service delivery assistance on under-served and high-risk populations - There are still pockets of under-served populations, both high-risk groups and those in hard-to-reach geographical areas. This group also includes postpartum women, post abortion

women, women medically qualified for tubal ligation and youth. A final effort is needed to help provide services to those who are the hardest to reach and whose participation will be necessary if the program is to be sustainable.

- To ensure that the FP/RH program that will continue after USAID’s phase-out reflects a culture of quality services for every client. This challenge remains, despite excellent progress on quality improvement in previous years. High quality both stimulates demand and contributes to more efficient utilization of facilities and so remains an important part of the problem that TAHSEEN is designed to solve.
- To strengthen the policy environment, the management and logistics systems, and the contraceptive supply needed to support a sustainable FP/RH program. This is an area where persistent barriers remain and can most easily obstruct achievement of the program’s objectives.
- To create sustainable shares for all sectors—public, commercial and NGO—in the provision of FP/RH services. The public sector’s share is currently rising but it is highly unlikely that it alone can provide the bulk of such services over the long term, especially in the absence of substantial donor support.

Three additional crosscutting themes—youth, gender, and sustainability—are integral elements of each result contained within TAHSEEN.

In September 2002, the CATALYST country representative arrived as a consultant; in February 2003, he became staff and began hiring the initial staff members. Most of the then current staff of approximately 40 people, however, were hired in the 6 months prior to this assessment. While several key staff members have substantial FP/RH experience, the majority were hired for other areas of expertise. The CATALYST pipeline analysis of May 27, 2004, indicated that the number of CATALYST staff would rise to 60 by the end of 2004.

PROGRAM DESCRIPTION

The CATALYST scope of work document quoted above is a seven-year plan, commencing in 2002 and ending in 2009; other documents refer to the 2002–07 timeframe. The scope is broad and ambitious. CATALYST is working

- at the central, governorate, and community levels;
- with the public, commercial, and NGO sectors;
- as a provider of technical assistance and training, as the direct implementer of certain activities, and as a broker for USAID with other cooperating agencies; and
- in four theme areas (priority groups, quality, institutional capacity and systems, and sustainability) with 10 key results and three crosscutting themes of youth, gender, and sustainability.

The draft “CATALYST Monitoring and Evaluation Plan, 2003–2009” is a 66–page document with about 45 outcome and process indicators for CATALYST results.

METHODOLOGY

The assignment plan anticipated that two members of the team would spend 7 days working, traveling, and interviewing in Egypt.² As discussed with USAID and CATALYST when the level of effort was being decided for Egypt and Peru, 1 week is too short a time to assess a large, complex project working at the central, regional, and community levels. However, the purpose of the visit was not to assess CATALYST/Egypt, but to view it as the largest program in the global CATALYST program, which was being assessed as one of two service delivery projects. Because USAID/Washington stressed the importance of seeing CATALYST work in the Egyptian town of Minia, the schedule was for three and a half of the interviewing days in Egypt to be spent within Upper Egypt. In Upper Egypt, interviews were conducted with many people representing different aspects of CATALYST's activities (see appendix B).

Understandably, with little time in the country and a particular USAID/Washington interest in Minia, the CATALYST schedule held little time for information gathering at the central level. The only meeting with the central Ministry of Health and Population (MOHP) (or central public sector officials) was a 1-hour meeting with the director of family planning. The CATALYST deputy director accompanied a team member to this interview at her request; once there, at the request of the family planning director, the CATALYST deputy left. Although CATALYST's work plans refer to many activities at the central level of the MOHP, the CATALYST schedule for the team did not include interviews with any central office staff who had been involved in these activities (e.g., technical assistance, training, and systems development, or discussions of integration or postabortion care [PAC]). No reports on institutional strengthening at the MOHP central level were provided.

CATALYST identifies many units and institutions as being collaborators at the central level on activities that are meant to have national impact. The CATALYST schedule for the team, however, did not include meetings on these activities with key collaborators, such as the NGO unit in the MOHP, the MCH department of the MOHP, the State Information Service, the Egyptian Pharmaceutical Trading Company, the Regional Center for Training, the Egyptian Family Planning Association, and commercial pharmaceutical companies (the Ask-Consult network). These activities were not assessed; CATALYST data on inputs with these different institutions are presented in the *CATALYST Quarterly Progress Report, January-March 2004*.

Meetings were held with the directors of four collaborating USAID CAs, the director of the USAID-assisted Clinical Services Improvement Project (CSI) and his top staff, the project director of an activity with Egypt's National Council for Childhood and Motherhood, and the MOHP director of family planning.

The findings focus on activities the team observed for two primary reasons:

- to maintain a balance between CATALYST and Advance Africa and the four country visits, for each of which USAID allocated an equal level of effort; and

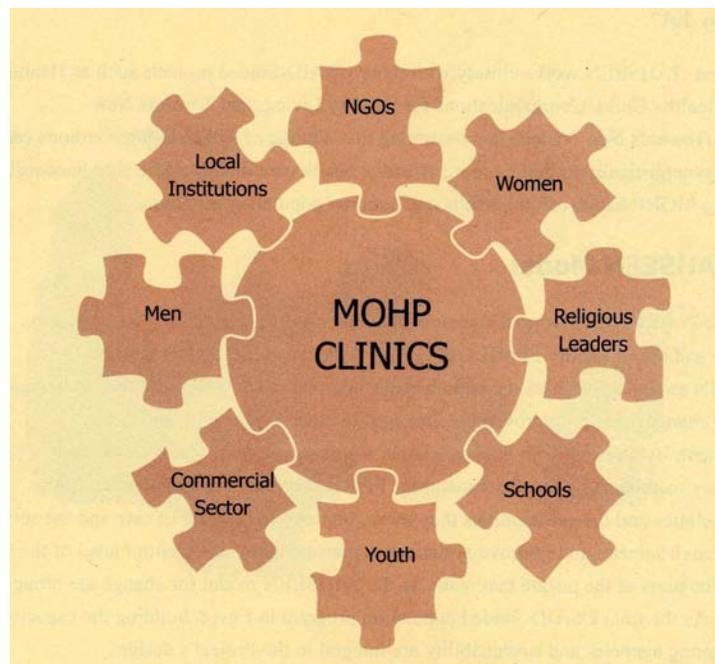
² One team member's flight delays resulted in her arrival 1 day late.

- to maintain the integrity of the findings, which are largely based on independent data collection by the assessment team.

THEME 1: FOCUSED ATTENTION ON PRIORITY GROUPS

The background documents indicated that CATALYST is to focus its attention on reaching underserved populations, including those with the lowest rates of contraceptive prevalence (rural Upper Egypt), postpartum women, postabortion women, women medically qualified for tubal ligation, low-parity women, and youth. The Upper Egypt governorate of Minia is the model for CATALYST’s reaching out to, mobilizing for, and serving the underserved. CATALYST describes the TAHSEEN model as “a comprehensive and inclusive approach to family planning and reproductive health that involves quality improvement, linkages to other sectors, community involvement, and capacity building, organized around four interlocking themes and three cross cutting strategies.” Figure D–1, from *Building Momentum for Change: The TAHSEEN Integration Experience in Minia, February 2003–February 2004*, presents CATALYST’s model.

**Figure D–1
CATALYST Model for Reaching Underserved Populations**



To date, CATALYST has worked with the supportive governor of Minia and governorate staff in five selected villages in Minia for the initiation of the model. Using clinic renovations (and the training of service providers within) of the MOHP’s rural health units³ as a community mobilizing core, CATALYST has worked with religious leaders, local institutions, the commercial sector, local NGOs, male groups (such as agricultural

³ In rural Upper Egypt, 63.5 percent of women using IUDs, 81.4 percent of women using injectable contraceptives, and 20 percent of women using oral contraceptives receive them from a public sector source. Twenty-seven percent of women who received any antenatal care received it from the public sector.

extensionists), schools, and youth (Minia University). The response from both local government and civil society has been enthusiastic and supportive.

The results of a peer education activity at Minia University were observed, which included such themes as premarital counseling, delaying age of first marriage, and the harmful effects of female genital cutting (FGC). The responses of both male and female students regarding the benefits of their newly acquired reproductive health knowledge are significant testimony to the effectiveness of CATALYST's approach to engaging youth; most participants perceived the training as life changing. Although this is a pilot effort, there are plans to replicate this model in other governorates. An active media group is also working in Minia, broadcasting regular radio programs that concern RH issues. The participation of religious leaders in project activities, such as meeting with the students at Minia University to dispel myths about the content of the laws of the Koran in terms of RH and in community activities, which on a regular basis disseminate health messages and use of family planning for spacing, bodes well for overcoming local, cultural misconceptions about FP/RH and gender issues.

As indicated in figure D-1, religious leaders are a key element in CATALYST's model. The team attended two meetings with Muslim and Christian leaders, and both were persuasive on the important role such leaders can have. Community meetings on women's health and empowerment, in which religious leaders were present on the podium, sent a powerful message to both women and men that women's health is important.

Plans were underway to expand the CATALYST model to an additional 20 villages in Minia. Minia leaders have worked with CATALYST staff to interest leaders in the governorates of Fayoum and Beni Suef, the next anticipated governorates for program introduction. CATALYST indicated that by March 2005, they would extend the model to an additional 80 villages in six governorates in Upper Egypt and to three urban slums of Cairo, and would establish two regional CATALYST field offices to support these activities.⁴

Whether the Minia model will lead to an increased use of FP/RH services by young or low-parity women, or to a greater use of FP/RH services in total, remains to be seen. Reviewing data for the first 9 months in light of outcome indicators for the project, CATALYST wrote, "Increases in total FP clients, youth clients, and low-parity clients have not yet been seen in the five rural health units where TAHSEEN has renovated facilities and trained providers."⁵ The data on three indicators are as follows for five MOHP/TAHSEEN-supported clinics in Minia that offer integrated services:

- Average number of clients seeking FP services (per day):
 - Quarter 3, 2003: 5.3 clients
 - Quarter 4, 2003: 5.1 clients
 - Quarter 1, 2004: 5.4 clients

⁴ Different versions of the introduction plan were perceived. The family planning director of the MOHP stated he had been informed that CATALYST would renovate 206 rural health units.

⁵ "Discussion, Outcome Indicator Results, January-March 2004," CATALYST (undated).

- Percentage of FP/RH clients less than 25 years of age to total clients:
 - Quarter 3, 2003: 14 percent
 - Quarter 4, 2003: 13 percent
 - Quarter 1, 2004: 11 percent

- Percentage of low-parity (1–2 children) clients to total clients receiving FP/RH services:
 - Quarter 3, 2003: 25 percent
 - Quarter 4, 2003: 27 percent
 - Quarter 1, 2004: 24 percent

In the discussion of these results, CATALYST wrote that the renovation of the clinics may have disrupted service delivery. It was also noted that “continued and intensified activities are planned at both the health unit and the community level in these five sites over the next year, with another year of phase out as well. These activities are expected to contribute to an increased demand and use of reproductive health services in the communities.”

The assessment team visited clinical staff on the gynecological ward of Minia Hospital to discuss PAC. This was the only opportunity in Egypt to verify the validity (accuracy) of information by obtaining input from a variety of sources. The obstetrician/gynecologist and two nurses had been involved in PAC activities in earlier years with the Healthy Mother/Healthy Child Project,⁶ and more recently with CATALYST. They recounted clinical protocols and training in manual vacuum aspiration in earlier years as well as recent successes in integrating family planning counseling and services on the ward level due to efforts led by CATALYST.

CATALYST, which has had a leading role in developing PAC programs globally (with notably successful programs in Peru and Bolivia), described its work in Egypt as being guided by its experience in Peru. CATALYST staff members from Peru have visited Egypt to share their experience and to train Egyptian staff. There was an acknowledged need in Egypt to push the PAC program beyond the clinical treatment of complications that John Snow, Inc. (JSI), the USAID contractor for the earlier maternal and child health project with the MOHP’s maternal and child health department, had introduced in the 1990s.

In the 1990s, JSI and the maternal and child health department made notable gains in including the management of bleeding in early pregnancy in emergency obstetric care.

⁶ In 1998, the MOHP, the Population Council, and the Healthy Mother/Healthy Child Project signed a memorandum of understanding for the integration of PAC into the emergency obstetric care package of services in Aswan and Luxor. As noted in the 2001 *Global Evaluation of USAID’s Postabortion Care Program*, by 2001 in Egypt, there had been PAC pilot studies in two MOHP hospitals, extensive operations research on PAC, the Healthy Mother/Healthy Child Project development of emergency obstetric care protocols (including treatment of postabortion complications), Healthy Mother/Healthy Child Project development of competency-based training modules for physicians and obstetricians, development of an MOHP package of essential services at various service delivery levels, and training in the treatment of complications using manual vacuum aspiration equipment in 12 hospitals in Upper and Lower Egypt. At that point, the challenge was to integrate the emergency obstetric care advances (which defined “management of bleeding in early pregnancy” at the levels of the household, community, primary health, district hospital, and general hospital) with family planning counseling and services.

Family planning counseling and services, under the responsibility of the Department of Family Planning in the MOHP, were missing. A great deal of work remained to be undertaken; CATALYST assumed responsibility for facilitating this within the Department of Family Planning in the last year. A CATALYST workshop report of March 2004 presents Egyptian discussion on the development of a comprehensive postabortion care package in Egypt.⁷

PAC is one example of the difficulties involved in integrating FP and MCH in Egypt and of the rivalry between the relevant parties. Discussions with both CATALYST and Healthy Mother/Healthy Child Project staffs on PAC indicate that collaboration between the two has not been good. CATALYST's USAID project manager believes and writes that CATALYST's efforts to be collaborative have been "exemplary." Strains exist between the two USAID-funded projects, but responsibility for the conflict is not being assigned here.

Comments

Development Model and the Role of a Cooperating Agency

Two collaborating USAID CAs and the MOHP at the central level commented that the development model that CATALYST is using in Minia includes the direct implementation of project activities. Two examples given were of CATALYST's being responsible for the redesign, renovation, and reequipping of the MOHP's rural health units (the architect works for CATALYST and funds are in CATALYST's budget), and the carrying out of community mobilization activities at the village level (rather than working through international private voluntary organizations or national NGOs that will have a long-term presence at the community level). CATALYST implements activities at the village level, in part through CATALYST central staff members who are implementation specialists (two of whom escorted the team during its few days in Minia).

Those commenting wondered whether the approach was sustainable and whether a more sustainable approach might be to strengthen either the ministry or CSI, the strongest NGO FP service provider, to carry out such activities. One person asked, "What will be the glue that holds activities together and maintains improved clinic facilities once CATALYST has phased out?" This question was discussed with CATALYST/Egypt, which stated that sustainability would be built in through a variety of mechanisms being developed on a pilot level in Minia, such as use of the service improvement fund at the

⁷ The Healthy Mother/Healthy Child Project's contributions to PAC in Egypt (supplied to CATALYST in April 2003) include the following, according to information supplied by the project:

- "An emergency obstetric care protocol that contains a chapter on abortion, with its different clinical types and how to diagnose and manage it.
- An emergency obstetric care flow chart that contains a chapter on abortion, which guides the obstetricians to rapid decisions at a glance concerning different clinical types of abortion.
- An emergency obstetric care module for bleeding in early pregnancy, which provides the facilitators with a sound grounding in competency-based training methodology, which, if implemented as designed, will result in physicians reaching a level of mastery in the skills and competencies required to diagnose and manage cases of abortion.
- A separate protocol and module which introduces MVA as a highly effective instrument to manage cases of abortion."

clinic level, community committees, and the support of civil societies. The CATALYST quarterly report of January–March 2004 indicates that “a full detailed expansion plan is expected to be finalized next quarter.”

Use of FP Services

There are seasonal fluctuations in the use of FP services. In Egypt, use often declines during Ramadan, which fell in 2003 during the fourth quarter. CATALYST will need data from at least five quarters to assess FP service statistics trends. Note below, however, that exit interviews with female patients in three clinics indicate that the number of female clients seeking curative services increased by 24.5 percent since renovations began.

THEME 2: IMPROVED QUALITY FOR THE CUSTOMER

A key activity under this theme is to refresh the Gold Star Program under the MOHP; one CATALYST indicator is the “number of MOHP clinics operating according to the new Gold Star standards.” For many years, the Gold Star, developed and funded by USAID technical assistance, had symbolized quality family planning services at MOHP service delivery points. Although data were not available on what percentage of MOHP facilities achieved and maintained Gold Star status at the height of the program’s success, a 1996 USAID evaluation indicated that the goal was to bring approximately “2,500–3,000 of the total 3,706 sites” up to standards within the following several years.⁸ Currently, there are approximately 5,600 MOHP units. Data from the Egypt service provision assessment of 2002 indicate that national levels of quality are not Gold Star status:

- 37 percent of sampled MOHP units had all the items needed to support quality FP counseling;
- 20 percent had all items (soap, water, latex gloves, disinfecting solution, sharps box) for infection control (51 percent had soap and 50 percent had latex gloves);
- 78 percent had equipment and knowledge for sterilizing/high-level disinfection processing; and
- 71 percent had conditions for quality pelvic examinations.

MOHP facilities with badly deteriorated quality continue to show the Gold Star emblem, which no longer symbolizes quality to providers or patients/clients.

CATALYST works at central, regional, and local levels to improve quality. As indicated, the assessment schedule did not include interviews with the MOHP at the central level on quality. The director of family planning did state that it was one of the three critical challenges facing the MOHP.⁹ The CATALYST work plan lists a number of activities to be undertaken in the future, including the development of a new Gold Star approach. In

⁸ Stephens, Betsy et al., *Midterm Evaluation of the Egypt Population/Family Planning III Project*, POPTECH Project Report No. 95–055–035, March 1996.

⁹ The other two were the incentives system and contraceptive security.

the draft CATALYST monitoring and evaluation plan, CATALYST indicates that “the new Gold Star approach will be injected in the MOHP system and cover all MOHP facilities through the MOHP trained staff.” It projects that the “number of MOHP clinics operating according to the new Gold Star standards” will be 50 by the year 2005.

CATALYST reports indicate that it is working to begin laying the foundation for a continuous medical education program and is revising and updating training courses for physicians and nurses to match the new integrated standards of practice in collaboration with both the MOHP and the Regional Center for Training. CATALYST is designing and implementing training courses for small numbers of personnel (principally, MOHP in Minia to date) on a variety of subjects: the integrated counseling training package, integrated supervision, clinic management training, financial management, and advanced supervision and leadership.

The team’s data on achievements in quality to date come from the program in Minia. At the five Minia rural health units recently renovated and refurbished by CATALYST, CATALYST staff indicated that quality standards apply to all aspects of the unit, from the examination room, to the laboratory, to the mini pharmacy, to the physical outside environment, and to housing for the physician. The clinic visited looked wonderful; clinic staff and the community were delighted. A recent postintervention survey of 135 clients in three of the five units compared customer satisfaction with data obtained in a preintervention survey of 250 client (women) exit interviews at the five clinics.¹⁰ Customer satisfaction with the service providers, laboratory, and pharmacy increased dramatically. The number of clients seeking curative services increased by 24.5 percent. As indicated above, however, service statistics to date show no increased use for FP/RH services.

CATALYST is also working on integration, as have past FP/RH projects in Egypt, to a limited extent.¹¹ The focus for CATALYST is Upper Egypt, with the expected output being “one-stop FP/RH/MCH services available to customers throughout Upper Egypt in public sector and NGO outlets” with a resulting increase in FP acceptors in such facilities.¹² CATALYST has developed curricula on integrated counseling and integrated supervision and is beginning to use them in targeted clinics in Minia. A key mechanism and achievement of CATALYST in Minia to promote integration is keeping a portion of revenues generated at the rural health unit for the use of the unit (the Service Delivery Fund). Staff hopes that these funds can be used for both the benefit of the unit as well as all staff.¹³ Integrated supervision still means supervision by both the FP and the MCH departments of the MOHP.

¹⁰ “Preliminary Findings of Post-intervention Surveys in Three Rural Health Units,” May 3, 2004.

¹¹ See Mona Kalifa and Abdel Ghani, “Developing MCH/FP Service Delivery Referral Linkages,” National Population Council, 1996, for efforts made a number of years ago to initiate integration.

¹² CATALYST scope of work for 2002–2009

¹³ The team met with six clinical staff members from the five renovated clinics to obtain their perspective on CATALYST’s work. Staff members were asked what their hopes for the clinic and community were over the next three years. They responded that they hoped that 8their essential supplies (soap, gloves, disinfectant) would be sufficient; for continuous training for staff; for clinics to stay clean; that there would be a waste disposal system in each clinic; for an administrative manager in each clinic; for more clinical equipment and more equipment in the adjoining personal apartment for the physician; for better supply storage space; and for a reduction of bureaucracy and paperwork.

Comments

Quality on a National Level

All the informants from collaborating USAID CAs and the MOHP family planning department expressed concern about the quality of family planning services on a national level. Previous efforts at improving quality as a top-down effort were reportedly effective at the time but were not sustainable. Will the coming development of a new Gold Star approach, new standards at the central level, and bottom-up efforts (with several hundred rural health units in Upper Egypt) be effective in raising quality in a significant way among the MOHP units nationwide? Will quality be sustained in those several hundred units after CATALYST phases out? In response to such questions, CATALYST and USAID/Egypt state that CATALYST is not designed to affect national quality, only Upper Egypt, but that they expect success in Upper Egypt to spread to other areas.

Integration

As discussed with many informants, FP/MCH integration on a national level is well into the future. A principal impediment is the different system of incentives for FP and MCH personnel at all levels of the MOHP. CATALYST has been working on reform of the system and will be presenting a proposal for it in the near future. Unfortunately, collaboration on integration with the USAID-funded Healthy Mother/Healthy Child Project managed by JSI (which has worked with maternal and child health personnel for over 15 years) has not been close. For the integration effort to be successful, the two activities funded by USAID must collaborate and speak with one voice.

THEME 3: STRONGER INSTITUTIONAL CAPACITY AND SYSTEMS

CATALYST is providing assistance in several areas to strengthen the MOHP's FP/RH management, including the development of a strategic plan and a system for providing incentives. One important contribution, which CATALYST provided to the team, was an analysis and a report (August 2003), *Estimating Ministry of Health and Population Contraceptive Commodity Costs Until 2017*. The report makes no recommendations and notes, "The team was not asked to make recommendations: the implications of the findings and conclusions of the study fall within the MOHP's policy remit, so the Ministry will decide how to proceed on the basis of the facts objectively presented in this report." The principal conclusion was that the MOHP faces a very large decrease (between 30–35 percent annually) in its contraceptive procurement budget and "there are no easy options for reducing this budget impact." The option of expanding domestic production was not seen to reduce costs. Shifting more of the load of contraceptive provision to the commercial sector would make a significant difference if the MOHP chose to pursue that route. The report notes, "The ministry will need to take care that the current stress in the commercial sector resulting from the depreciation of the (Egyptian) pound does not lead to a sudden collapse of commercial interest in the contraceptives market." The principal responsibility for dealing with the policy implications of this report lie with the POLICY II Project.

THEME 4: ACHIEVING SUSTAINABLE SECTORAL SHARES

CATALYST is working to expand both the NGO and commercial sectors' roles in FP/RH. The premise for doing this is indicated in the CATALYST scope of work: "The public sector's share is currently rising but it is highly unlikely that it alone can provide the bulk of such services over the long term, especially in the absence of substantial donor support." The Egypt Interim Demographic and Health Survey 2003 (EIDHS 2003) indicates that the percentage of current users who obtained their method from a public sector source rose from 36 percent in 1995 to 49 percent in 2000 and to 56 percent in 2003. The NGO sector's share declined from 9.7 percent (1995) to 5.1 percent (2000) to 3 percent (2003). The share of the pharmacies fell from 23 percent (1995) to 16.3 percent (2000) to 15.6 percent (2003). During this time, contraceptive prevalence (modern methods) rose from 45.5 to 56.6 percent.

In rural Upper Egypt (where CATALYST is focusing its efforts and where its model is centered around renovating and improving MOHP rural health units), the percentage of users of public sector facilities rose from 35 percent (1995) to 56 percent (2000) to 64 percent (2003). Contraceptive prevalence almost doubled during that period, increasing from 24 percent (1995) to 40.2 percent (2000) to 44.7 percent (2003).

In Minia, in accordance with the perceived MOHP judgment of the proper role for most NGOs in FP/RH, CATALYST is working with NGOs to improve their information, education, and communication (IEC) capacity and referrals to MOHP facilities. Additionally, the CATALYST 2004 work plan indicates that CATALYST is working to strengthen the MOHP NGO unit and ensure continuous collaboration among the different MOHP units working with NGOs.

The CATALYST 2004 work plan indicates that it will work to strengthen two NGO sector institutions that are providing clinical services: the Egyptian Family Planning Association (EFPA) and CSI. One task in the work plan is "to support CSI through to self-reliance." The team visited CSI headquarters and received an annual report for January–December 2003. Despite a declining national market share since 1995, use of CSI's clinic capacity (93 clinics, some with multiple examination rooms) has steadily increased, to an average of 19 FP/RH clients per day per examination room. CSI reports that clinic revenues cover 52 percent of total operating costs. CATALYST contracted an outside firm to assess the best way to support CSI self-reliance. The undated final report, *CSI Legal Status Assessment Final Report*, recommends the creation of an independent association as the permanent structure and status for CSI and that USAID should provide it full political and programmatic support.

The last principal result to be achieved is the expansion of the commercial sector's role in FP/RH. In coordination with the Communication for Healthy Living Project, managed by the Johns Hopkins University, CATALYST is working to expand the Ask–Consult Network in geographic areas in Upper Egypt targeted by CATALYST. CATALYST faces real political challenges to its success in this area. As noted above, the pharmacy's market share has declined steadily over the last 10 years. In the last few years, the commercial sector has been badly hurt by the devaluation of the Egyptian pound; reportedly, stocks are down and there is little or no pharmaceutical interest in contraceptive commodities.

The POLICY II Project, which is responsible for forwarding the CATALYST report, *Estimating Ministry of Health and Population Contraceptive Commodity Costs Until 2017*, to the Minister of the MOHP, indicated that now is not the politically appropriate time for such discussions.

Comments

Achieving sustainable sectoral shares is one of four themes; however, strategies to achieve it do not appear to be integrated with the strategies of the other themes. Renovating and equipping MOHP rural health units is the central mobilizing component of “focused attention on priority groups,” although

- CSI has traditionally been strong in Upper Egypt and has nine centers (two temporarily closed) in Minia alone and another 30 in other governorates of Upper Egypt, and
- CATALYST is simultaneously trying to promote the pharmacies as sources of supply in the same region.

Achieving sustainable sectoral shares is a political objective for which the MOHP at the highest levels is responsible. CATALYST should not be held responsible for expanding the share of the NGO or commercial sectors, since so many decisions that affect sectoral shares are not in their control.

CONCLUSIONS

CATALYST has worked hard in the last year across many fronts in a very difficult political environment. The team observed project activities and interviewed counterparts at the local level. It was obvious that CATALYST generated an enthusiasm and hope at the local level and among civil society that local level change might happen. It is unfortunate that there has been only a year of activities to assess at present, three and a half years into the CATALYST project.

CATALYST is approaching FP/RH with strategies different from previous USAID FP/RH projects. One critical difference is the addition of development from the bottom up through community mobilization, including CATALYST staff having a more direct role. A second is a focus on Upper Egypt. It is too early to tell whether these strategies will be effective in increasing the use of FP/RH services among priority groups.

At the time of this assessment, CATALYST/Egypt was planning for a major program expansion in Upper Egypt during the last year and a half of the project. However, assuming that USAID does not extend the CATALYST agreement, CATALYST/Egypt will have to carefully plan how to manage a timely and responsible phaseout by September 2005. In written responses to a draft of this report, both CATALYST and USAID/Egypt wrote that they planned such a phaseout.

PERU COUNTRY REPORT

PROGRAM DATA

Country Program Objective: Contribute to USAID/Peru's objective of "expanding sustainable opportunities for improved quality of life of Peruvians through democratic institutions and processes."

Major Program Components

1. Accreditation and certification
2. Improvement of health conditions in seven regions
3. Other FP/RH initiatives, mostly with local NGOs

Cost: \$12.1 million in field support plus \$22,000 in core funds. Field support expenditures as of April 2004 amounted to \$6.6 million.

Key Partners

- Peruvian Ministry of Health, central, regional, and district levels
- Peruvian medical associations of physicians and nurses
- Commission for the Accreditation of Faculties and Schools of Medicine (CAFME)
- Medical associations of schools of medicine, nurses, and midwives (ASPEFAM, ASPEFEEN and ASPEFOBST)
- Peruvian NGOs (Apoyo a Programas de Población [APROPO], Instituto Peruano de Paternidad Responsable [INPPARES], PRISMA, Asociación para el Desarrollo Amazónico Rural [ADAR], Asociación de Promoción Agraria y Defensa de la Vida [AGROVIDA], and Movimiento Manuela Ramos [MMR])
- Schering and Pfizer pharmaceuticals

BACKGROUND

During the last decade, investments in health programs in Peru by USAID and other donors have led to improvements in many health indicators. For example, according to the 2000 DHS, infant mortality dropped from 57 to 33 deaths per 1,000 live births between 1991 and 2000, and maternal mortality decreased from 280 to 185 deaths per 100,000 between 1991 and 2000 (one of the highest in Latin America). The use of modern methods of contraception has increased, but there are significant differences between the health status of urban and rural populations.

Table D–2
Urban and Rural Health Indicators, Peru

Indicator	Urban	Rural	National Average
Contraceptive prevalence, all methods	73.0	61.5	68.9
Contraceptive prevalence, traditional methods	16.3	19.8	17.5
Unmet need for family planning	7.6	14.9	10.2
Deliveries in a health facility	82.4	23.8	57.9

Use of contraception has also increased. Currently, 69 percent of women in union are practicing family planning; 50 percent of them use modern methods. While 19 percent of women use traditional methods (14.4 percent use rhythm and 3.2 percent use withdrawal), only 62 percent of the women surveyed using rhythm or withdrawal knew their fertile period.

Selected data on the health status of women include the following:

- Pan American Health Organization (PAHO) data show that most maternal deaths are due to direct and avoidable causes, such as hemorrhage (44.8 percent), complications from puerperium (10.9 percent), and complications from abortion (12.3 percent).
- CATALYST estimates that more than 410,000 induced abortions are performed annually (figures obtained from a Pathfinder International/Flora Tristan report in 2004, funded by the Ford Foundation, not USAID), and of these, 30 percent usually result in complications (with only 50 percent of those women ever reaching a hospital).
- DHS 2000 data show that 22 percent of females under the age of 19 are already mothers—51 percent of those pregnancies are unplanned—and that only 21 percent of them know where to access health services.

There has been progress in recent years in the expansion of health services to the general population (the DHS estimate of total population in 2000 is 25.7 million). This has occurred despite years of economic recession and political controversies, the ending of President Fujimori’s third term (which ushered in a new presidency in 2001), and successive changes of health ministers. Currently, the public health sector—comprised of the Ministry of Health (MOH), the social security system, and the armed forces and police—controls 51 percent of the hospitals, 69 percent of the health centers, and 99 percent of the health posts (which are mostly located in remote and rural areas of Peru). However, from the point of view of most health donors, the quality of health care is deficient, and services remain inequitably distributed within geographic regions and socioeconomic levels. Poverty and the lack of health services are heavily concentrated in rural areas; more than half of rural Peruvians are considered extremely poor.

In 2002, USAID developed a five-year strategy, “Improved Health for Peruvians at High Risk,” that aims to ensure that

- quality health services are accessible and used,

- Peruvians practice healthy behaviors, and
- health sector reform is more responsive to the health needs of the population.

The three-pronged approach of the strategy, “improving the quality and efficiency of health services, promoting healthy behaviors and avoidance of health risks by individuals and communities, and supporting broad policy reforms” is the essence of what the Mission envisioned to improve the health of high-risk Peruvians by 2006. The Mission supports activities designed to have nationwide impact, and other activities designed to promote the quality of life in a geographically concentrated area (seven coca-growing regions).

This program is being implemented through centrally funded mechanisms that replaced an earlier bilateral health program. Four centrally funded mechanisms implement USAID’s health program, which in FY 2003 amounted to \$21.9 million: *PHRplus*, the *POLICY* Project, the *CHANGE* Project, and *CATALYST*.

To date, *CATALYST/Peru* has received \$12.1 million in Mission funds (field support). Both the Mission and *CATALYST* indicated that a principal reason for early interest in the *CATALYST* mechanism by the Mission was the belief that within *CATALYST*, a broad range of health activities beyond FP/RH was possible. Consequently, *CATALYST/Peru* encompasses a diversified portfolio of health and health-related activities, of which FP/RH is acknowledged to be only a small part. According to USAID/Peru, “In a time of turmoil and instability in the Peruvian health sector, the really important story in an assessment of *CATALYST*’s performance in Peru has been its flexibility in being able to adjust to constantly shifting priorities and counterparts, its agility in being able to move quickly in response to unforeseen requirements and needs, and its very low management burden for USAID/Peru.”¹⁴

The *CATALYST/Peru* key partners are the MOH (at the central level and at the regional and district levels in the seven regions), the private sector health associations, and numerous, local NGOs. *CATALYST/Peru* also implements several small, centrally funded initiatives. USAID/Peru and *CATALYST* stated that in Peru, the Mission holds *CATALYST* responsible for two indicators:

- percentage of institutional births, and
- percentage of women who know their fertile period.

The Peru 2000 DHS indicates that 62 percent of women using rhythm or periodic abstinence know when their fertile period is. The DHS breaks the data out in terms of users of these methods, but not by region.

¹⁴ Written communication from Richard Martin, USAID/Peru, to Kellie Stewart, October 4, 2004, in response to a review of this country report.

PROGRAM DESCRIPTION

Accreditation and Certification: Expenditures Through February 2004, \$810,000 (13 percent of total)

Under this component, CATALYST is working to improve the quality of public sector services by supporting the accreditation of health facilities, to strengthen the accreditation processes of medical, nursing, and obstetrics (midwives) faculties and schools, and to strengthen the recertification processes of health professionals. CATALYST's partners are those institutions that

- provide health services (the MOH and its regional and district-level facilities),
- train health professionals (ASPEFAM, ASPEFEEN, and ASPEFOBST),
- recertify health professionals (medical associations of physicians and nurses), and
- institutionalize health norms (CAFME).

Comments

The above activities, which are designed to have a long-term impact on improving the quality of health care in Peru, are reported to be doing very well.¹⁵ The USAID Mission is particularly pleased with the results to date and commented on the effectiveness of working with professional associations and academic institutions as a strategy to produce rapid change in quality standards. To build consensus among the key staff of professional associations on the quality standards for accreditation and certification, CATALYST arranged for observation visits to countries that have normative systems in operation and to the United States (these included visits to the American Medical Association and the U.S. Board of Examiners). Recent results include the Peruvian Medical Association's plans to use a new approach to recertify professionals on performance rather than knowledge, and the Association of Faculties and Schools of Medicine's success in 2003 in implementing a countrywide medical examination held on the same date.

CATALYST's work with the MOH also has been successful in supporting the development of national guidelines for reproductive health; procuring vaccines, coolers, and other equipment under child survival funds; and improving the accreditation processes of MOH facilities nationwide. CATALYST has already integrated PAC services into emergency obstetric care and safe motherhood programs in public sector facilities at the national level and has trained over 1,000 health professionals (physicians, nurses, and midwives) in about 50 major hospitals and 800 health facilities throughout the coastal, highlands, and jungle areas of Peru.

¹⁵ Team members did not have expertise in the assessment of medical accreditation and certification, and did not assess the program. Moreover, only several hours were available for assessment.

Improvement of Health Conditions in Seven Regions: Expenditures Through February 2004, \$3. 8 million (64 percent)

The seven poor, rural, coca-growing regions of Peru are Huanuco, Ucayali, San Martin, Cuzco, Ayacucho, Junin, and Pasco. CATALYST's objectives there are to improve the capacity and quality of obstetric emergency services and other health problems in public sector health facilities, including those primary health facilities operated by local health administrative committees, and to promote healthy behaviors and environments.

To achieve these objectives, CATALYST has worked with the seven district technical offices to

- assess the capacity of health institutions and identify health needs;
- develop culturally appropriate training models;
- provide medical equipment, as needed; and
- organize community efforts for citizens' participation in health promotion activities and surveillance of health facilities.

The region of Huanuco was the first site of implementation and was used as a model for replication in Ayacucho, Junin, and Ucayali—regions in which CATALYST is currently engaged in various levels of implementation.

Comments

USAID/Peru expressed satisfaction with the progress of these activities. CATALYST/Peru is perceived to be implementing an integrated development approach that links FP/RH services to other nonhealth interventions, such as those in the areas of education, democracy, and environment. The best example of CATALYST work in the promotion of healthy municipalities is found in the Huanuco region. In 2003, Huanuco district-level health authorities and local leaders developed and published a regional health plan. This included a strategy to achieve strategic health objectives by 2006 as well as a plan to monitor and evaluate results. Currently, 75 percent of the districts (of 76) have identified and begun to implement culturally appropriate health interventions by working with schools, markets, and families. The initiative also seeks to facilitate community planning of high-quality FP services, which can prevent unintended pregnancies that lead to unsafe abortion, as well as to promote referrals to health facilities for treatment of abortion complications (i.e., the integration of FP and PAC at the community level). The long-term outcomes anticipated are that healthy behaviors progressively become the social norm (such as institutional childbirth, promoting hand washing, preparing nutritionally balanced food, and changing environmental conditions that facilitate the spread of mosquito-borne diseases and other illnesses). This ongoing and future work in five of the seven regions will reach a population of over 3 million, where 32 percent of the population suffers from chronic malnutrition and 25 percent of women receive no prenatal care.

Examples of activities in the regions include CATALYST moving into the seven departments to increase the capacity of health facilities in the provision of emergency obstetric and PAC services. As part of these efforts, CATALYST, building on an earlier Pathfinder project, expanded the use of a software program, Obstetric and Neonatal Functions (FON), which allows health facilities to assess the quality of its services in the obstetrics area through the analysis of data on complications and mortality. This tool also allows health facilities to determine their training needs. The number of facilities with CATALYST-trained staff using FON has increased from 26 to 843.

CATALYST is working to reduce maternal mortality by promoting childbirth in health facilities with trained staff. As indicated in table D-3, more than half of all women delivered at home in all but one of the six targeted departments. In Huanuco, among the regions with the highest maternal mortality in Peru, midwives and health promoters were trained to promote institutional delivery. Jointly with USAID and the United Nations Children’s Fund (UNICEF), the project is supporting an MOH district-level initiative to transfer pregnant women 2 weeks before delivery from areas with no health facilities to *casas de espera* (community homes), supported mainly by civil society, to ensure institutional childbirth. Currently, there are 18 *casas de espera* in Huanuco, and CATALYST plans to replicate this initiative in other regions. Also, out of 198 facilities in Huanuco that provide obstetric care, 142 (72 percent) have installed FON with technical assistance from CATALYST.

Table D-3
Contraception and Deliveries in Six Targeted Departments
(Peru DHS 2000)

Department	Percentage of Deliveries in a Health Facility in the Last Five Years	Contraceptive Prevalence, Modern Methods	Contraceptive Prevalence, Rhythm and Withdrawal
Ayacucho	47.2	33.1	21.8
Cusco	39.4	43.8	19.1
Huanuco	28.3	46.0	13.3
Pasco	50.7	50.4	18.6
San Martin	45.8	57.5	12.1
Ucayali	46.3	58.9	7.8
National Average	57.9	50.4	17.5

Other Family Planning and Reproductive Health Initiatives, Mostly With Local Nongovernmental Organizations

CATALYST, in partnership with a local NGO (APROPO) and Schering, is implementing for a second year a social marketing project to prevent sexually transmitted diseases (STDs), HIV/AIDS, and unwanted pregnancies in 10 cities in Peru. The program aims to strengthen the private distribution of contraceptive methods, improve access to contraceptives and STD treatment products, and promote healthy practices in the prevention of STD and unwanted pregnancies. This activity, with a total budget of \$490,000, is very promising.

In collaboration with INPPARES and Schering, CATALYST supports a network of midwives in the city of Lima as providers of FP/RH services, called RedPlan Salud. This

network began in 5 districts in Lima and is currently serving 21, with about 200 midwives officially registered and an additional 251 participating unofficially. The network serves as an alternative to public sector FP/RH services. Midwives provide FP/RH counseling services and sell contraceptives at a low cost.

Also working with INPPARES, CATALYST provides support to two kiosks in peri-urban areas of Lima that provide outreach to adolescent educational services. Although this is a small activity, it has the potential for future expansion if additional funding is identified. Subgrants to local NGOs include one to PRISMA to provide training in healthy behaviors and small microenterprises, and to APROPO to provide loans to small pharmaceutical companies to provide them access to contraceptives at advantageous prices.

CATALYST has had an Optimal Birth Spacing Initiative (OBSI) pilot program in Peru through technical assistance and a subgrant to ADAR, a small NGO in the Amazon department of Loreto. Contraceptive prevalence in Loreto is 63.1 percent; modern method contraceptive prevalence is 48.3 percent. CATALYST, working with ADAR, has developed an OBSI bulletin, mobilized an OBSI regional forum for health professionals, held workshops for health professionals, developed IEC materials, and undertaken an OBSI-related baseline study. ADAR, promoting optimal birthspacing in 50 small communities in the region, has provided family planning services to 3,550 women.

A gender-based violence program that seeks to develop a model and strategies to enable individuals and communities to promote and defend women's rights is being initiated in a rural site and in a marginal urban area of Lima. The program will work through local NGOs that specialize in working with youth. A team member attended the first baseline data-gathering meeting in Lima, which had about 15 women from the local area in attendance.

CATALYST Data on Peruvian FP Clients, Commodities, and Couple Years of Protection (CYPs)

- RedPlan: 29,401 consultations, of which 8,646 were for family planning, with a contraceptive distribution equivalent to approximately 3,000 CYPs
- OBSI pilot project (with ADAR): 1,137 family planning clients, who were 34 percent of the clients counseled (CYP data not provided)
- Social marketing (with APROPO): 195,000 condoms distributed (CYP: 1,625)
- Expanding method mix in emergency centers (with Flora Tristan): 2,264 clients
- Yes! youth project in Lima (with INPPARES): total youth accepting FP: 2,253, averaging 11.5 percent of youth counseled (total CYP: 11)
- Three youth activities: 17,713 visitors (unknown number or percentage of youth accepting FP or contraceptives distributed)

Conclusions

- The CATALYST program in Peru responded to the USAID/Washington former Office of Population, Health, and Nutrition core funds' mandate to advance the global health agenda by generating lessons learned and best practices knowledge, which have broad application across multiple country programs.

- CATALYST has been responsive to USAID/Peru in the implementation of a complex program that works in the public and private health sectors to ensure that quality health services are accessible and used as well as to promote the practice of healthy behaviors. CATALYST/Peru has brought to the project excellent technical FP/RH capabilities (found in its highly qualified and motivated, largely Peruvian professional staff), superb management, and a good portfolio of health activities with numerous innovations. Given time, these will achieve the desired objectives of the Mission's health strategy.

ZIMBABWE COUNTRY REPORT

PROGRAM DATA

Country Program Objective: Integration of FP and HIV/AIDS services

Program Components

1. Strengthening the Zimbabwe National Family Planning Council expanded CBD program
2. Integration of FP and HIV/AIDS services in selected mission hospitals
3. RH information for orphans and vulnerable children
4. Family life education (with consortium partner Forum for African Women Educationalists/Zimbabwe [FAWEZI])

Cost: \$1,361,668 (core: \$263,000; field support: \$1,098,668)

Key Partners

- Zimbabwe National Family Planning Council (ZNFPC)
- Centers for Disease Control and Prevention Caring for HIV and AIDS, Prevention and Positive Living (CHAPPL) initiative
 - Howard Mission Hospital
 - Tshelanyemba Mission Hospital
 - St. Theresa Mission Hospital
 - Gutu Mission Hospital
- Catholic Relief Services (CRS), Support to Replicable, Innovative, Village/Community-level Efforts (STRIVE) Program
 - Save the Children/United Kingdom
 - Batsiranai (Help One Another)
 - Diocese of Mutare Community Care Program (DOMCCP)
 - Rural Unity for Development Organization (RUDO)
- Zimbabwe Ministry of Health and Child Welfare (MOH&CW)
- Population Services International (PSI)
- FAWEZI

BACKGROUND

The ZNFPC is a parastatal organization that works under the supervision of the Ministry of Health and Child Welfare. For more than 20 years, the ZNFPC has been responsible for the implementation of a nationwide community-based distribution (CBD) program to deliver nonclinical FP services to rural areas of the country (the MOH&CW is responsible for the provision of clinical services). Since its inception, the ZNFPC CBD program has made significant contributions to overall contraceptive prevalence in Zimbabwe. At its peak in the late 1980s, the program was serving approximately 25 percent of users of modern family planning methods (1988 Zimbabwe Demographic and Health Survey [ZDHS]). The program's market share subsequently declined to 18 percent in 1994 and to only 6 percent in 1999.

In 1999, the ZNFPC conducted an assessment of its CBD program with financial support from USAID/Zimbabwe and technical support from the Population Council and Family Health International (FHI). The assessment (which had been prompted at least in part by the Mission's strong interest in strengthening the HIV-related skills of the CBD agents) identified several shortcomings of the program: CBD agents were responsible for overly large geographic areas; the roles of CBD agents were too restrictive (i.e., limited to family planning); the program lacked an effective referral strategy for other reproductive health and HIV/AIDS services; and the program's management information system (MIS) was not being used effectively as a management tool. The ZNFPC requested assistance from USAID/Zimbabwe to help strengthen the CBD program based on the recommendations in the assessment. The Mission was prepared to respond positively, albeit modestly, to the ZNFPC request, but had not yet identified an assistance mechanism.

Advance Africa participated in the subsequent assistance program largely by chance. A recently arrived staff member of the USAID Mission's Health, Population, and Nutrition (HPN) office was aware of the new Advance Africa project via her contact in Washington with the project's first cognizant technical officer (CTO). The Mission's HPN officer, moreover, was personally acquainted with Advance Africa's deputy director—whose visit to Zimbabwe in early 2001 convinced the Mission that Advance Africa could serve as an appropriate way to respond to the ZNFPC proposal.

Advance Africa and the ZNFPC developed an assistance plan that called for the implementation of a two-phase expanded CBD program. The first phase would focus on the development of a pilot effort in one district in each of eight provinces. The second phase would introduce the project in a second district in each of those provinces. (The country is comprised of 57 districts in 11 provinces, plus the separate administrative districts of Harare and Bulawayo). According to senior officials at ZNFPC, their understanding was that USAID/Zimbabwe would be prepared to assist in a nationwide expansion of the program in 2005 if these two phases demonstrated the value and viability of the new model.

Advance Africa initiated its assistance effort in 2001, with most activities that year focused on technical assistance, including the development of training plans and materials and revising the MIS. Although the project was troubled by some start-up problems, over the past two years it has successfully demonstrated the potential value of the expanded CBD model (described below). Over this same period, however, the country's deteriorating economic situation has significantly undermined ZNFPC's capacity to serve as a responsive and responsible counterpart to the project. Indeed, by 2003, several factors led the Mission to conclude that it would not support an extension of the expanded CDC project when the initiative ended in 2005, including

- obvious erosion of ZNFPC's viability as a partner (such as staff shortages, lack of budget for operational costs, and a slow or inadequate demonstration of financial accountability);
- deficits in the Mission's population funding (these funds have lower priority than HIV/AIDS funding); and

- the imposition of Brooke Amendment restrictions on the Mission’s ability to work with the government of Zimbabwe, including ZNFPC.

Faced with the option of terminating what was emerging as a valuable model, the Mission chose instead to maximize the demonstration project’s dimming prospects by linking it to other activities in the project’s 16 target districts. Specifically, USAID invited the Advance Africa team to explore ways of introducing family planning into other ongoing HIV/AIDS efforts in the country. Advance Africa proposed one such link with a mission hospital program supported by the CDC (the CHAPPL project). The Mission helped negotiate a second initiative with a USAID–supported program (CRS STRIVE) that was focused on the needs of orphans and vulnerable children. Both activities are described below.

At the time of this assessment, Advance Africa and the ZNFPC were beginning phase two of the expanded CBD program, the extension of the model into eight additional districts. Work had not yet begun on the new partnerships with mission hospitals and organizations working with orphans and vulnerable children; design efforts were just beginning on the development (with Advance Africa consortium partner FAWE) of a life skills education program with the Zimbabwe chapter of FAWE. These activities are described below.

The Advance Africa/Zimbabwe program is managed by FHI. The Advance Africa country director noted that the Zimbabwe project seeks technical support from the FHI regional office in Nairobi and has had very few substantive dealings with Advance Africa headquarters in Arlington, VA, other than financial and management support.

PROGRAM DESCRIPTION

Strengthening the ZNFPC Expanded CBD Program

(Funding: \$284,272 in field support)

The expanded CBD program being supported by Advance Africa closely follows the directions set forth in the 1999 assessment. Its essential purpose is to redirect the activities of CBD agents to include an expanded focus on reproductive health beyond family planning, particularly on HIV/AIDS/STDs, home-based care, and voluntary counseling and testing (VCT). Key elements of the program include the

- training of CBD agents in their new responsibilities,
- introduction of a new category of volunteer worker (the depot holder), and
- development of a revised MIS, which would capture data concerning the expanded CBD agenda, including information regarding client referrals to VCT centers (primarily to 18 new start VCT centers operated by PSI).

The introduction of the volunteer depot holder into the CBD model is key—he/she frees the CBD agent from time-consuming travel to villages in a 20–km radius to resupply clients with contraceptives. This leaves significantly more time for CBD agents to counsel clients on a variety of RH issues and to spend more time reaching out to

underserved or vulnerable populations, such as youth, people living with HIV/AIDS, and males.

Advance Africa and the ZNFPC launched phase one of the project in April 2001. Major elements of Advance Africa support over the subsequent 14 months (to August 2002) included the development of training materials and protocols (with assistance from the Centre for African Family Studies [CAFS]); implementation of a baseline study and creation of a database for the eight districts; support for training project personnel (training of trainers, group leaders to supervise CBD agents, CBD agents, and depot holders); and the provision of operational support costs for some elements of the program, including monthly stipends for the depot holders.

Work on the revised MIS was not completed in time to be integrated into phase one training programs. Advance Africa subsequently developed an extensive array of data collection and reporting instruments and incorporated them into training for the phase two program. ZNFPC has not yet recruited data entry and data analysis personnel, who would help ensure that the information being collected would be used for management purposes after completion of Advance Africa assistance.

Observations of project operations in four districts (two in each phase) indicated a high level of satisfaction on the part of CBD agents and depot holders. Several CBD agents pointed out that they were using the additional skills and time afforded by the project to increase the range and depth of discussions with clients and to refer clients to VCT centers. Depot holders seem to draw considerable psychological satisfaction and enhanced self-esteem from their ability to serve their neighbors' contraceptive needs. Both categories of worker expressed disappointment, however, with the support they receive from ZNFPC headquarters. One of the major problems confronting the project has been the departure of some CBD agents (full time, salaried employees of the ZNFPC) and volunteer depot holders (paid a modest stipend equivalent to US \$4 monthly by Advance Africa).

This disappointment is symptomatic of a larger crisis within ZNFPC, where management capacity and budgetary resources have deteriorated markedly as a result of the country's economic situation. Factors such as an annual inflation rate of up to 600 percent, lack of resources to purchase fuel, the departure and nonreplacement of key personnel (including some especially talented managers recruited away from ZNFPC by Advance Africa), and an overall drop in Zimbabwe government budgetary resources have seriously disrupted ZNFPC's capacity to function as a viable partner in the project. As noted above, this reduced capacity, combined with a lack of population funds and Brooke Amendment restrictions, has led the USAID Mission to conclude that it will not be able to support further replication of the expanded CBD program model.

Comments

Although the expanded CBD program is in jeopardy of being abandoned, there are some reasons for optimism. Advance Africa/Zimbabwe maintains that the project has succeeded in heightening consciousness in the country regarding the need to integrate HIV/AIDS and family planning services. They add, moreover, that the project has trained

provincial training teams in the 16 participating provinces, and that these teams have the skills to continue training new cadres after the conclusion of Advance Africa assistance.

ZNFPC leaders also assert that they intend to seek alternative funding to extend the model nationwide. Specifically, it is developing a proposal to the Zimbabwe government's National AIDS Committee for funds to continue some training activities, it plans to ask the MOH&CW for funds needed to recruit additional CBD agents, and it plans to solicit support from other donors and the private sector. This latter initiative needs to be supported by the completion of a comprehensive evaluation of the project's experience, an evaluation which the ZNFPC could use to market the activity to other donors. It was recommended to Advance Africa and the USAID Mission that planning begin now to undertake that evaluation and to document the results of the pilot project, while it is still being implemented. A realistic assessment of the pilot project's prospects needs to anticipate the strong possibility that it will not be continued after the conclusion of Advance Africa support.

Integration of FP and HIV/AIDS Services in Selected Mission Hospitals

(Funding: \$498,263, including \$298,263 in field support and \$200,000 in core. Core funds were reprogrammed from their originally intended use, which was to establish VCT centers at ZNFPC clinics.)

Mission hospitals are a main source of health care in Zimbabwe, especially in rural areas, where they provide services to approximately half the population. The CHAPPL project works with 10 mission hospitals to introduce HIV testing and counseling services, prevention of mother-to-child transmission (PMTCT) interventions, biosafety measures for hospital staff, and with support from USAID/Zimbabwe and JSI's DELIVER project, the beginning of an antiretroviral treatment program for selected patients.

With the expanded CBD program faltering in 2003, the Mission urged Advance Africa to seek additional partnerships that might increase the project's usefulness in the country. Advance Africa/Zimbabwe subsequently made contact with the CHAPPL project and developed an initiative with them to support the integration of family planning and reproductive health services in 4 of the 10 hospitals participating in the CHAPPL project. Three of the four hospitals are in districts covered by the expanded CBD program and were selected deliberately to enhance community-level linkages between the two projects. Advance Africa's role will be to help incorporate family planning and reproductive health content into the VCT, PMTCT, and other HIV/AIDS-related services being developed under the CHAPPL project. In effect, this initiative reverses Advance Africa's role in the expanded CBD program, which is to integrate HIV/AIDS/STD services into an existing family planning program.

Because activities under the Advance Africa/CDC partnership have yet to begin, it is too early to assess their performance. Discussions with the medical directors of two of the hospitals (Howard Hospital in Mazowe District, Mashonaland Central Province, and Tshelanyemba Hospital in Kezi-Matobo District, Matebeland South Province) indicate that they are enthusiastic about the approach and looking forward to the added value of their collaboration with the Advance Africa project.

Comments

Neither hospital director was aware of the short duration of the assistance forthcoming from Advance Africa (about one year). One of the directors, moreover, had recruited additional nursing staff whose salaries will be covered by Advance Africa—setting up the possibility of staff disruptions once the partnership ends. Nonetheless, both directors indicated that the bulk of Advance Africa’s assistance was focused on staff training so that it would be more likely for the hospitals to continue to offer better integrated services after Advance Africa concluded its assistance program. It is suggested that the USAID Mission consider using the follow-up project to Advance Africa (should there be one) to continue this initiative with the mission hospitals.

RH Information for Orphans and Vulnerable Children

(Funding: \$289,509 in field support)

In 2001, CRS was awarded a grant by USAID/Zimbabwe to enhance the capacity of institutions that were assisting children affected by AIDS in Zimbabwe. Under its STRIVE program, CRS is helping 17 international and indigenous NGOs carry out interventions in psychosocial support, food security, education assistance, and economic strengthening.

As part of its 2003 effort to maximize the impact of the Advance Africa/Zimbabwe project, USAID/Zimbabwe negotiated an agreement between Advance Africa and CRS whereby Advance Africa would help develop and support the integration of reproductive health services into the programs of some of the 17 organizations participating in the STRIVE program. Following a review of proposals from seven of the organizations, Advance Africa selected four (see Key Partners above) to participate in the activity. All four organizations are implementing programs that support adolescents (12–18 years) rather than young children. Typical interventions supported by the CRS project include training in teenage parenting, peer counseling, home gardening, establishment of linkages with community health workers, and support for youth activities. Advance Africa’s role will be to build into these youth programs FP/RH information and, to the extent desired by the partners, family planning services.

Advance Africa has not yet signed memoranda of understanding with any of the four organizations, so it is too early to assess the performance of this activity. Representatives of the organizations contacted (Batsiranai and DOMCCP) nonetheless indicated a high degree of satisfaction with Advance Africa’s collaboration in developing the new initiative.

Comments

Similar to the concern raised with regard to the mission hospital activity, Advance Africa has not been sufficiently candid with its STRIVE partners regarding the short duration of its assistance program. Partners need this information to do responsible forward planning. The USAID Mission should consider continuing this initiative under any follow-on activity to the Advance Africa project (should there be one).

CRS and FHI (representing Advance Africa) worked out a creative way to manage the two organizations' different principles regarding family planning. Rather than execute a memorandum of understanding between FHI and CRS, the parties agreed that FHI would execute direct agreements with each of the four participating organizations. This approach could be relevant to USAID/CRS cooperative ventures in other countries.

Family Life Education

(Funding: \$63,000 in core)

Advance Africa consortium member FAWE is working with the Zimbabwe chapter of the organization (FAWEZI) to develop a life skills education course for use with children 10–18 years of age. The initiative is a follow up to a training-of-trainers workshop sponsored by Advance Africa/Nairobi for five FAWE national chapters, including Zimbabwe, held in Harare in 2003. The subproject, which was being designed in Harare (with technical assistance from an Management Sciences for Health [MSH] consultant) at the time of the assessment, will train 20 province-level and 20 district-level FAWEZI members currently working with young people in schools and youth groups. Government of Zimbabwe counterparts include the Ministry of Higher Education and the Ministry of Education, Sport, and Culture.

FAWEZI cites research in Zimbabwe that shows that girls frequently leave school early for a variety of cultural, religious, and socioeconomic reasons. FAWEZI believes that some of these factors can be addressed by empowering children with knowledge about the importance of education in their life as well as by instilling skills in goal setting and decision-making. Course topics include career guidance, social ranking, assertiveness and self-esteem, body language, and—regarding adolescent reproductive health—physiology and anatomy, pregnancy, information about STIs, and reproductive rights.

Comments

The life skills education materials being developed by FAWEZI may help make the educational experience of young people in Zimbabwe more holistic, and may better prepare them to be responsible adults. It was noted, however, that the content of the life skills education materials is very conservative—especially in a country suffering from HIV prevalence of over 25 percent. FAWEZI officers cite the very conservative position of the Zimbabwe government, noting, for example, that its counterpart ministries would thwart a more focused RH-related curriculum for adolescents. UNICEF, however, has already introduced a straightforward set of HIV/AIDS instructional materials into the primary and secondary curricula, with the cooperation of the Ministry of Education. Somewhat surprisingly, FAWEZI was only anecdotally aware of the UNICEF effort, and had not examined any of that program's instructional materials—or completed any meaningful desk review of the relevant literature—before preparing its proposal to Advance Africa.

Integration Working Group (IWG)

(Funding: No discrete line item; staff time charged on a level-of-effort basis)

Advance Africa/Zimbabwe led the formation of the Zimbabwe FP/HIV/AIDS Integration Working Group (IWG), which came about as a result of a FP/HIV/AIDS integration

meeting hosted by Advance Africa in September 2003. Advance Africa serves as the executive secretariat for the IWG, which includes a wide range of Zimbabwean public and private sector organizations responsible for RH policy and services. The IWG is currently serving as the steering committee for the Zimbabwe portion of a five-country family planning assessment being conducted by FHI. A USAID Regional Economic Development Services Office (REDSO) East Africa study will examine how the HIV/AIDS epidemic has affected family planning needs and services in five countries in eastern and southern Africa.

CONCLUSIONS

The Advance Africa program in Zimbabwe is responding closely to tasks identified for it by USAID/Zimbabwe—indicating that **the project is a good steward of the USAID Mission’s field support funds**. Advance Africa’s project proposal to USAID for the expanded CBD program, for example, was a slightly revised transcription of a proposal initially submitted to USAID by ZNFPC, and passed to Advance Africa by USAID. The project’s collaboration with the STRIVE program, moreover, was negotiated by the USAID Mission. Advance Africa took the initiative in the development of a partnership with the CHAPPL project and in its support for the IWG. The FAWE/FAWEZI initiative is a special case, apparently reflecting an internal Advance Africa consortium commitment to facilitate FAWE linkages with its national affiliates in countries where an Advance Africa program is in place.

The project’s dutifulness in responding to Mission requirements **diminished its opportunity to apply the tools—such as strategic mapping and the Best Practices Compendium**—highlighted by Advance Africa as central to the project design process. Advance Africa/Zimbabwe follows a participatory approach to planning with its partners, but the rigor of the strategic mapping process is not observed. Advance Africa has never received copies of the Best Practices Compendium CD for distribution to host country partners.

External circumstances—above all, a severe economic crisis that eroded the management capacity and viability of ZNFPC—are undercutting the prospects of extending the expanded CBD program. Were economic conditions more favorable, **expanding the model—even to nationwide replication—would be quite possible, even likely**. Advance Africa did its part in helping to field a practical, cost-effective response to Zimbabwe’s HIV/AIDS crisis.

MOZAMBIQUE COUNTRY REPORT

PROGRAM DATA

Country Program Objectives: Complete the unfinished work of the Health Services Delivery Support (HSDS) project, and reposition family planning

Program Elements

1. HSDS unfinished work
2. Advance Africa field-supported initiatives
3. Core-funded activities

Cost: \$6,613,700 in field support, plus approximately \$120,000 in core

Key Partners

- Ministry of Health, Division of Community Health (MOH/CH)
- Johns Hopkins University, Health Communications Project (JHU/HCP)
- Helen Keller International (HKI)
- Save the Children/United Kingdom (SCF/UK)
- World Vision
- Project Hope
- Medical Care Development International (MCDI)
- Terre des Hommes
- Health Alliance International
- Forum for African Women Educationalists/Mozambique (FAWEMO)

BACKGROUND

Advance Africa's principal thrust in Mozambique has been to serve as a stopgap measure to continue work begun but not completed under a previous USAID Mission contract with JSI (the Health Services Delivery Support [HSDS] project), which ended in mid-2003. The objective of HSDS was to enhance reproductive health, including family planning, through a two-pronged strategy: health sector support and service delivery. In line with MOH priorities at the time, HSDS invested most of its resources into interventions to reduce maternal mortality, including essential obstetric care and child survival, rather than into family planning. When the project ended, much work still remained to be completed, particularly in family planning.

Because of procurement issues, USAID/Mozambique could not extend HSDS, even in light of the family planning gap and other uncompleted work. Rather than issuing a new request for application (RFA) in the middle of a strategic planning cycle, the Mission used field support funds to enlist the services of a number of CAs (MSH, JHU/HCP, HKI) to continue or take over ongoing HSDS activities. It then looked to USAID/Washington for a centrally funded CA to assume responsibility for the overlooked family planning agenda. Moreover, the Mission also asked Advance Africa to serve as a coordinating body for the work of the other CAs, and to serve as a pass-through and coordination mechanism for the NGO partners previously funded by JSI under the HSDS project.

ADVANCE AFRICA PROGRAM ELEMENTS

Advance Africa's portfolio in Mozambique consists of both residual tasks carried over from HSDS and new endeavors focused on FP/RH, some of which were anticipated but never formally launched under HSDS. In some cases, new initiatives have been added to carryover activities.

The unfinished work includes

- finishing the rehabilitation of several maternity units left over from a larger scale rehabilitation project,
- supporting a network of youth-friendly clinics started under the JSI project,
- emergency obstetric care training,
- training in biosafety, and
- the funding of subgrants of five NGOs working in six provinces.

USAID also asked Advance Africa to coordinate the work of the CAs and grant-funded NGOs, with the understanding that the primary task was to develop and manage a consolidated performance monitoring and reporting system for these organizations.

Seventeen maternity units in Zambezia and 16 in Nampula were identified for rehabilitation under the HSDS project. As part of the support for emergency obstetric care activities, facility upgrades were intended to enhance staff morale and draw in more women to deliver under the supervision of trained providers. Rehabilitation of most but not all facilities has been completed under Advance Africa. Some renovation work will not be completed by the end of the Advance Africa/Mozambique project; several facilities still remain to be properly equipped. Advance Africa's responsibility terminates once the clinics become fully functional. The MOH is tasked with the ongoing maintenance of both facilities and equipment.

Advance Africa also produced manuals for emergency obstetric care training planned under HSDS; the United Nations Population Fund (UNFPA) is extending this training to five hospitals in five provinces. In addition, under the NGO component, communities in Nampula and Zambezia have been trained to recognize when women require emergency obstetric care. Evidence suggests that family planning use has increased following interventions to improve knowledge about it.

Advance Africa inherited 10 youth-friendly clinics (SAAJs) in six provinces (one each in Manica, Sofala, Niassa, and Gaza, and three each in Nampula and Zambezia) from the previous project. Training of staff took place under HSDS; Advance Africa is responsible only for monitoring and supervision. These SAAJs are all located on the grounds of or near health facilities where clinic staff has also been trained to be more sensitive to adolescent FP and RH needs. (UNFPA assists a parallel network of SAAJs primarily

located near schools.) The issue of dispensing contraceptives to adolescents appears to be less sensitive in Mozambique than in Zimbabwe.

Advance Africa has taken the biosafety activities that were outlined but never carried out under JSI's emergency obstetric care interventions as a starting point for initiating infection control training for provincial hospital and health center staff in Zambezia and Nampula. This endeavor is expected to be inaugurated under the United Nations Development Programme (UNDP) in other provinces as well as to selected districts in Nampula and Zambezia, and also extended to provincial and district cleaners. In collaboration with JHU, Advance Africa also has developed a series of infection control posters that are disseminated in facilities following training to remind health workers about hand washing, control of hazardous medical waste and needles, use of gloves, and other biosecurity measures.

Over half of Advance Africa's field support budget is allocated directly to six NGOs (SCF/UK, Health Alliance International, World Vision, Project Hope, Terre des Hommes, and MCDI) working in six provinces (Nampula, Niassa, Zambezia, Gaza, Manica, and Sofala) that previously received funding under JSI subgrants. The money is allotted directly to the NGOs by MSH. Advance Africa's role is as a coordinating body for these NGOs as well as for the CAs, which assumed responsibility for the non-FP activities begun under HSDD. Its principal responsibility is consolidating collected data into a quarterly monitoring report for USAID, the MOH, and the implementing partners.

Under the previous JSI project, quarterly provincial meetings were held, but the information collected was not standardized, which made it difficult to monitor or compare project achievements or lack of achievements. Using Microsoft Project Manager, the Advance Africa NGO coordinator (who has since left the project) created a standardized tracking system with specific indicators to measure coverage more efficiently and effectively and to pinpoint where projects are underachieving. He also reinforced the quarterly meeting concept so that it and joint reporting are now being institutionalized. In addition, he personally developed some very useful qualitative analytical tools, including intelligent indicators and a value-added measure, which enable program managers to visualize the magnitude of missed opportunities for antenatal care, attendance at birth by a trained birth attendant, postnatal care, and family planning. While these tools do not provide answers, they stimulate problem analysis and evidence-based planning. The science behind these innovations is simple, replicable, and transferable, making them excellent candidates for inclusion in Advance Africa's Best Practices Compendium.

One of Advance Africa's new initiatives is carrying out the FP training that was not completed under the JSI project. This marks the first time in 13 years that MOH staff is receiving refresher training in family planning. In line with Advance Africa's commitment to repositioning family planning, the training focuses on shifting the message from limiting the number of children to spacing births.

The family planning training is being carried out in conjunction with training in integrated supervision, another Advance Africa initiative that aims to standardize supervision guidelines and reporting protocols for the different departments under the MOH/CH (including nutrition, adolescent health, school health, reproductive health, and

integrated management of childhood illness [IMCI]). Advance Africa has had a key role in developing the integrated supervision manual, including reporting instruments and supporting the training of relevant health staff. The training has been completed at the central level (35 persons trained); it is in the process of being expanded nationally, with the training schedule staggered in three regions to cover all relevant personnel. Of the 356 targeted personnel, 185 have been trained to date. Plans are underway to extend the integrated supervision training to the district level before the end of the project. Advance Africa is confident that the training will be completed by that time.

In addition to training inputs, Advance Africa is helping the MOH develop an FP policy for Mozambique. Following a birthspacing request for proposal (RFP) workshop held in December 2003, the Advance Africa deputy director from the headquarters office held advocacy meetings with MOH officials and other concerned stakeholders at central and regional levels. Interviews with several MOH informants and NGO partners indicate that Advance Africa's dissemination of the latest health benefits data regarding longer birth intervals is convincing policymakers, program managers, and clients alike to take optimal birthspacing more seriously. To further this agenda, Advance Africa is providing technical assistance to the MOH in Mozambique to elaborate a family planning strategy that will be incorporated into a broader maternal mortality reduction strategy, thereby codifying family planning and longer birth intervals as health interventions.

Much to the distress of the USAID Mission, Advance Africa, with only 4 months to go, had yet to have a monitoring and evaluation plan in place. Due to recruitment delays, only recently, in fact, did the project hire a monitoring and evaluation specialist. In addition to setting up a monitoring and evaluation plan, he is charged with designing instruments for monitoring the SAAs, overseeing the training for the Optimal Birth Spacing Initiative (OBSI) operations research described below, and developing a knowledge, attitudes, and practices (KAP) survey for the NGOs to implement.

With core funding, FAWEMO is marshaling a multisectoral initiative to integrate FP/RH/HIV/AIDS messages into school curricula. In addition to the advocacy initiatives summarized above, funds are supporting Advance Africa, Save the Children/US, and the MOH to undertake a three-phase OBSI operations research project in Zambezia and Nampula. The research is in response to DHS data indicating that women are already spacing births, but that the intervals vary widely by province. The protocol is in the final stages of development, and Advance Africa hopes that the first phase of the research will be completed by the end of the project. It is expected that Advance Africa will monitor the implementation of phases two and three from their headquarters. Core funding is also supporting the integration of FP into selected prevention of PMTCT sites.

OBSERVATIONS

From the Mission's perspective, Advance Africa did not fulfill its potential. However, the Mission acknowledged that the project has begun some promising initiatives that warrant further attention. Given the short time left in the project, the Mission is not pressing for any major changes.

Advance Africa in Mozambique, as in Zimbabwe, has shown itself to be an appropriate and useful instrument for managing USAID field support funds. The project has

responded effectively to the Mission agenda's while at the same time, it has demonstrated considerable flexibility and responsiveness to internally identified needs as they arise. It has also contributed significantly to Intermediate Results (IRs) to increase service delivery, enhance quality of care, and raise awareness of FP/RH among consumers and decision-makers. After only about a year in full-scale operation, the project will leave behind a legacy that includes

- new MIS tools and procedures for CA/NGO/MOH coordination;
- a national commitment to repositioning family planning;
- upgraded family planning skills for nurses and midwives;
- an integrated supervision model that will support RFP strategies;
- greater awareness at all provider levels of infection control, which should contribute to reduced maternal mortality and other nosocomial morbidity and mortality; and
- increased community involvement in problem identification, priority setting, and identification and implementation of interventions.

Notwithstanding these achievements, much of the unfinished work that Advance Africa took on from HSDS will still be incomplete by the end of project. This is due to the enormity and questionable sustainability of the tasks as well as to the start-up delays and the slow overall pace of the project. The project should have begun quickly, as senior staff were drawn from the predecessor project and the two regional RH assistants had significant health ministry experience, but it did not.

Serious communication lapses between the Advance Africa director and regional staff in Harare as well as apparent personality differences with some MOH staff contributed to its sluggish start and its subsequent slow implementation. The director of community health observed that the communication lines with Advance Africa were at times so confusing that it seemed as though he was dealing with two projects rather than one. He also complained about receiving incomplete data from the Provincial Directorate of Health and the District Health Directorate in Zambezia and Nampula, where Advance Africa has sent staff specifically to enhance coordination and provide technical assistance. The pace and efficiency of the project have picked up somewhat since the regional office was phased out, and the deputy director from the headquarters office has had a key role through periodic visits.

Even so, monitoring and evaluation activities may not be completed by the end of the project. While the local consultant is highly skilled and familiar with the project's context, it is difficult to conceive how he will be able to fulfill his responsibilities before the project is phased out, without additional human and financial resources.

The impact of Advance Africa's training activities could be greatly diluted without a future, strong Mission commitment. Although Advance Africa developed useful follow-up instruments, only a small proportion of the trainees will be part of a follow-up effort

before the project ends. Any follow-on mechanism should make this a priority for both family planning and integrated supervision to build on the investment to date. Similarly, Advance Africa's phasing out of Mozambique calls into question the fate of the OBSI research that is just beginning.

The MIS innovations developed under Advance Africa—most notably the intelligent indicators and the value-added measure—are not only extremely useful, but also have great potential for expansion in Mozambique and elsewhere. Any successor project should be encouraged to familiarize itself with these tools and make an effort to enhance their institutionalization. It is also critical that the project's achievements and lessons learned be consolidated and documented to support future expansion.

APPENDIX E

MISSION SURVEY RESPONSES

MISSION SURVEY RESPONSES

Mission Survey for Advance Africa: Angola

1. **Implementation Results:** Were the Advance Africa interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

The Angola program has been in operation for just over 3 months so cannot answer the question adequately. However, the program has great potential to increase use of quality family planning and reproductive health services. The approach taken has a big component of educating MOH workers (out of and in their work place) to improve their skills to provide quality services, and a similarly big component of increasing community awareness about FP/RH through ICC/IEC programs. Working with the MOH and other providers such as UNFPA to equip health facilities with modern contraceptives will ensure stability even after phase out of the program.

2. **Scale and Importance:** Have the Advance Africa interventions been replicated at a broader level beyond the original implementation site? If Advance Africa activities were scaled-up, what has been your experience with scale-up?

N/A

3. **Strategic Fit:** Were the Advance Africa interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

The strategy supports both the Mission and the MOH strategies.

4. **Management of Resources:** How has Advance Africa managed its personnel and resources in your country? If there were problems, did Advance Africa resolve them in a timely fashion?

This has been done well under the circumstances. Starting up a program in Angola is always a challenge. Obtaining a license from the government to allow organizations to operate could take as long as one year; it is therefore impossible to put anything in place until this is done. From this background, it took long for Advance Africa to have an operational management team in place. For the first 3 months of office start up, Advance Africa engaged a consultant and entrusted him with project funds and all that Advance Africa represented in Angola. Advance Africa also did not have an account and was using the consultant's bank account to transfer project funds, which is highly irregular.

So far, this has all been resolved. There is a functional management team with orientation from Advance Africa HQ and support staff on the ground, an account has been opened through MSH, and operating systems are in place. Problems that came up

touching on both the consultant and the project funds have been resolved in a timely manner.

5. **Timeliness, Technical Approach, and Style:** Please comment on Advance Africa's technical proficiency, timeliness, and cultural appropriateness.

Very good. The team on the ground has all the qualities mentioned and has the language to communicate effectively to the communities.

6. **Collaboration with Partners:** How well did Advance Africa coordinate with its consortium partners in providing needed assistance? How well did Advance Africa collaborate with in-country CAs/organizations and local government institutions?

So far, all Advance Africa activities are a collaborative effort with other CAs and partners and, more importantly, with the MOH. This collaborative effort started from the time of strategic mapping and baseline survey and has continued to date.

7. **Positive Outcomes:** What were the most positive outcomes of Advance Africa's work in your country?

Introducing reproductive health and birth spacing in Angola; this is the first program in Angola. NB: The MOH does have a program running but it has always been very weak and is only reaching a minimum of the population living in major towns.

8. **Challenges and Constraints:** What did not work out so well? Why?

Too early to tell but also refer to question 4 above.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

Replication of the successful interventions into other areas in the future and integration of MCH programs into FP/RH programs; to have interventions addressing main causes of mortality and morbidity in Angola such as malaria, diarrheal diseases, HIV/AIDS, etc. The rationale behind this is that if Angolan children continue to die, then birth spacing will not make sense to the populations.

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

As mentioned above

What was missing under the existing arrangement?

Adequate integration of programs related to RH; on the other hand, there was need to start from somewhere and slowly expand and that is what Advance Africa did.

What could have been foregone?

Nothing

10. Additional Comments: **Please add any further comments you'd like to make regarding Advance Africa's work in your country.**

FP/RH has been a much required intervention in Angola; Advance Africa program was timely and should continue after the pilot project phases out in October of 2004.

The ending of the Angolan War provided opportunities that would impact directly on populations. The high fertility rate (7:1) would ensure continued growing populations and fewer deaths from the enduring peace. Opened borders would also mean an increased risk of contracting HIV/AIDS and other STIs, taking into account that all surrounding countries have a high incidence of HIV/AIDS (between 20–40 percent).

These facts need to be factored in when designing future Advance Africa programs for Angola.

Mission Survey for Advance Africa: Democratic Republic of Congo

1. **Implementation Results:** Were the Advance Africa interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

Advance Africa's activities just started in the DRC in December 2003. The training of supervisors should help to improve the quality of family planning services that are delivered by the SANRU project. This will be measured by program manager visits over the next few weeks. All other activities (development of BCC materials for example) are still in their early stages and measurement is difficult.

2. **Scale and Importance:** Have the Advance Africa interventions been replicated at a broader level beyond the original implementation site? If Advance Africa activities were scaled-up, what has been your experience with scale-up?

N/A at this time.

3. **Strategic Fit:** Were the Advance Africa interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Advance Africa worked hard to make sure the needs of the Mission were met and has made an effort to incorporate the National Reproductive Health Program.

4. **Management of Resources:** How has Advance Africa managed its personnel and resources in your country? If there were problems, did Advance Africa resolve them in a timely fashion?

A poor selection of a local hire was made as Advance Africa tried to be amenable to the partner's concerns (they had had problems with other TA partners). Problem has not been resolved in a timely fashion, but there is hope that it will be in the future.

5. **Timeliness, Technical Approach, and Style:** Please comment on Advance Africa's technical proficiency, timeliness, and cultural appropriateness.

The caliber of Advance Africa's work (apart from the local hire) thus far has been high. Consultants are experts in their field. Advance Africa has made an effort to get planned activities implemented quickly and has been responsive to local cultural needs.

6. **Collaboration with Partners:** How well did Advance Africa coordinate with its consortium partners in providing needed assistance? How well did Advance Africa collaborate with in-country CAs/organizations and local government institutions?

Recent consultants have been from CAFS, AED, and MSH. They worked hard to collaborate with all local institutions that would be using BCC materials when they organized their final designing.

7. **Positive Outcomes:** What were the most positive outcomes of Advance Africa's work in your country?

They are in the process of added technical expertise for a partner who needed it.

8. **Challenges and Constraints:** What did not work out so well? Why?

Local hire. Advance Africa should have interviewed the candidates.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

What was missing under the existing arrangement?

What could have been foregone?

10. Additional Comments: **Please add any further comments you'd like to make regarding Advance Africa's work in your country.**

Mission Survey for CATALYST: Egypt

1. **Implementation Results:** Were the CATALYST interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

Although CATALYST has been in-country with a team hired and oriented now for just a year and a few months, I believe it has laid a very, very solid foundation for major improvements in the clinical and non-clinical FP program that will soon be measurable—and I believe it will measure impressive improvements. It has worked at the national level and established an impressive program and level of local involvement in the state of Minya that will be replicated within the next two years in all of Upper Egypt. The amount of work in Minya, and the complexity and extent of local involvement and ownership, far exceeds the first annual work plan and anything I expected to see in the first year.

2. **Scale and Importance:** Have the CATALYST interventions been replicated at a broader level beyond the original implementation site? If CATALYST activities were scaled-up, what has been your experience with scale-up?

CATALYST has not had sufficient time in Egypt to scale up beyond the first state of Minya in Upper Egypt—but I believe it will meet the schedule of scaling up to all of Upper Egypt within the next 24 months.

3. **Strategic Fit:** Were the CATALYST interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Yes—the CATALYST interventions were specifically designed and tailored to support the Mission strategy and the Mission project design as well as the government strategy. To date, they have successfully supported them and we fully expect that to continue.

4. **Management of Resources:** How has CATALYST managed its personnel and resources in your country? If there were problems, did CATALYST resolve them in a timely fashion?

Personnel and resource management has been exemplary, with no problems.

5. **Timeliness, Technical Approach, and Style:** Please comment on CATALYST's technical proficiency, timeliness, and cultural appropriateness.

CATALYST put together an extremely impressive technical team of mostly local experts and some international experts for the country team. It has called on consortium member experts to provide short-term support—all of it impressive. In recruiting extremely well-qualified local experts and a COP who speaks Arabic and knows the region well, cultural

appropriateness has been well addressed. CATALYST has been very flexible in responding to MOHP requests for assistance above and beyond the work plan, prioritized well and met all important deadlines.

6. **Collaboration with Partners:** How well did CATALYST coordinate with its consortium partners' in providing needed assistance? How well did CATALYST collaborate with in-country CAs/organizations and local government institutions?

Coordination with consortium partners has been strong and their resources were called upon as needed. CATALYST has taken the lead in coordinating with related USAID health and education projects, and actively sought out other relationships with important GOE entities, such as the National Council of Childhood and Motherhood and the National Council of Women. They have repeatedly sought out other CA colleagues, looked for means of interproject cooperation for synergistic impact, and organized meetings, with the COP demonstrating exceptional leadership in this area.

7. **Positive Outcomes:** What were the most positive outcomes of CATALYST's work in your country?

To date, the widespread energy and enthusiasm in Minya from a very wide array of civil society to support the FP program has been the most impressive outcome. The feeling of local ownership is very strong as CATALYST is widely seen as an entity willing to listen to them and respond to their needs. I believe we will see strong program impact soon in Minya as a result. It is also generating a lot of interest from neighboring states.

8. **Challenges and Constraints:** What did not work out so well? Why?

To date, everything has worked out well.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

No thoughts on this yet—will be better prepared when we meet with the evaluation team.

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

A serious issue for Missions is the reducing staff numbers, resulting in the need to have fewer "management units"—agreements, etc. Global projects that have an even broader base for one-stop shopping would be welcome. For example, the CATALYST project would be even more beneficial to us if it had an FP/POP/RH policy component.

What was missing under the existing arrangement?

See above.

What could have been foregone?

Nothing for our purposes.

10. Additional Comments: **Please add any further comments you'd like to make regarding CATALYST's work in your country.**

This is the most exciting project I've seen, and the potential it has to make major improvements in the program here is enormous.

Mission Survey for CATALYST: India

Please note that from the beginning of USAID/India's association with CATALYST last year, the Mission perspective on the mechanism is that it has been used purely as a pass through to access the current CEDPA team through a field support mechanism. CEDPA has a long and illustrious history here in India through the ENABLE project, little of which is due to its relatively newer association with the CATALYST mechanism. Additionally, we started using the mechanism only a year ago, so results that are discussed below are attributable to CEDPA's technical assistance to our bilateral program through the years, not to CATALYST as a broader organization. While there have been several visits from CATALYST staff, we have not had sufficient experience to judge the consortium's added value vis-à-vis the already existing value of CEDPA/India. Therefore, please view these responses as coming from a perspective of looking at the country office of CEDPA/India, not as comments on the overall performance of the CATALYST consortium in the country.

1. **Implementation Results:** Were the CATALYST interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

Using CATALYST as a funding mechanism to access the CEDPA/India team, technical assistance was provided for the community-based distribution component of the Mission's bilateral Innovations in Family Planning Services (IFPS) Project. With pilots with NGOs and dairy cooperatives as early as 1994, CEDPA has provided technical inputs to evolve the program to suit the specific needs of the state of Uttar Pradesh. Efforts over the past year have focused on making the CBD programs sustainable, enhancing ownership by implementing agencies so that such programs can be continued without financial support, and developing an adolescent health program. Evaluations of individual CBD projects show that contraceptive prevalence increased by 2–3 percentage points annually in areas covered. The Mission's annual indicator survey shows that modern method contraceptive prevalence in NGO areas is 6 percentage points higher than in non-NGO areas. Adolescent health activities designed by CEDPA have been adopted by the UP state government and this year, day camps during summer vacation are planned in conjunction with the Department of Education in all 70 districts of the state. Adolescent health and family life education is part of the curricula planned for the camps. All of these impacts are due to the bilateral program, to which CEDPA has contributed technical assistance.

2. **Scale and Importance:** Have the CATALYST interventions been replicated at a broader level beyond the original implementation site? If CATALYST activities were scaled-up, what has been your experience with scale-up?

USAID/India's bilateral program supports community-based distribution activities with a population coverage area larger than most countries in the world. Currently, CBD programs cover a population of approximately 21 million—roughly equivalent to the entire population of Ghana or Romania and twice the size of Zambia or Senegal.

However, in terms of importance, even this impressive scale is dwarfed by the population of Uttar Pradesh (~170 million) and the magnitude of the need that dilutes achievements when measured on a statewide basis.

What the activities have proven is that NGO and other community-based distribution systems can operate at substantial scale in northern India and that such programs can address reproductive health. (In the early days of the program, there was even doubt as to whether NGOs would want to work on reproductive health issues, due largely to the unique history of family planning in Uttar Pradesh.) CEDPA played a role in developing the systems that enabled the current scale to be reached, but one cannot characterize the program as “CEDPA’s activities” or “CATALYST’s activities.” The government of India is currently looking at these systems as models for national implementation, but is unlikely to adopt them without modification.

- 3. Strategic Fit:** Were the CATALYST interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Involvement of the NGO and private sectors has been a major strategic emphasis for the Mission. We see many of the models developed in IFPS, particularly the CBD approach, as ready to transfer to the government for wider adoption. This leaves a different range of engagement between the public and private sectors as USAID’s future focus. Thus, while there has been an impressive strategic alignment in the past, we anticipate moving in other directions in the future.

- 4. Management of Resources:** How has CATALYST managed its personnel and resources in your country? If there were problems, did CATALYST resolve them in a timely fashion?

CEDPA has managed resources well, in a manner appropriate to its role in India.

- 5. Timeliness, Technical Approach, and Style:** Please comment on CATALYST’s technical proficiency, timeliness, and cultural appropriateness.

CEDPA has been extremely flexible and accommodating in carrying out its activities in a timely manner. Their style and technical approach has been appropriate for India. As mentioned above, this assessment is relevant to CEDPA and its country office, not to the broader CATALYST consortium.

- 6. Collaboration with Partners:** How well did CATALYST coordinate with its consortium partners’ in providing needed assistance? How well did CATALYST collaborate with in-country CAs/organizations and local government institutions?

There has been no formal collaboration between CEDPA and other CATALYST consortium partners for the IFPS project but information sharing at informal levels has helped CEDPA work. CEDPA works in close coordination with the other CAs providing technical assistance to the IFPS project and has served as the focal point for administrative matters for the IFPS CAs. CEDPA enjoys a good rapport with SIFPSA,

the implementing partner of USAID/India for the IFPS project in UP, and with organizations in other areas covered by the project.

7. **Positive Outcomes:** What were the most positive outcomes of CATALYST's work in your country?

Traditionally, the Indian NGO sector, particularly in UP, has worked on social issues other than health. NGO health programs were more confined to health camps and charitable hospitals. Work on reproductive health was uncommon as discussing women's health was taboo. CEDPA has contributed to changing that situation in UP, where now close to 100 organizations in 38 districts are IFPS partners, and grassroots level workers go house to house to counsel women and provide contraceptive information and services. The village level workers themselves have been empowered not only to provide contraceptive advice and services but also as women who play a more proactive role in social issues in the community. At least a dozen CBD workers have gone on to be elected to local government positions, largely due to the sense of empowerment they gained through participating in the program.

8. **Challenges and Constraints:** What did not work out so well? Why?

Our constraints have been more at the Mission level, involving funding. These have had an impact on program directions. Diminished resources mean a diminished program.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

I look at this question from a very India specific viewpoint, and within India, it's a viewpoint heavily focused on Uttar Pradesh (the country's largest state). For us, the challenge is ensuring the sustainability of the huge CBD efforts we have ongoing. The other is developing better mechanisms for managing NGOs—umbrella NGOs, mother NGOs, etc.—that can help an overburdened government manage a large number of NGO projects. Another challenge is developing an enabling policy and government bureaucracy environment for enhanced partnerships between the public and private sectors. I think the technical details are the easy part (if anything can be called easy about them); the real challenge is the management hurdles that are in the way of the systems functioning properly.

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

In terms of a follow-on global CA, we need flexibility, top notch capability, and Mission-level CTO responsibility. One needs access to the world's best expert in XYZ on a recurring basis, but not on permanent staff (at least in India). I think we're less interested in just putting money into field support and would want more direct Mission control.

What was missing under the existing arrangement?

What could have been foregone?

Missing has been the economic assessment element. There must be a keen eye toward the cost of interventions and an understanding of cost-effectiveness and cost efficiency. NGO projects are successful at raising contraceptive prevalence, but at what cost and in comparison to what other methods of working toward the same goals? If I have only \$100 to spend, how much should I put on NGO projects in order to get the largest increase in X indicator? Economic analyses help convince ministries of finance about the need to spend so much money in the health sector as well as help with resource allocations within the health sector. Obviously such analyses have to be conducted by experts, not by those with only superficial familiarity with the issues.

10. Additional Comments. **Please add any further comments you'd like to make regarding CATALYST's work in your country.**

None.

Mission Survey for Advance Africa: Mozambique

1. **Implementation Results:** Were the Advance Africa interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

Yes. In collaboration with JHU, Advance Africa is supporting the Ministry of Health (MOH) in the design of a new FP policy. Advance Africa also participated in increasing the capacity of health workers to provide quality FP services in two major provinces through training personnel and supplying medical and surgical materials to some 25 rehabilitated maternities in two provinces.

2. **Scale and Importance:** Have the Advance Africa interventions been replicated at a broader level beyond the original implementation site? If Advance Africa activities were scaled-up, what has been your experience with scale-up?

Not yet. Advance Africa started the implementation of activities only in May 2003 and there is no experience with the scaling up process yet.

3. **Strategic Fit:** Were the Advance Africa interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Yes. The Advance Africa intervention was designed taking into consideration the USAID strategic plan and the MOH operational plan. In terms of being successful in supporting both the Mission and government strategies, the interventions are still ongoing, but the Mission feels that they are on track.

4. **Management of Resources:** How has Advance Africa managed its personnel and resources in your country? If there were problems, did Advance Africa resolve them in a timely fashion?

Advance Africa had, and is still having, a difficulty in managing its in-country staff, and they have not been successful in solving this issue up until now. Personality issues amongst senior staff overshadowed good management quality and some positions were not filled on time. In terms of management of other resources, no comments.

5. **Timeliness, Technical Approach, and Style:** Please comment on Advance Africa's technical proficiency, timeliness, and cultural appropriateness.

Advance Africa was very slow in starting activities in-country. The Mission recognizes that there were some constraints from the MOH and the Mission; however, when the ground was ready Advance Africa was unable to respond quickly. Part of the reason was that Advance Africa had a Regional Director assisting different countries at the same time, and no one was in country to assume leadership and make decisions.

No comments on the technical approach. The Mission believes that interventions were culturally adapted to the Mozambican situation.

6. **Collaboration with Partners:** How well did Advance Africa coordinate with its consortium partners in providing needed assistance? How well did Advance Africa collaborate with in-country CAs/organizations and local government institutions?

In general, Advance Africa is playing an important role in coordinating a consortium of 5 CAs and six NGOs, operating at the central level and in 6 provinces in the country. Advance Africa also participates actively in coordination forums with other partners.

7. **Positive Outcomes:** What were the most positive outcomes of Advance Africa's work in your country?

*Because Advance Africa interventions in Mozambique are for a short period, we can only talk in terms of outputs and not really outcomes. The most expected outcomes are the elaboration of a final draft of the **FP policy and production of new supervision tools.***

The most positive outputs produced by Advance Africa so far include:

- 1. Child spacing seminar*
- 2. Distribution of medical and surgical equipment to 25 rehabilitated maternities in 2 provinces (Zambezia and Nampula)*
- 3. Seminar and consultancy on supervision*
- 4. Coordination of interventions implemented by 6 NGOs with operation plans and activities of district and provincial health departments*

8. **Challenges and Constraints:** What did not work out so well? Why?

The major challenge for the project is to ensure good coordination of the different intervenients in developing the FP policy.

Constraints:

- 1. Delays in getting implementation plans done and approved*
- 2. Delayed commencement of interventions*
- 3. Key personnel management problems*

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

- *Improve the provision of technical support at both central and provincial levels on supervision of FP and RH programs.*
- *Assist the government in elaborating an FP strategy and its operation plan and incorporation into the maternal mortality reduction strategy.*
- *Ensure a close link between Advance Africa and communication interventions to address specific issues that could improve FP and RH.*

- *Ensure that HIS is linked to clinical programs of Advance Africa and forms the basis for decision-making at all health care levels.*

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

- *Interventions with linkages between PMTCT/RH/FP programs*
- *Maternal nutrition/PMTCT/low birth weight and perinatal mortality*
- *Linkages between FP policy, procurement and logistics of contraceptives*
- *Operation research in FP/RH*
- *Technical support to the MOH to better articulate an advocacy of the importance of female literacy/FP/PMTCT and maternal mortality*

What was missing under the existing arrangement?

What could have been foregone?

10. Additional Comments: **Please add any further comments you'd like to make regarding Advance Africa's work in your country.**

Mission Survey for CATALYST: Peru

1. **Implementation Results:** Were the CATALYST interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

Yes, CATALYST is working on a variety of fronts to increase use of sustainable, quality family planning and reproductive health services. CATALYST is supporting improvement of the quality of public sector MOH reproductive health services in USAID/Peru's seven-department geographic emphasis area in the central jungle part of Peru. More importantly, CATALYST has the lead in our effort to move the provision of contraceptives to users out of subsidized government establishments and into unsubsidized private sector points, such as pharmacies.

2. **Scale and Importance:** Have the CATALYST interventions been replicated at a broader level beyond the original implementation site? If CATALYST activities were scaled-up, what has been your experience with scale-up?

CATALYST's work with contraceptive social marketing is national in scope, although clinic-based interventions are concentrated in our geographic focus area in central Peru. Experience and models from the work in a single central jungle department (Huanuco) has now been scaled up to the full seven-department USAID focus area.

3. **Strategic Fit:** Were the CATALYST interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Yes, CATALYST is fully integrated into the Mission strategy, both geographically and in terms of interventions. CATALYST not only "supports" the strategy, it is the lead partner in many activities.

4. **Management of Resources:** How has CATALYST managed its personnel and resources in your country? If there were problems, did CATALYST resolve them in a timely fashion?

CATALYST does a good job of managing its resources, which are considerable in Peru. Of course, as with all field support mechanisms, here in the Mission we are not as aware as we would like to be of the pipeline and burn rate.

5. **Timeliness, Technical Approach, and Style:** Please comment on CATALYST's technical proficiency, timeliness, and cultural appropriateness.

Generally excellent. CATALYST has been flexible and responsive in a highly volatile health sector. CATALYST is very client oriented, providing the Mission with the services we seek and consulting to be sure planned activities meet the Mission's requirements.

6. **Collaboration with Partners:** How well did CATALYST coordinate with its consortium partners' in providing needed assistance? How well did CATALYST collaborate with in-country CAs/organizations and local government institutions?

CATALYST is the biggest in a community of partners and coordinates conscientiously with other CAs (POLICY, PHRplus, CHANGE) and with local organizations, including the MOH.

7. **Positive Outcomes:** What were the most positive outcomes of CATALYST's work in your country?

There are lots. Progress toward certification/accreditation of medical professionals and their training institutions is a real triumph. Coordination with the top-priority Alternative Development counternarcotics program is another. Progress toward contraceptive sustainability by stimulating private sector provision is encouraging.

8. **Challenges and Constraints:** What did not work out so well? Why?

USAID/Peru's population/reproductive health program has been battered by political and religious extremists in recent years. CATALYST/Pathfinder struggles with USAID to deflect and prevent disruptive attacks. The most helpful role for Pathfinder in this minefield is not clear to Pathfinder or to us in USAID.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

I would like CATALYST to pick up more of the communication/behavior change activities that are currently the responsibility of the terminating GH CHANGE project.

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

Communication/education/behavior change emphasis.

What was missing under the existing arrangement?

We're happy with the current arrangement, including the consortium participants.

What could have been foregone?

The core-funded initiatives that are added occasionally to our bilateral activities.

10. **Additional Comments:** **Please add any further comments you'd like to make regarding CATALYST's work in your country.**

CATALYST has been a major asset to the USAID/Peru RH/FP/health program. It has mobilized extraordinary Peruvian technical talent and is exceptionally agile and flexible.

Mission Survey for Advance Africa: Senegal

1. **Implementation Results:** Were the Advance Africa interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

USAID/Senegal requested Advance Africa assistance to strengthen the national health monitoring system generally. Advance Africa's work in Senegal was not directed toward increasing quality FP services per se. USAID was very happy with Advance Africa's work regarding monitoring. The monitoring system has been effectively revised, updated, and is functioning as well as expected.

2. **Scale and Importance:** Have the Advance Africa interventions been replicated at a broader level beyond the original implementation site? If Advance Africa activities were scaled-up, what has been your experience with scale-up?

Yes, Advance Africa's work regarding monitoring was targeted toward USAID-assisted districts, but as this is a national activity, all health districts benefited indirectly from Advance Africa's assistance.

3. **Strategic Fit:** Were the Advance Africa interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Yes, Advance Africa's work here was tailored to revise and re-establish the monitoring system of the MOH. This is both part of USAID's strategy and the MOH's strategy. Advance Africa's support was very beneficial toward this objective.

4. **Management of Resources:** How has Advance Africa managed its personnel and resources in your country? If there were problems, did Advance Africa resolve them in a timely fashion?

Advance Africa in the beginning assigned a Togolese citizen to work on the Senegal activity. He worked very well with the MOH and with our other CAs. He understood and worked within the specific limitation of Advance Africa's mandate in Senegal (monitoring only). Because Advance Africa did not have sufficient buy-in support to fund an expatriate employee in Senegal, he was released and replaced with a Senegalese citizen. We did have some concerns about the manner by which this "consultant" was recruited and the manner by which he worked outside of the Advance Africa/Senegal SOW.

5. **Timeliness, Technical Approach, and Style:** Please comment on Advance Africa's technical proficiency, timeliness, and cultural appropriateness.

To the extent that Advance Africa worked within its Senegal-specific SOW, USAID was content with the technical content, timeliness, and cultural appropriateness of its work in Senegal.

6. **Collaboration with Partners:** How well did Advance Africa coordinate with its consortium partners in providing needed assistance? How well did Advance Africa collaborate with in-country CAs/organizations and local government institutions?

As discussed above, its work regarding monitoring was well coordinated with partners, CAs and the MOH.

7. **Positive Outcomes:** What were the most positive outcomes of Advance Africa's work in your country?

The monitoring forms were updated to include FP and HIV/AIDS indicators; the new forms were tested and are now being applied nationwide.

8. **Challenges and Constraints:** What did not work out so well? Why?

When Advance Africa worked outside of its mandate. USAID has a cooperative agreement with MSH to implement its FP/MH component. The MOH doesn't want Advance Africa to be working on FP or FGC activities that are otherwise the domain of USAID's CA.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

What was missing under the existing arrangement?

What could have been foregone?

Since we didn't intend to use Advance Africa for FP service delivery activities, we really have no comments to offer regarding these questions.

10. Additional Comments: **Please add any further comments you'd like to make regarding Advance Africa's work in your country.**

None other than the above.

Mission Survey for CATALYST: Yemen

1. **Implementation Results:** Were the CATALYST interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

There are no measures of the program at this point since it has just started.

2. **Scale and Importance:** Have the CATALYST interventions been replicated at a broader level beyond the original implementation site? If CATALYST activities were scaled-up, what has been your experience with scale-up?

No, program is just beginning.

3. **Strategic Fit:** Were the CATALYST interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Yes, CATALYST interventions in Yemen were specifically designed and tailored to support the Mission strategy.

4. **Management of Resources:** How has CATALYST managed its personnel and resources in your country? If there were problems, did CATALYST resolve them in a timely fashion?

There are no problems.

5. **Timeliness, Technical Approach, and Style:** Please comment on CATALYST's technical proficiency, timeliness, and cultural appropriateness.

CATALYST's technical proficiency at this stage is too early to judge. (Will show once activities start). There was a slight delay. CATALYST's team shows a high sense of cultural appropriateness.

6. **Collaboration with Partners:** How well did CATALYST coordinate with its consortium partners' in providing needed assistance? How well did CATALYST collaborate with in-country CAs/organizations and local government institutions?

CATALYST is working closely with the other USAID health and education projects, sharing information and coordinating interventions. Coordination with local government institutions is also visibly present and successful in bringing (together) governorate level and central level counterparts to work more closely to the project.

7. **Positive Outcomes:** What were the most positive outcomes of CATALYST's work in your country?

In this short period of just 3 months, it can be said that the most important outcome has been the ability of CATALYST to make field visits to all the governorates, collect data, and make significant progress toward the selection of districts where it will operate. Some team building with counterparts has been achieved through field activities and special events, such as attending the ANE conference.

8. Challenges and Constraints: What did not work out so well? Why?

The start up, in terms of setting up the office, may have been a little slower than expected due to the delay in appointing a COP.

9. Future Directions: What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

What was missing under the existing arrangement?

What could have been foregone?

In Yemen, it is a matter of investing in increasing access to services; most existing clinics are badly equipped and staffed. In the long term, the real difference is going to be made through the proper training and staffing of health care services, including measures to motivate staff to work in districts (such as housing) and measures to increase their income.

10. Additional Comments: Please add any further comments you'd like to make regarding CATALYST's work in your country.

Too early to tell, but the potential is very good to provide some needed assistance.

Mission Survey for Advance Africa: Zimbabwe

1. **Implementation Results:** Were the Advance Africa interventions in your country useful in increasing use of sustainable, quality family planning and reproductive health services through clinical and non-clinical programs? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve use of family planning and reproductive health services.

N/A: The overall focus of the Advance Africa program in Zimbabwe is to integrate HIV activities into existing family planning programs—not to increase the use of FP/RH services.

2. **Scale and Importance:** Have the Advance Africa interventions been replicated at a broader level beyond the original implementation site? If Advance Africa activities were scaled-up, what has been your experience with scale-up?

Advance Africa has been unable to scale up activities as a result of the weakness of its local partner, the Zimbabwe National Family Planning Council (ZNFPC). The ZNFPC, a government parastatal, is Zimbabwe's principal provider of RH services and is the only logical partner for Advance Africa's activities. However, due to its weaknesses, ZNFPC has proved to be a poor partner, limiting Advance Africa's ability to scale up. This was beyond the control of Advance Africa.

3. **Strategic Fit:** Were the Advance Africa interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy? Did they successfully support the Mission and/or government strategies?

Yes. Yes. Yes.

4. **Management of Resources:** How has Advance Africa managed its personnel and resources in your country? If there were problems, did Advance Africa resolve them in a timely fashion?

We have been pleased with the Advance Africa/Zimbabwe staff. However, it seems that at times there have been competing agendas from Advance Africa/Washington, which demonstrate a lack of knowledge of what is needed/appropriate for Zimbabwe.

5. **Timeliness, Technical Approach, and Style:** Please comment on Advance Africa's technical proficiency, timeliness, and cultural appropriateness.

Advance Africa has performed well in all three areas.

6. **Collaboration with Partners:** How well did Advance Africa coordinate with its consortium partners in providing needed assistance? How well did Advance Africa collaborate with in-country CAs/organizations and local government institutions?

Advance Africa/Zimbabwe is staffed completely by FHI personnel. They cooperated well.

7. **Positive Outcomes:** What were the most positive outcomes of Advance Africa's work in your country?

Due to circumstances beyond the control of Advance Africa (i.e., the deteriorating political, social and economic environment and the weakness of Advance Africa's main partner, ZNFPC) the program has had limited success in Zimbabwe. In recognition of these constraints, the program is being adjusted to focus on areas with greater opportunity.

8. **Challenges and Constraints:** What did not work out so well? Why?

See question 7 above.

9. **Future Directions:** What future directions or activities do you believe would improve clinical and non-clinical service delivery programs?

Increased and systematic integration of family planning/reproductive health services into HIV/AIDS activities, PMTCT, OVC programs, etc.

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

Given our limited resources, this is not a priority area of interest.

What was missing under the existing arrangement?

Conceptually, integration is a good idea. However, the Advance Africa program suffered from not being able to get out into the field and market its services. Better guidance and support from USAID/Washington might have helped Advance Africa develop more partnerships.

What could have been foregone?

No comment.

10. **Additional Comments:** Please add any further comments you'd like to make regarding Advance Africa's work in your country.

Advance Africa was unable to adequately "sell" the idea of integration in Zimbabwe to make reproductive health a recognized, integral and key component of a comprehensive HIV/AIDS program. More advocacy was needed, including dissemination of lessons learned.

APPENDIX F

**ADVANCE AFRICA AND CATALYST
MONITORING AND EVALUATION PLANS**
(from Advance Africa and CATALYST)

ADVANCE AFRICA

Monitoring and Evaluation

2005 Objectives

To ensure accountability to USAID and the Advance Africa Project's stakeholders by demonstrating how the project achieves progress towards its goals as defined by the results framework; to produce Advance Africa end-of-project M&E results

Background

Since March, the Project Deputy Director has been responsible for overseeing the project's M&E needs, supported by existing project staff and working closely with country projects M&E personnel. In addition, the Project Director who has strong M&E background through her training in public-health has been participating in the development of the M&E framework. The M&E specialist of the MSH/EQUITY Project in South Africa has also been hired as a short-term consultant to assist in developing the end of project evaluation activities based on the project's global M&E plan, and is working closely with the Project Senior M&E Specialist and under the supervision and guidance of the Project Director and Deputy Director.

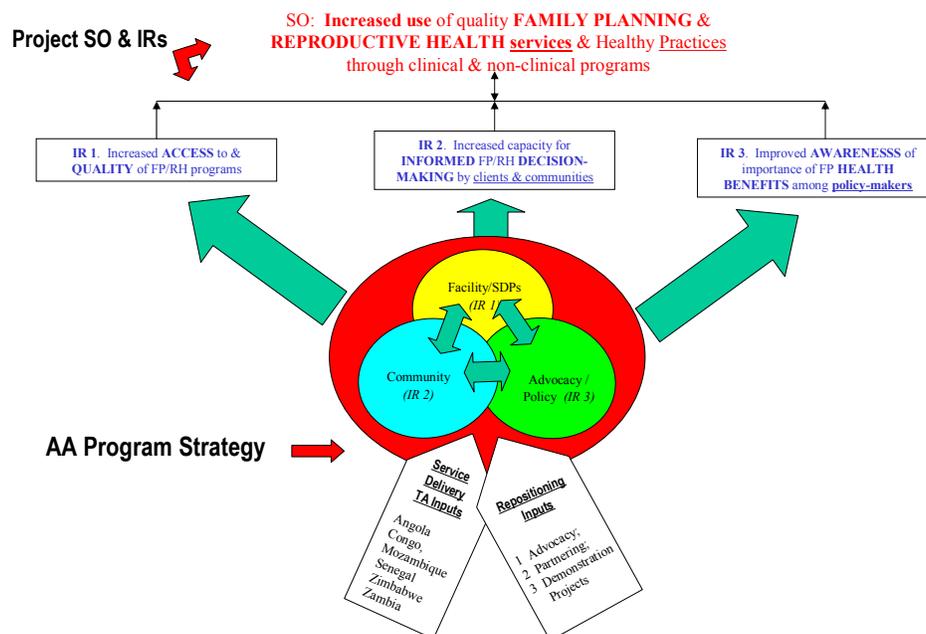
A Comprehensive M&E Strategy

A comprehensive monitoring and evaluation strategy requires monitoring of project activities during the different stages of project implementation: monitoring inputs, processes, outputs, outcomes and impact. End-of project evaluation - a systematic analytical effort that asks why certain results have been achieved - is planned and conducted in response to specific management questions about performance of the repositioning strategy activities. The evaluation will not only focus on why results are or are not being achieved; they may also address issues such as relevance, effectiveness, efficiency, impact, or sustainability. The evaluation will use available monitoring result from the global Advance Africa monitoring data, covering the life of the project from its inception in 2001 to the end in 2005.

The hierarchical nature of Advance Africa places several challenges of centrally funded projects related to the conduct of M&E within the project. While M&E is conceptually

directed from the Advance Africa central program, it is inevitably carried out either at the country project or regional project level. This has required that the projects at the country or regional level be developed in accordance with the overall strategy of Advance Africa for M&E. It also required that M&E data and information follow a clear path, from the country or regional project level to the central level. This also means that the central level success in meeting the project SO and IRs, as defined by USAID/Washington, depends on information obtained through the country and regional programs about their project activities.

Contribution of AA Program Strategies to Project SO & IRs



The global Advance Africa M&E plan takes into consideration the revised Results Framework and aligns country programs with the global intermediate results and strategic objective. The plan identifies four key areas of M&E activities:

1. Monitoring workplan activities using the Knowledge and Information management exchange database (KIX);
2. Supporting Country Projects with collection and/or analysis of country-level data for indicators aligned to the global SO and IRs;
3. Use country data and evidence from regional activities to monitor and evaluate progress of the Repositioning Strategy;
4. Qualitative assessment of achievements during the project years 2001-2005;

1) Monitoring of Work-plan Activities Using the Knowledge and Information Management database (KIX)

Activities for the final year work plan will be monitored using the indicators described in the table under each intervention section. Each activity will be linked to the expected product or output, the expected outcome, the indicator/s for monitoring the activity/activities, as well as the intermediate results to which the activity contributes.

Once the work plan has been finalized, the Knowledge and Information Exchange Management database (KIX) will be adapted to take into consideration the revised work plan activities.

The KIX is a useful and simplified way of tracking project activities at both the global and country levels, and analyzing and reporting on progress by IR. The KIX is capable of producing a variety of reports about project components as well as country activities. Advance Africa staff worldwide can access the database and print reports using template report formats and ad hoc searches. The objectives of KIX include providing a mechanism to link progress reports and indicator data to specific Advance Africa activities; simplifying the preparation of periodic and final project status reports to project managers, USAID missions, and USAID/W; storing descriptive information about project activities and progress in a manner that can be easily searched to respond to ad-hoc queries; as well as cataloging documents/tools produced. Every activity will be accounted for in terms of its contribution to the intermediate results.

2) Supporting Country Projects with collection and/or analysis of country-level data for indicators aligned to the global SO and IRs

A major support activity that will need immediate action after the work plan is approved is that of “*data-mining*” to work with the country projects to make sense of the data that are available or needs to be collected and extract that which can be aligned to the global project indicators, as well as setting baselines and targets where such do not exist. This will involve aligning the information flow with the activities that contribute to a specific intermediate result during the life of the project and implementation of activities in each country.

Partial Results Framework with Indicators

SO: Increased use of quality FAMILY PLANNING & REPRODUCTIVE HEALTH services & Healthy Practices through clinical & non-clinical programs

Indicator SO1.

Couple Years Protection, by method

Country (1)	Activities (2)	Data (3)
Angola	Y	N
Congo	Y	Y
Mozamb.	Y	Y
Senegal	N	N
Zimbabwe	Y	Y

Indicator SO2.

Modern method CPR, by method, for various targeted sub-populations

Country	Activities	Data
A	Y	N
C	Y	Y
M	Y	Y
S	N	N
Z	Y	Y

Indicator SO3.

% AA FP Programs with at least 4 of 5 birth spacing program operational elements

Country	Activities	Data
A	Y	N
C	Y	N
M	Y	N
S	N	N
Z	y	N

At both regional and country level, data will be collected and reported for indicators of access and quality of FP/RH programs; the capacity of clients and communities for informed FP/RH decision making; as well as awareness of importance of FP health benefits among policy-makers.

Sustainability and Capacity building indicators will be monitored using data on skills transfer and training of health service providers and other health professionals. Community level indicators will include modern method contraceptive prevalence as well

as clients' knowledge attitudes and practices relating to FP/RH and HIV/AIDS. Facility level indicators will include quality and availability of FP/RH services integrated in other health programs such as HIV/AIDS and PHC, as well availability of condoms and contraceptive stocks in health facilities.

The detailed M&E Plan will list the indicators for each country programs, as well as methods to be used for data-collection and timelines.

Angola - Rapid data-collection using the LQAS Methodology in Angola

To address data-needs for the Angola country program, Advance Africa proposes to use Lots Quality Assurance Sampling method for conducting community based surveys, and a quick facility-level assessment. The objective of this proposed study will be to assist the country program to collect baseline, monitoring and evaluation data for measuring progress towards meeting the expected results in the 8 intervention municipalities and 14 health facilities. The country-level results will contribute directly to the overall project intermediate results and strategic objective.

Since the LQAS community and facility survey data-collection methods are rapid and cost-effective, Advance Africa proposes to use staff already involved in the country program to support their supervisory responsibilities. Advance Africa believes this method can easily be adapted and used in other countries where insufficient data exists to measure progress during the final year of project implementation.

Democratic Republic of Congo (DRC)

In the DRC, Advance Africa technical support has been through SANRU III, whose goal is to strengthen management capabilities in rural health zones in order to increase their capacity to promote a minimum PHC package including maternal and child health, reproductive health and family planning. The memorandum of understanding signed by Advance Africa and SANRU II attempts to create an outline for the conditions and procedures for collaboration and the sharing of resources between Advance Africa and SANRU III to ensure practical results in the DRC. Process and output data has been collected and reported on by SANRU III, but little outcome and impact data exists. Some

of the results from the second UNICEF Multiple Indicator Cluster Survey (MICS II) undertaken in the DRC will be used as baseline data.

The proposed LQAS surveys in DRC will be done with SANRU as part of a M&E capacity building initiative to mainly look at trends. The LQAS initiative would then continue under SANRU after the end of Advance Africa activities in the country, and would form part of the project's evaluation activities at the end of the 5 year project which Advance Africa has been supporting. The direct evaluation of Advance Africa intervention in DRC will be mostly process evaluation and the LQAS surveys proposed will somehow tell us the effect of our support to SANRU III project at the intervention level..

Technical support will be needed by the country office to collect or mine existing data that can be used for outcome and impact evaluation, and the LQAS method is proposed for relevant data collection for the country program.

Mozambique

In Mozambique, a baseline survey with data on the key project indicators (contraceptive prevalence, knowledge relating to FP/RH issues) was conducted in 2001 and a follow-up survey is currently underway. A nation-wide demographic and health survey has also been just been completed. Sufficient data therefore exists for the Mozambique country project, and minimal technical assistance will be required.

In addition, the Optimal Birth Spacing Project (OBSP) is in the process of conducting a rapid diagnostic study to identify current knowledge of the community, the health providers, families and the women themselves about the benefits of optimal birth spacing and the risks of high maternal and child mortality related to short intervals. The information gained from this study will be used to develop, implement and test the feasibility of a birth-spacing intervention. Following implementation of the intervention, quantitative data collection related to reported knowledge gained about the benefits of optimal birth spacing and the risks of short intervals, and reported intended duration to space and use of FP will be conducted.

A comprehensive country–project M&E plan has been developed and will ensure that all necessary data related to the overall project strategic objective is collected and analyzed by the end of the project. The country also has an experienced fulltime M&E specialist.

Zimbabwe

In Zimbabwe, there has been much reported data-collection activities, most of which are part of the on-going routine management information system developed by the local partner organization – ZNFPC. The draft country M&E Plan also has a good framework with clearly defined strategic objective and intermediate results. However, there has been very little success in reporting on the indicators defined in the framework. There will be a definite need technical support to be provided to the country M&E officer in order to ensure reporting of project results according to the agreed indicators and IRs, as well as providing assistance in compiling the final country M&E report. The country program’s data needs and proposed method for data collection will be outlined after an initial assessment of available data in the country, to be conducted in early July by an Advance Africa consultant.

Senegal

Advance Africa technical assistance in Senegal relates to strengthening FP through performance monitoring improvement at district using health coverage measurements approach and tools developed by Advance Africa. These are inspired by the WHO/UNICEF global performance monitoring for the PHC health care services, developed when launching in the African region the Bamako Initiative strategy in the 1980s. The country project ends in July 2004 and reporting will be limited to indicators illustrating institutionalization and use of the performance monitoring guide revised and disseminated by Advance Africa. If available, impact data will be analyzed and used for comparison with similar indicators for other intervention countries.

3. Use country data and evidence from regional activities to monitor and evaluate progress of the Repositioning Strategy

The Repositioning Strategy will be monitored and evaluated using country data and evidence from regional activities. Indicators will be developed and monitored for the project's special initiatives of Best Practices, Strategic Mapping, and Performance Monitoring Plus. Data for these indicators will be collected during upcoming regional and country workshops and conferences, and well as through the use of questionnaires sent out to the users and beneficiaries of the special initiatives.

The detailed M&E plan will list the proposed indicators and methods for collection of data and evidence of the results of Advance Africa's Repositioning Strategy.

For the key indicators identified in the global Project Results Framework, baseline values for each indicator will be set based on available data, and where possible targets set for the final year of project implementation. This exercise will take into consideration project activities that might have ceased in some countries, as well as the fact that in some countries such as Angola, activities only started towards the end of the life of the Advance Africa Project.

4. Qualitative Assessment of Achievements during the Project Years

Advance Africa will conduct qualitative assessments to complement the quantitative data collected as described above. Quantitative data are necessary for tracking trends accurately, while qualitative data will be used to understand the context in which the trends occurred and interpreting the quantitative data.

Such qualitative assessments will include:

- following up beneficiaries of Advance Africa supported workshops/conferences and users of Advance Africa tools to see whether the knowledge and information gained at the conferences /workshops or from Advance Africa tools is being put into practice;
- whether service-delivery level training is having any impact of practices of service-providers (quality of care) and to assess client-satisfaction with services rendered;
- Sustainability of the key interventions introduced and/or supported by Advance Africa;
- A description of the major accomplishments of the Advance Africa activities, and how programming has advanced the state-of-the-art in family planning /reproductive health service delivery;
- Identification of areas of particular promise or key evidence-based approaches that can be further developed (the unfinished agenda);
- Identification of activities or interventions that required the greatest effort and proved most difficult to implement;
- Identification of specific obstacles to achieving results and what lessons have been learnt in the process.

These qualitative assessments will include a number of selected focus-group interviews, interviews with key informants, or using self-assessment questionnaires sent out to individuals or recipient NGOs.

M&E Personnel

From the above list of activities (detailed in full in the M&E Plan), it is evident that the present Advance Africa M&E personnel will need the additional services of consultants to assist with implementing the M&E plan, especially at the field-level. Current Advance Africa staff in Washington are assisting with capturing data and updating the KIX on a monthly basis.

The Senior Technical Advisor for M&E, based in Washington, will oversee the work in Congo, where a local consultant will be identified to assist with mining and analysis of existing data.

It is proposed that the present Advance Africa Country M&E Technical Advisor based Mozambique assist with the M&E activities in Angola. A scope of work has already been developed and forms part of the Global M&E Plan.

Advance Africa will identify a consultant to provide limited technical assistance to the Zimbabwe project, as well as continue with the technical support activities to Advance Africa/Washington M&E unit started by the MSH M&E Advisor based in South Africa.

CATALYST

Monitoring & Evaluation Plan

May 2003

Submitted: Core Funds and Country Programs in Peru, Bolivia, and India

CATALYST Consortium

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INTRODUCTION

The CATALYST Monitoring and Evaluation System provides policy makers, program managers and practitioners at the central and field levels important information on the status of interventions in process and on conclusions and recommendations stemming from interventions. The M&E System consists of M&E plans designed for core-funded and CATALYST country programs; a database that contains information about program results per established indicators; a reporting system to provide status of results to USAID and other interested parties; and a research and evaluation advisory panel that reviews the plans, indicators and other applied and operations research elements. As part of the M&E System, technical assistance is provided by CATALYST Washington-based staff for the design and implementation of M&E activities in the field programs.

In May 2002, CATALYST submitted to USAID the revised theoretical framework for the Monitoring and Evaluation System. The next step is to submit the M&E plans, which summarize the M&E activities to be conducted and which provide the timeline for data collection, analysis and evaluation.

As of May 2003, CATALYST implements core-funded activities and eight country programs, i.e. Bolivia, Cambodia, Egypt, India, Iraq, Laos, Peru and Pakistan. Due to the timing and nature of field buy-ins, the routine USAID funding cycles, and the recent constraint on fieldwork inflicted by the Iraq War, the M & E plans will be submitted in five stages:

1. Current submission includes core-funded activities and three countries, i.e. Bolivia, India and Peru. These are the most mature field programs. Data are already being collected and analyzed for some of the activities.
2. By July 1, submission of the 2003 the M&E Plan for Egypt after fieldwork will be completed by the CATALYST Monitoring and Evaluation Specialist. The largest and most complex of the field programs, Egypt activities have begun only recently.
3. M&E plans for Cambodia, Iraq, Laos and Pakistan will be designed and submitted once the country programs are formulated and approved. These four country programs are in various stages of design and negotiation so submissions will probably be staggered over the next few months.
4. M&E plans for any additional field buy-ins will be submitted as those new programs are designed and funded.
5. Revisions to existing core and country M&E plans, due to either major program revisions or to funding of new activities, will occur annually with the CATALYST Work Plan submission.

Each M&E plan contains the following information: name of the activity, evaluation question to be answered, indicator(s) to answer the question, data collection mechanism, funding source and amount, date of data collection and analysis, product to be generated and expected date of submission to USAID/W.

Note that the period of time covered by each M&E plan varies slightly due to differing program implementation schedules and funding cycles. However, all M & E activities in

this current submission for core activities and three country programs occur during the period January 2003 - September 2004.

FOCUS OF EVALUATION ACTIVITIES AND PRINCIPLES GUIDING THE CONSTRUCTION OF THE M&E PLANS

The following principles and assumptions were used in the construction of the M&E plans. They are organized in terms of the focus of indicators by Intermediate Result, methodological considerations, and the approach to reporting.

Focus of indicators by Intermediate Result (IR)

IR 1: Increased Access to and Improved Quality of FP/RH Clinical and Nonclinical Programs

Given the mandate under IR1 and the current portfolio under implementation, the evaluation questions focus on:

- policies, strategies, guidelines or protocols adopted in support of the core programmatic areas for CATALYST (e.g., optimal birth spacing, postabortion care, expanded method mix, family planning counseling);
- increased access to reproductive health services and products;
- improved quality standards in the different services by programmatic area;
- impact of services on contraceptive use.

IR 2: Increased capacity for informed FP/RH decision making by clients and communities

Regarding IR2, the focus is on:

- level of community participation in the design, implementation and/or evaluation of RH services,
- changes in relevant behavior determinants and behavior at the client and community levels addressed by educational and behavior change communication (BCC) efforts; and
- links to nonhealth activities.

IR 3: The increased capacity of the public and private sectors to sustain quality FP/RH programs

Regarding IR 3, the focus is on:

- partnerships formed between the public, private and commercial sectors in support of the expansion and/or maintenance of RH services and products;
- support leveraged through those partnerships;
- clients informed and/or served through those partnerships; and
- when appropriate, the percent of self-sufficiency achieved by RH health programs.

IR 4: Scaled-up and Improved FP/RH Service Delivery through other Agency/Donor/Foundation Programs

Regarding IR 4, the focus is on:

- Adoption and expansion of evidence-based best practices through CATALYST programs;
- Support leveraged from the donor community in support of the expansion and adoption of those practices.

Gender is a cross-cutting theme and is integrated into the different activities particularly those associated with IR's 1 and 2.

Classification of Indicators

Indicators are classified into three basic categories: essential, tools for program management, and specific to grantee requirements. After collapsing indicators with similar or equivalent language, there is a universe of 26 essential indicators and over 100 indicators for program management and grantee requirements. Indicators classified as essential are those that will be reported to USAID on a regular basis as listed below under Reporting. CATALYST has identified in the M & E plans which indicators it considers essential.

Methodological and Practical Considerations

The current submission is based on guidelines established with the CATALYST Contract Technical Officer (CTO) at USAID after discussions on earlier versions of M & E plans. The guidelines for the revisions are attached. CATALYST commissioned additional expert reviews from Consortium members specializing in monitoring and evaluation to validate the revisions. This submission incorporates comments from those reviewers, Joseph Valadez (AED) and Cynthia Green (CEDPA). Responses to specific questions and issues raised by the CTO and by the external reviewers are attached.

The following methodological considerations are highlighted:

- **Behavior change:** From the behavior change perspective, emphasis is placed on actions undertaken by policy makers in support of CATALYST programmatic areas, the adoption of protocols by service providers, RH service-seeking and contraceptive use by clients, and actions undertaken by family members or the community at large in support of both service-seeking and contraceptive use.
- **Standardized instruments:** The measurement of provider performance may include measures of competence and proficiency as defined by the Quality Assurance Project and could be based on an approach similar to the QIQ methodology developed by the Measure Project. The emphasis will be on standardized instruments for evaluating provider performance. For example, Pathfinder has developed observation checklists for evaluating compliance of providers to the clinical and counseling guidelines for PAC services. They have been tested in both Bolivia and Peru. These guidelines would be used and adapted, if need be, to the scale-up of the PAC model in other countries.
- **Qualitative approaches:** Qualitative approaches to data gathering will be used to complement quantitative data. This is particularly appropriate in situations where interventions are exploratory in nature, where the intervention is responsive to contextual needs and may vary from site to site, or where the intervention is clearly innovative. A perfect example of this situation is the evaluation activities

connected to the community element of PAC services. Another example is the Documentation Report on The Pilot Integration of Injectables into CBD Projects in Uttar Pradesh, India.

- **Conferences:** The focus on evaluating conferences will be two-fold. One, a knowledge pre-post test before and after the conference. And two, a delayed follow-up 6 and 12 months following the conference to focus on actions undertaken as a result of knowledge and attitudes changed by the conference.
- **Publications:** The evaluation of publications is limited to the PAC Consortium newsletter. That evaluation will focus on measuring use of the newsletter, new knowledge acquired through the newsletter, and actions undertaken based on knowledge acquired.
- **Practical Considerations:** No tracking sheet was developed for activities in the work plan that are still under discussion, that reflect tasks CATALYST staff need to perform as part of their responsibility, or that require minimal involvement by CATALYST. Indicators for activities, which are yet to be defined or are under negotiation are included for contextual clarity and are marked illustrative (e.g., PAC Initiative: Community Service Provider Partnerships, Redplan Peru Phase 2).

M & E SYSTEM REPORTING

There are three types of M&E Reports.

- **Annual Reports on Essential Indicators.** The M&E System will generate these reports annually in the month of September, prior to the Annual Results Review and the Management Review. Special biannual reports on the essential indicators will be submitted when the status of activities contributing to results measured by the essential indicators requires it and by a programmatic decision made by the Activity Director.
- **Special Evaluation Reports.** These reports are related to specific activities and respond, with a few exceptions, to the interests of country programs. They are completed for annual activities, activities of special interest and those that are innovative in nature. Examples include: Redplan Phase 1 Evaluation Report, Final Evaluation Report on the Expansion of Method Mix in India or the Romania OBSI Grant Final Evaluation Report. Note that for Special Evaluation Reports written in foreign languages, Executive Summaries in English will be generated. Included in the attachments is a timeline for the delivery of Special Evaluation Reports for core-funded activities, Bolivia, India and Peru. This timeline will be included in the performance monitoring system created for the overall CATALYST Project. The list of Special Evaluation Reports in the timeline will be updated when final decisions are made regarding the recipients of PAC grants and the sites for the PAC partnerships,
- **Results Summary Sheets.** These will be generated for management including the status of all indicators. These reports will be generated biannually to coincide with field submission of updated information pertaining to training and service statistics as well as findings of special evaluations.

IMPLEMENTATION OF M&E ACTIVITIES

Personnel and Responsibilities

The M&E staff is comprised of a Senior Evaluation Advisor and an Evaluation Advisor at CATALYST headquarters plus an Evaluation Officer in countries with complex programs. As of May 2003, Egypt and Peru have local Evaluation Officers and an Evaluation Officer will be hired in Pakistan.

The Washington-based M&E staff focus on the evaluation of the core funded activities, provide support to other research activities financed with core funding (e.g., Case Study on Profamilia's Role in Health Sector Reform in Colombia), and interact with the field-based evaluation staff to develop and implement M&E Plans for the different country programs. In countries where there is no resident M&E staff, the staff provide direct assistance in the design and implementation of M&E activities and/or provide support to hired consultants.

The DC-based evaluation staff integrate information on plans and results generated by the country programs to similar information generated by core funded activities, and provide M&E reports to USAID/W. They also participate in the preparation of work plans as well as results and management reviews. The responsibility for completing M&E products receiving core funding resides with the Washington-based M&E staff. By the same token, the responsibility for completing M&E products in the country programs resides with local Evaluation Officers. The Washington-based staff have provided and will continue to provide technical assistance in the selection of appropriate methodology, instruments and data analysis.

Research and Evaluation Advisory Panel

The Research and Evaluation Advisory Panel has three main functions.

Review of M&E Plans. This review can include and not be limited to: appropriateness of evaluation objectives and questions given CATALYST's mandate and IR's; approval of indicator typology to inform different stakeholders; and adequacy of methods to respond to evaluation questions and selected indicators.

Advise on Research Design, Methods and Data Analysis. The panel can be consulted on the research design and data analysis plan for specific studies. When consulted on this matter, the panel may suggest optimal research designs to attribute changes to interventions and alternatives to data analysis to identify relationships and possible causal links between variables.

Definition of OR Objectives and Content. CATALYST faces the need to explore issues pertaining to the efficiency of its programs through operations research. The panel will provide guidance on which OR studies to pursue and how to implement the activities.

Upon approval of this submission, the panel will be convened to approve the indicator typology. The major task of the panel during this meeting will be to reduce the universe of indicators CATALYST had identified as essential to a manageable number. For this

purpose, it will be comprised of representatives from four institutions: USAID, CATALYST, a CA specializing in measurement, and a CA specializing in research in the reproductive health field. For other matters, members of the panel may change to include, for example, the Evaluation Officers from Advance Africa or the Evaluation Officer of YouthNet, or other projects funded by the USAID/Global Health Bureau.

CHALLENGES AHEAD

Development of the Database: The tasks ahead of us are challenging. As part of the M&E System, CATALYST will develop a database containing information for all the indicators. The structure of the database is already under consideration and will be determined after the review of parallel databases is completed and in consultation with and shared with field offices. The latter will be in charge of updating the information in the database and submitting to Washington periodically for management of the data at the central level. Information pertaining to core-funded activities will be updated regularly as well. A mini-manual providing definitions for the indicators and providing guidance on how to input the data into the database will also be generated.

Core and Field Data Requirements for Measuring Progress. CATALYST implements both new and inherited country programs. Cambodia, Egypt, Iraq, Laos and Pakistan and Iraq belong to the first category. Bolivia, India and Peru belong to the second. Harmonizing the data requirements needs for central reporting with country programs will be more challenging in the inherited programs. Suggestions for making changes concerning what is reported and how it is reported will require further negotiations. These negotiations may include funding decisions (e.g., levels and sources).

Funding Constraints: A table summarizing funding levels by funding source for evaluation activities is attached. This table includes only the funding for the evaluation activities pertaining to the M & E plans submitted at this time. The information is incomplete since we have no firm cost estimates for evaluation activities in India. Information available suggests, however, that core budget is assuming responsibility for a major portion of the funding. Missions need to provide additional support for evaluation activities. Additional funds will be required from the Mission in Bolivia, Peru and India to cover a larger proportion of the cost of evaluation activities. CATALYST will develop more detailed budgets and request CTO assistance in obtaining additional field funding.

Attachments:

1. Table 1: Timeline of Evaluation Products Included in Submission by IRs

Attachment 1

Table 1 - Timeline of Evaluation Products Included in Submission by IR's

IR 1	FY 02-03	FY 03-04				FY 04-03
	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1
OBSI						
◆ Bolivia Grant, Final Evaluation Report (Full report in Spanish, Exec Summary in English)				x		
◆ Bolivia Grant, Midterm Evaluation Report (Full report in Spanish, Exec Summary in English)			x			
◆ Guatemala Conference Evaluation Report: Changes in Knowledge		x				
◆ Peru Grant, Final Evaluation Report (Full report in Spanish, Exec Summary in English)						X
◆ Peru Grant, Midterm Evaluation Report (Full report in Spanish, Exec Summary in English)				x		
◆ Romania Grant, Final Evaluation Report						X
◆ Romania Grant, Midterm Evaluation Report					x	
PAC						
◆ Case Studies Community Component (Countries to be determined)						X
◆ Global: Synthesis of Lessons Learned, Implementation of Community Component						X
◆ Global: (Full report in Spanish, Exec Summary in English) Newsletter Readership Report						X

	FY 02-03	FY 03-04				FY 04-05
IR 1	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1
◆ India, Final Evaluation Report on the Expansion of the Method Mix in Pilot Projects in Jharkhand						x
◆ Peru, EMM in Emergency Centers Evaluation Report (Full report in Spanish, Exec Summary in English)		x				x
Other Reproductive Health Programs						
◆ India, Case Study on the Integration of HIV/AIDS Prevention into RH Services						x
◆ Peru, Accreditation and Certification Midterm Evaluation Report (Full report in Spanish, Exec Summary in English)					x	
◆ Peru, Accreditation and Certification Final Documentation Report(Full report in Spanish, Exec Summary in English)						x
	FY 02-03	FY 03-04				FY 04-05
IR 2	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1
◆ Bolivia, Army Trainers Midterm Evaluation Report(Full report in Spanish, Exec Summary in English)					x	
◆ India, Evaluation Report on the Development and Implementation of AH/FLE Training Plan in Utter Pradesh						x
◆ Peru, Alcance Follow-up Evaluation Report(Full report in Spanish, Exec Summary in English)		x				
◆ Peru, Cooperandes Evaluation Report(Full report in Spanish, Exec Summary in English)			x			
◆ Peru, Kallpa Hotline Evaluation Report(Full report in Spanish, Exec Summary in English)	x					
◆ Peru, YES Stations, Final Evaluation Report (Full report in Spanish, Exec Summary in English)	x					
	FY 02-03	FY 03-04				FY 04-05
IR 3	Qtr 4	Qtr 1	Qtr2	Qtr3	Qtr4	Qtr 1
◆ India, Documentation Report on Employer Sector Projects						x
◆ India, Evaluation Report on Training Quality of Modal NGO's						x
◆ Peru, REDPLAN Final Evaluation Report (Full report in Spanish, Exec Summary in English)	x					
◆ Peru, Social Marketing of Contraceptives and Antibiotics for STI's, Evaluation Report (Full report in Spanish, Exec Summary in English) (Full report in Spanish, Exec Summary in English) ¹⁶						

Note: CATALYST has M&E plans at the field level for Mission buy-ins.

¹⁶ Production and delivery dates to be determined.

APPENDIX G

REFERENCES

REFERENCES

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POPTech POPULATION TECHNICAL ASSISTANCE PROJECT

1101 Vermont Ave., NW Suite 900 Washington, DC 20005 Phone: (202) 898-9040 Fax: (202) 898-9057 www.poptechproject.com