Population Services International (PSI)
Support for International Family Planning Organizations 2: Sustainable Networks (SIFPO2)
April 2014 to April 2019

Year-Two Annual Report:
October 1, 2015 to September 30, 2016
(January 2017 Revision)

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Acronyms

ACT	Artemisinin-based combination therapy
ADEMAS	Agency for Development and Social Marketing
AE	Adverse event
AGYW	Adolescent girls and young women
AHME	African Health Markets for Equity
ASF	Association de Sante Familiale
BOD	Board of directors
BTL	Bilateral tubal ligation
CBO	Community-based organizations
CDHS	Cambodian Demographic Health Survey
CEO	Chief executive office
CHPs	Community health promoters
CM	Community mobilizers
CME	Continuing medical education
CMS	Clinic management system
CNAA	Contraceptive Security Commission
CYP	Couple years of protection against unintended pregnancy
DFID	Department for International Development
DHIS2	District Health Information System 2
DHS	Demographic Health Survey
DIB	Development impact bond
DRC	Democratic Republic of the Congo
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSRSE	Department of Reproductive Health and Child Survival
E2A	Evidence to Action
EC	Emergency contraception
EMR	Electronic medical record
EVD	Ebola Virus Disease
FP	Voluntary family planning
FP2020	Family Planning 2020
FPW	Family planning workforce
GBV	Gender-based violence
HANSHEP	Harnessing Non-state Actors for Better Health for the Poor
HC3	Health Communications Capacity Collaborative
HMIS	National Health Management Information System
HNQIS	Health Network Quality Improvement System
HQ	Headquarters
HR	Human resources
HSS	Health system strengthening
HTS	HIV testing services
IBP	Implementing Best Practices
ICEC	International Consortium for Emergency Contraception
ICFP	International Conference on Family Planning
ICRW	International Center for Research on Women
IPC	Interpersonal communication
IPPF	International Planned Parenthood Federation
IQAF	Integrated quality assurance framework
IRH	Institute for Reproductive Health
IUD	Intrauterine device
KCCA	Kampala Capital City Authority
LARC	Long-acting reversible contraceptive method

LARC/PM CoP	Long-acting reversible contraceptive and permanent method community of practice
LLIN	Long-lasting insecticidal nets
LMIC	Low and middle income countries
LNG-IUS	Levonorgestrel intrauterine system
M&E	Monitoring and evalutaion
M360	Medicines 360
M4M	Metrics for Management
MC	Method choice
mHealth	Mobile health
MI	Motivational interviewing
MIS	Management Information Systems
MoH	Ministry of Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Equality, Elderly, and Children
MoUs	Memorandums of Understanding
MSI	Marie Stopes International
MVU	Mobile video unit
NAA	National Aids Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	Non-governmental organization
NMCHC	National Maternal and Child Health Center
NMI	Non-monetary incentive
NSV	Non-scalpel vasectomy
OC	Oral contraceptive
OCP	Oral contraceptive pill
PBCC	Provider behavior change communication
PM	Permanent method
PMTCT	Prevention of mother-to-child transmission
PNSR	National Program for Reproductive Health
PP	Post-partum
PPFP	Post-partum family planning
PPIUD	Post-partum intrauterine device
PPP	Public-private partnership
PRH	Population and Reproductive Health
PSI	Population Services International
PSI-C	Population Services International in Cambodia
PSI-TZ	Population Services International in Tanzania
PSK	Population Services International Khmer
QA	Quality assurance
QIP	Quality improvement plan
R4D	Results for Development
RFQ	Request for quotation
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SAE	Serious adverse event
SBCC	Social and behavior change communication
SC	Supply chains
SF	Social franchising
SFH	Society for Family Health
SFMWG	Social Franchise Metrics Working Group
SIFPO2	Support for International Family Planning and Health Organizations 2
SMO	Social marketing organization
SMS	Short-message service
SPIRES	Standford Program for International Reproductive Education and Services

SQHN	Sun Quality Health Network
SSV	Supportive supervision visits
STI	Sexully transmistted infection
TA	Technical Assistance
TB	Tuberculosis
TMA	Total Market Approach
ToT	Training of Trainers
UCSF	University of California, San Francisco
UHC	Universal health coverage
UHF	Uganda Health Federation
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WHO	World Health Organization
WHP	World Health Partners
WRA	Women of reproductive age
Y	Youth
YFHS	Youth-friendly health services
YW	Young women

Annual report summary: October 2015 to September 2016

The Support for International Family Planning Organizations 2 (SIFPO2): Sustainable Networks, year-two annual report describes activities implemented by Population Services International (PSI) and its partners: Stanford Program for International Reproductive Education and Services (SPIRES), the International Center for Research on Women (ICRW), Results for Development (R4D), and PharmAccess.

SIFPO2 works to strengthen voluntary family planning (FP) programs and other health services worldwide, with a focus on strengthening private sector channels, including social franchise networks. SIFPO2 is committed to the principles of voluntarism and informed choice in FP and reproductive health (RH) while reaching underserved populations, particularly youth, across the 24 Population and Reproductive Health (PRH) Priority and Ouagadougou Partnership Countries.

Year-two activities are anchored in SIFPO2's foundational themes of: expanding method choice (MC) within the context of informed choice; wide-reaching social and behavioral change communications (SBCC); strengthening the FP workforce; supporting a total market approach (TMA); leading with evidence; expanding access for youth; promoting gender equality; increasing health financing for FP; and reinforcing social franchising (SF). Project activities are implemented through field support in Benin, Cambodia, Democratic Republic of Congo (DRC), Ghana, Guatemala, Malawi and Swaziland and with core funding in DRC, Mali, Mozambique, Senegal, Uganda and Zambia.

SIFPO2 has an impact across all countries where PSI implements FP projects. Below are some highlights of work during this reporting period:

MC: In year two, PSI expanded post-partum intra-uterine device (PPIUD) services in Mali and designed a PPIUD training program for Haiti. In addition, the foundation was laid for introducing levonorgestrel intrauterine system (LNG-IUS) to PSI's network members in Nigeria and Zimbabwe. PSI continues to lead and promote method choice through its role as secretariat for the Long-acting Reversible Contraceptives (LARC) and Permanent Methods (PM) Community of Practice (CoP), which, in 2016, focused on task sharing and youth.

SBCC: In year two, PSI used SBCC to generate demand for voluntary FP among women, girls, men and boys. This included providing input into the Health Communications Capacity Collaborative (HC3) Service Communication Implementation Kit, developing a communication plan for the upcoming Sayana Press introduction in Benin, and in Malawi conducting 42 SBCC activities reaching 100,410 youth with SBCC messages, among others.

Family planning workforce: PSI built capacity for its staff around the world to better serve FP clients by piloting an expanded quality assurance (QA) system and integrating SafeCare in Uganda, as well as strengthening capacity around data use for program management through a training for staff in Benin, DRC, Mali, Madagascar and Senegal. PSI also worked to support the FP workforce through the prototyping of a continuing medical education (CME) video component that will enhance provider supportive supervision.

Quality assurance: In year two, PSI developed QA leadership positions in each region to provide technical support and service delivery to regional programs with the support of PSI's global medical director. In the last year, these regional leads have led quality assurance audits in five countries: Nepal, Tanzania, Ethiopia, Nigeria and Mozambique. PSI also developed a technology-based quality management tool containing a clinical checklist for every FP/RH service offered, bringing standardization in quality across PSI's entire global service delivery network.

TMA: In year two, PSI has been developing and globally disseminating its work on TMA via the UNFPA-USAID working group on TMA and various other forums, including a SIFPO2-funded regional workshop on TMA for FP for PSI network members in Asia. At the country level, with SIFPO2 core support, PSI has

been applying a TMA for FP work in Senegal, Cambodia and Mozambique, primarily by undertaking total market landscaping, based on the PSI production-to-use spectrum. One notable success from this work, is an enhanced government strategy for FRPH in Senegal.

Leading with evidence: Guided by both its organizational priorities and those of PRH, PSI has increased its use of DHIS2, not only for monitoring and accountability, but also for improved decision making. In year two, PSI worked to integrate an mHealth e-referral system with DHIS2 in Nepal and Tanzania, as well as additional training in Cambodia.

Youth: In year two, PSI continued to scale up youth-friendly health services (YFHS) by training staff from nine Francophone countries to mainstream YFHS in the public sector and private franchise networks. Following the year-one and year-two trainings-of-trainers in YFHS, staff in 16 African countries trained 1,199 providers and 235 referral agents in YFHS. PSI also launched a partnership in Mozambique to make pharmacies youth-friendly, conducted youth mystery client studies, and incorporated standards related to the inclusion of youth in PSI's global QA system for FP.

Gender equality: In this reporting period, PSI developed a mixed-media campaign in the Democratic Republic of Congo (DRC) to constructively engage men as users and supporters of FP. This included the integration of FP messages into a popular national Congolese television show. PSI and ICRW also disseminated the results of a couple communication study that focused on men married to adolescent girls in Zambia.

FP and health financing: During this period, R4D worked collaboratively with the PSI country platforms and local government agencies in Nigeria, Tanzania and Uganda to advance priority options for the sustainable financing and delivery of voluntary FP services.

Social franchising: PSI continued to invest in the Tunza Social Enterprise in East Africa both with a vision of more sustainable and equitable access to quality health services, as well as a view to strengthening the network's ability to sustainably leverage public financing opportunities. In year two, SIFPO2 also directly supported work on the EquityTool to better understand the wealth profile of clients and make resource allocation decisions.

PSI thanks USAID for its continued support in these areas, which enables PSI, its network members and its partners to grow these activities in a way that achieves a wide-ranging and catalytic impact.

SIFPO2 results framework

Result 1: Strengthened organizational capacity to deliver high quality FP/RH and other services to target groups

- 1.1 Global organizational systems that strengthen FP and other health program performance improved, streamlined and disseminated
- 1.2 Innovations, tools and approaches for delivering FP services to target groups tested, implemented and disseminated

Result 2: Increased sustainability of country-level FP and other health programs

- 2.1 Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged
- 2.2 Capacity of local partners to provide quality FP and other health services built
- 2.3 Innovative partnerships to strengthen service delivery networks pursued

Success stories

SIFPO2 PSI at the International Conference on Family Planning (ICFP)

In January of 2016, a group of PSI staff attended ICFP in Bali, Indonesia to contribute to and learn from the collaborative global knowledge on FP efforts around the world. With SIFPO2 funding, PSI presented research, participated in events, and facilitated an interacti
ve booth.

PSI presented findings on seven topics. On health system strengthening in DRC, findings showed that 57% of FP clients get their method through the private sector, and that franchised clinics and pharmacies delivered 600,000 CYPs over four years. PSI also shared results from Guatemala on a public sector task sharing project that enabled auxiliary nurses to offer LARCs, ultimately increasing service volume while maintaining both quality and informed choice. From this study, the government agreed to change policies and pre-service curriculum.

On using technology to improve health outcomes, PSI researchers presented on DHIS2, which improves evidence-based decision making, reduces costs, improves effectiveness and makes it easier to access and use data. SIFPO2 staff showed how, in Mozambique, mHealth has enabled more rapid use of program monitoring data for decision-making and client exit interviews at scale, leading to improved performance at multiple levels.

PSI also presented results of a SF study in Kenya, with findings that suggest that franchising helps private providers expand their businesses and serve more clients with a wide range of voluntary FP options. Researchers from Ethiopia presented the results of an FP/HIV service integration project for female sex workers, which resulted in many women voluntarily choosing to adopt a FP method.

In collaboration with other global organizations, PSI helped to lead sessions and events around voluntary FP for youth: PSI, FHI360, E2A, USAID, and WHO organized a session on the scale-up and sustainability of approaches for youth-friendly contraceptive service delivery. During the breakout sessions, PSI-Madagascar shared its work on making youth-friendly services available in private franchised clinics with integrated health service delivery.

PSI and other partners launched a consensus statement supporting the expansion of contraceptive choice for young people to include LARCs. At present, more than 50 leading global health and development organizations have endorsed the statement. At ICFP, PSI co-led an event to celebrate this statement.

Lastly, PSI operated an interactive booth that brought visitors through a day in the life of a woman we serve who benefits from integrated services and a TMA. The booth also engaged visitors to identify what FP and UHC coverage meant for them, and culminated in a wall of these ideas.

Advancing technology to improve quality and assist decision making

PSI has developed the tablet-based Health Network Quality Improvement System (HNQIS), which is designed to work with PSI's other QA tools and resources to support quality improvement across all health areas, including FP. In year two, PSI:

Finalized the development of the HNQIS app for Android: The complete app is now available for PSI quality assurance officers on Google Play to download directly on their Android tablets.

Successfully launched HNQIS in Nigeria, DRC, Kenya, Cambodia, Zimbabwe, and Tanzania, and conducted baseline assessments in each. Preliminary data from Kenya, where the app was first launched, is expected soon.

Finalized the development of health area checklists: In line with international standards, PSI's global standards and respective national guidelines for quality care, the content development for key health areas was completed and approved for use at the country level. Currently the HNQIS app caters for the following health areas with the expectation to add to this list in the near future: family planning, maternal and neonatal health, newborn resuscitation, integrated management of childhood illness, malaria, HIV, voluntary medical male circumcision, sexually transmitted infections, tuberculosis, cervical cancer, hypertension.

Conducted system administrator training: In countries where HNQIS has been launched, the core team has identified the HNQIS staff to support the use of the app from a technical point of view. PSI has conducted remote trainings to capacitate the HNQIS System administrator in managing users, organization units and day to day troubleshooting. An HNQIS administration training manual has been developed for this training. The HNQIS administration has worked to finalize the configuration of users and organization units in PSI's DHIS2 instance. Users receive log-in credentials when they download the app from Google Play, and are able to log into the system and see the health facilities and services for which they supervise.

Conducted end-user trainings and developed an end-user training manual: PSI has successfully carried out end-user trainings in Nigeria, Kenya, DRC, Tanzania, Zimbabwe and Cambodia. At training closure, they received training manuals as a reference material to support them during their supervision visits. The manual supports quality assurance officers in using the HNQIS app to conduct supportive supervision visits, give feedback for improvement as per areas identified, monitor providers' progress over time, and schedule follow-up visits according to a prioritization matrix that takes into account providers' quality of care score and client load.

Developed data-to-action framework: The HNQIS app has been developed for tracking and improving quality at facility level. Data collected from HNQIS is linked with DHIS2. Data analysis conducted in DHIS2 allows project managers to inform their decision making progress based on the most up-to-date information on quality of health service provision by providers. Based on data users' need to inform their decision-making process, PSI has worked to develop a data-to-action framework (D2Af) for HNQIS data users. The D2Af aims to link HNQIS indicators with activities that follow in order for the project managers to make evidence-based decision. The D2Af also offers a list of visuals that help project managers in tracking progress. These visuals are the ones that appear on PSI's DHIS2 server, so that the D2Af acts as a link between quality indicators and evidence-based decision making. In conjunction with the development of the D2Af, data user training has been carried out in both DRC and Nigeria with the anticipation of carrying out user trainings in other countries once their baseline assessments are complete.

Year-two activities and progress

Result 1: Strengthened organizational capacity to deliver high quality FP/RH and other services to target groups

Sub-Result 1.1: Global organizational systems that strengthen FP and other health program performance improved, streamlined and disseminated

1.1.1. Pilot expanded QA system in one USAID PRH priority country

Anticipated year-two outputs:
A. Adapted QA system developed
B. Health area standard operating guidelines developed
C. Framework for integrated service delivery QA alignment developed

Year-two progress on outputs (October 2015 to September 2016):

PSI continues to expand its QA system to accommodate its growing networks and increasing scope of FP and integrated services, with an eye to creating a more sustainable, locally governed mechanism.

An integrated quality assurance framework (IQAF) is the foundation upon which PSI's health areas and social franchises streamline and improve QA strategies and programs. This integrated framework will be based on PSI's six quality standards for health care service delivery, and how the standards apply to each health area. (The six standards are: operational excellence, technical competency, client safety, informed choice, privacy and confidentiality and continuity of care.) The IQAF will outline how PSI's technical teams can collaborate, share resources and plan activities, both at the country level and at headquarters (HQ). Additionally, the IQAF will suggest quality management tools and techniques that will increase efficiency and encourage local participation among multiple health areas that impact uptake of FP.

In this reporting period, there were two distinct phases in the work related to IQAF. In the first phase, PSI engaged a consultant to build on the 2015 IQAF work, and prepare structured guidelines utilizing the six set standards across multiple health areas for which PSI provides services (1.1.1.A). PSI then created a framework and suggested processes to facilitate the integration of multiple health areas and their quality management processes (1.1.1.C). The second phase was aimed at implementing these guidelines in a particular country setting to test the applicability of the framework and further refine the overall quality management structure to suit practical requirements of health service delivery in a low and middle income (LMIC) setting. For the purpose of this activity, Uganda was chosen as an area that could provide the best learning possible environment to leverage this opportunity.

Thus, a separate project was designed to include new health areas using the newly defined quality assurance framework. The permanent FP method of using bilateral tubal ligation (BTL) along with maternal health and cervical cancer (1.1.1.B) were selected for this purpose. The exercise summarized quality checklists so that they are user friendly, and align with the PSI global standards. The quality improvement plan (QIP) utilized the PSI global health standards and standard-based management and recognition (SBMR) methodology used by JHIEPGO. This particular step used the existing quality manuals as background and looked at the IQAF materials provided, the PSI LARC manual and the PACE Uganda QIP manual in totality, to eliminate redundancies. The end goal was to create an abridged version of the PACE QIP manual that addresses the challenges raised by the quality assurance officers, such as the 'bulkiness' of the QIP tools that can occur with an integrated QA framework, as well as the lack of a simplified scoring system. The drafted QIP manual was then shared within the PACE Uganda network for feedback and inputs.

The next planned steps for this activity are to organize a one-day meeting with relevant PACE QA staff to consider suggested revisions and a follow-up workshop after the development of the QIP to disseminate the report to PACE staff and selected ProFam providers.

1.1.2. Integrate SafeCare with PSI's QA Approach in one USAID PRH priority country

Anticipated year-two outputs:
A. Pilot of SafeCare QA approach integrated with PSI's QA approach in one country
B. Recommendations for improved cost efficiency of implementing SafeCare

Year-two progress on outputs (October 2015 to September 2016):
Through its close collaboration with Uganda Health Federation (UHF) and PSI's implementing partner in Uganda, PACE, PharmAccess initiated SafeCare in 47 facilities in Uganda within the last year (1.1.2.A). In order to expand SafeCare to improve the overall quality of health facilities cost-effectively, the pilot focused on building the capacity of local parties, UHF and PACE, to implement SafeCare. The year's activities focused on conducting initial assessments, developing QIPs and beginning to mentor the facilities to implement the improvements needed to move to a higher level in subsequent assessments.

At the beginning of year two, the UHF team assessed clinics with close PharmAccess support, and by June 2016, the UHF assessors were comfortable and competent performing basic SafeCare assessments alone, increasing the cost-effectiveness of conducting the assessments (1.1.2.B). Initial assessment data as well as QIPs for facilities assessed were reviewed by PharmAccess Amsterdam, as part of ongoing mentorship for the two UHF assessors. However, during Q4, the review activities were transferred to PharmAccess Nigeria, again lowering the cost of the overall program and facilitating south-south partnership.

Facility quality improvement spotlight: Span Medicare Clinic

Based on the assessment findings from Span Medicare Clinic's initial assessment, a 38-activity quality improvement plan was developed. These activities relate to patient rights, emergency preparedness and measures for infection prevention. In addition, they included risk reducing activities related to MNCH and operating theater services.
The facility began implementing the quality improvement activities by April 2016. By September 2016, 65% of the activities had been implemented, while nearly all remaining activities were being worked on. The activities in their implementation plan include: increased awareness of patients rights through a new patient rights charter and improved privacy for patients; procurement of resuscitation equipment and training for staff so they are prepared and skilled to use the equipment correctly in emergencies; development of standardized policies for infection prevention control; and guiding documents for MNCH staff. PharmAccess and PACE staff will use the success of this clinic to motivate other clinics in the coming months.

As a part of the development of more cost effective and efficient facilitation models and tools, staff from PharmAccess Nigeria were introduced to the UHF and PACE team. In Nigeria, PharmAccess have piloted

the use of WhatsApp for remote facilitation interactions. In year three, the goal is to set up a similar pilot in Uganda, connecting healthcare facilities to PACE facilitators, allowing them to communicate with a group of facility owners simultaneously to actively engage them in particular quality improvement topics, and stimulate social and peer-to-peer learning.

In August 2016, PSI and PharmAccess HQ staff met with PACE staff in Kampala to evaluate progress and plan ahead for the coming program year. During the meeting, the parties agreed to focus on the following:

- Cost-effective implementation of QIPs, either in the form of the WhatsApp group or another innovation
- Alignment of the available business tools and support to the facilities with PACE and UHF;
- Establishment of data sharing and systems integration between the SafeCare database AfriDB at PAI and DHIS2 at PACE;
- Advocacy to stimulate the alignment of the government's self-assessment tool and the SafeCare standards and the development of a licensing agreement for SafeCare activities for UHF;
- Continued support from SafeCare to the PACE team in both onsite and remote facilitation approaches, using SafeCare quality improvement support tools, covering both clinical and business related aspects; and
- Continued discussions between PharmAccess and UHF, focusing on the licensing agreement for the usage of SafeCare standards, methodology and tools outside and beyond the scope of the SIFPO2 program.

1.1.3 Enhance quality monitoring through improved data collection: A Health Network Quality Improvement System (HNQIS)

Anticipated year-two outputs:

A. Enhanced provider feedback component on the tablet that incorporates video-based coaching
B. Planning component on the tablet that facilitates prioritization of visits
C. Full QI System deployment to at least one SIFPO2 priority country

Year-two progress on outputs (October 2015 to September 2016):
SIFPO2's continued support of PSI's HNQIS application has been critical to finalizing technical components and to positioning this tool as PSI's institutional approach to quality improvement. In accordance with SIFPO2 deliverables, HNQIS is fully deployed and in use in Kenya (1.1.3.C). Four other PSI network members, Cambodia, DRC, Nigeria and Tanzania, are in the final stages of preparation for full deployment in the field. HNQIS will be in use in these four countries by January 2017.

The HNQIS's planning component (1.1.3.B), which facilitates prioritization of visits based on client volume and quality scores, has been finalized. The latest application release offers enhanced features for increased user-friendliness and accuracy.

During the last reporting period, PSI enhanced the provider feedback component to include video-based coaching (1.1.3.A). Given that PSI is seeking ways to make sure HNQIS remains relatively "light" and does not take too much time to load or consume too much battery life, PSI has identified a way to store these videos outside of the HNQIS app so it will not interfere with the app's performance. Significant technical developments to introduce this feature took place during this reporting period, and it will be field tested in December 2016. Piloting this feature among live HNQIS countries will take place in Q1 2017; PSI will ensure that it receives feedback from the field on how this feature can enhance provider feedback and complement individualized provider behavior change communication (PBCC) strategies.

1.1.3.1 Strengthening FP referral systems in PSI

Anticipated year-two outputs:

A. A survey of the methods employed, both within PSI and in wider literature

B. A pilot in one PSI Network Member based in USAID Priority RH country using technology aided referral tracking (the description of the method followed in the pilot will be available. The results from the pilot might not be available by the end of this work plan year, but PSI is confident it will launch the pilot this year).

Year-two progress on outputs (October 2015 to September 2016):
Creating strong referral systems are a key aspect of providing women with a wide range of FP services and products. Certain methods, like LARCs, are not available at health facilities and completed referrals are an important pillar of providing method choice and integrated service delivery. PSI has completed a literature review of referral methods, which is enhanced with PSI FP referral case studies to consider approaches used, as well as document lessons learned and best practices. By December 2016, the paper and a summary piece will be disseminated internally with the aim of helping network member decision makers identify which type or referral system, technology and processes might be most effective to increase access to FP products and services in their contexts (1.1.3.1.A).

In addition, PSI is developing an e-referral system in Tanzania to test strategies to improve interpersonal communication (IPC) agent-initiated referral completion and tracking (1.1.3.1.B). The e-referral system process flow follows these four steps:

- **Step 1, Issuing the referral:** The IPC agent meets the client, gathers her information and issues either a paper referral or electronic referral.
- **Step 2, Pre-redemption of the referral:** In this step, the client has the referral, but has not yet redeemed the referral. The system generates reminders to both the client and the IPC agent reminding them of the referral and its expiration date. In addition, expired referral reports are generated for the IPC agent.
- **Step 3, Redemption of referral:** During this step, the client goes to the health facility to complete the referral. Once the completion is recorded in the system, the client, IPC agent and the provider all receive thank you messages.
- **Step 4, Client follow-up and satisfaction:** In client follow up, a message is sent to successfully referred clients to provide further information regarding the FP method selected, including follow up appointments, information of adverse events and self care. For client satisfaction, a message is sent immediately to successfully referred clients to enquire if they are satisfied with the quality of the provider's service after a set period of time, the system will also enquire if they are satisfied with the FP method provided.

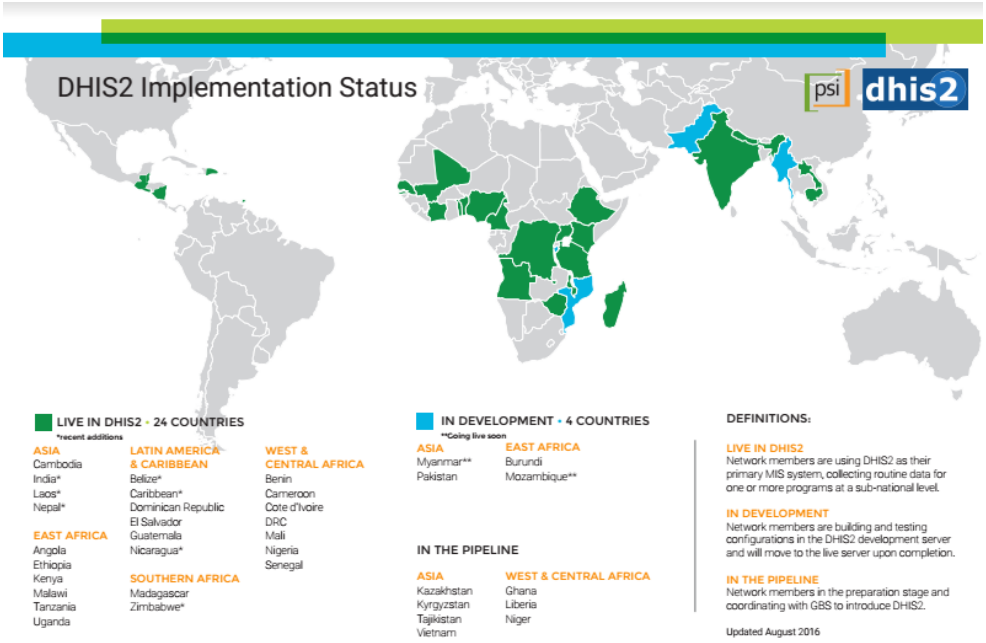
Approaches, lessons learned, and recommendations will be documented and can be shared with other SIFPO2 countries looking for ways to strengthen their outreach work.

1.1.3.2 Leading with evidence: Data for decision making skills for FP managers in Francophone Africa

Anticipated year-two outputs:
A. Workshop to drive FP/RH evidence-based decision making

Year-two progress on outputs (October 2015 to September 2016):
The Francophone West and Central Africa region Data for Decision Making Workshop for FP/RH managers took place in Dakar, Senegal, June 14 to June 17, 2016. Twelve participants from the USAID PRH priority countries of Benin, DRC, Mali, Madagascar, and Senegal attended the training. Two participants from Cameroon also attended, and their costs were covered by non-USG funding. The workshop was facilitated by a cross-disciplinary team that included the West and Central Africa Regional Evidence Lead, a Global Business Systems Program Manager, a FP Technical Advisor and the SIFPO2 Deputy Director.

The intent of the workshop was to drive evidence-based FP/RH decisions by strengthening capacity around data use for RH program management. More specifically, program managers were taught how to access and use the abundant data now available from DHIS2, client-based records and other sources; and in doing so, make decisions that have more impact, with greater efficiency. During the workshop, participants learned how they can efficiently make use of program data (both research and routine monitoring) and developed plans to increase data use, both within their teams and more broadly within their platforms, along with measurable indicators to follow up on these plans. The workshop also introduced the technical side of making dashboards within DHIS2 and the barriers and challenges staff face in analyzing data and making decisions. Participants left with their own customized D2Af to improve and implement.



The workshop evaluation showed that the project manager participants:

- Better understood ways to monitor programs, use data for decision-making, and use information systems to improve program performance
- Learned best practices for data visualization and dashboard development
- Improved technical skills on use of DHIS2 for data use

Workshop participants are now being followed by the West and Central Africa Regional Evidence Lead, in collaboration with local monitoring and evaluation (M&E) teams, to guide the implementation of their Data to Action Frameworks and to continue strengthening technical skills on data use and interpretation with DHIS2.

1.1.4. Support the FP workforce through implementation of PSI's CME program

Anticipated year-two outputs:

A. Plan developed for an eLearning CME application

B. Rapid prototyping session conducted in one PSI country where CME eLearning application will be piloted

Year-two progress on outputs (October 2015 to September 2016):

CME is an important tool for ensuring that FP providers are knowledgeable of the current contraceptive technology and are imparting the newest information through counseling and practice. PSI's network members currently provide CME via various mechanisms, including: feedback during supportive supervision visits, global webinars, and QA audits. Under SIFPO2, PSI has conducted a global landscape assessment that reviewed the use of CME in FP programming globally and within the PSI network. The results identified an opportunity for PSI to expand its CME work to technology-based CME via a new tablet-based supportive supervision system (called HNQIS, described in 1.1.3).

In year two, PSI identified CME FP videos that demonstrate FP procedures including IUD and implant insertion and removal, post-partum IUD insertion, and strong FP counseling. (1.1.4.A) These videos will

provide on-the-job coaching support with animated illustrations to demonstrate proper technique. Taking advantage of the presence/attendance of PSI staff from five countries in Washington D.C., PSI conducted a rapid prototyping session (1.1.4.B) among its five local QA experts who attended the QA strategy meeting in July. Prototyping how the videos will link to the checklists within the HNQIS system led to the new model that will be piloted in year three.

1.1.5. Enhance contraceptive security in the South East Asia region through a new FP product introduction using TMA

Anticipated year-two outputs:
A. Market plan developed for one new FP product

Year-two progress on outputs (October 2015 to September 2016):
In SIFPO2 year one, in partnership with Accenture Development Partners, PSI conducted a market assessment in Southeast Asia in order to evaluate how to strengthen PSI's capacity to support the total FP market in the region. In SIFPO2 year two, PSI used Accenture's findings to decide which FP product or products and countries to prioritize for exploration of the financial viability of a potential introduction. Comparing product price points with the ability to pay of each wealth quintile, the findings uncovered a potential need for a third generation oral contraceptive pill (OCP) that would be affordable for clients in the third wealth quintile in Cambodia.

In Cambodia, PSI and Population Services Khmer (PSK) reviewed market data gathered through the TMA process this year, culminating in an internal workshop in September 2016 that identified and prioritized market constraints. The analysis validated the need to introduce a third generation oral contraceptive pill as part of a range of voluntary FP products and provided insights in addition to those identified by Accenture. In Cambodia, 95% of all OCPs distributed in the market are second generation OCPs. Evidence indicates side effects are a major reason for all method discontinuation, and the same is true for OCPs, which have a 27% first-year discontinuation rate.

To guide the management of PSI's products and services in Cambodia and other countries, PSI developed a portfolio management tool which guides the journey from identifying new opportunities to grow the market for a health area like FP to developing an execution plan that addresses financial viability. The portfolio management tool includes a series of steps from market landscape analysis to identifying a solution with financial validation.

In the next quarter, PSI will spend out the year-two funds for activity 1.1.5 by using the portfolio management tool described above and completing the Cambodia OCP market introduction plan (1.1.5.A). No additional year-three funding is needed to complete this. After December 31, 2016, PSI will use its own resources to take forward the OCP introduction in Cambodia. As with many SIFPO2 activities, the injection of funding from USAID catalyzed action that will be continued with other resources. In this case, PSI-PSK aims to achieve full cost recovery for the OCP in Cambodia, contributing to the activity's goal of enhancing contraceptive security.

1.1.6. Continue collaboration in generating shared metrics for social franchising, through Social Franchise Metrics Working Group (SFMWG) and other groups

Anticipated year-two outputs:
A. A metric to measure 'additionality'
B. Increased use of wealth indices to measure equity
C. Pilot testing a unified approach to assessing clinical quality in social franchises

Year-two progress on outputs (October 2015 to September 2016):
PSI has continued its participation in the SFMWG, whose meetings this year were dedicated to defining and advancing the use of specific shared metrics, namely additionality and quality. The group is awaiting

results from a pilot test on the proposed approach for measurement of additionality (1.1.6.A), using Marie Stopes International's (MSI) Impact2 calculator, and has defined a scope of work to further a shared, efficient way of assessing FP service quality.

Finally, work on equity has heightened, due to PSI's leadership in designing a simplified way of assessing client socio-economic status, which has been converted into a mobile application (www.equitytool.org) (1.1.6.B). The EquityTool is a mobile or tablet-based app that can be used to quickly evaluate the relative wealth of program beneficiaries. Currently more than 35 countries are covered by the equity tool and another 10 countres will be soon.

1.1.7. Franchised clients in context: Understanding the wealth profile of health services clients, and the validity of rapid approaches to assess equity

Anticipated year-two outputs:
A. Study design and report on secondary analysis; potentially a draft publication
B. Study design of validation study, and selection of validation sites
C. Commencement of validation study

Year-two progress on outputs (October 2015 to September 2016):
As PSI and other franchisors systematically assess equity by capturing the wealth profile of their clients, questions emerge as to what an optimal client wealth distribution should be, and how franchise clients compare to other clients of health services in the public, private, or not-for profit sectors. In order to better understand this context and measure equity, PSI is making a comparative assessment of the wealth of health services clients.

To date, a study design has been developed (1.1.7.A), for a study to be conducted within the Tunza social franchises with PS Kenya. PSI has hired M4M to oversee the implementation of this research and conduct the analyses.

As a foundation for this study, M4M also conducted a literature review on all published and grey literature related to wealth assessments of patients seen in clinics for any kind of curative or preventive health service in Kenya between 2005 and 2016. Extensive data analyses of equity by health area, sector and channel in 13 additional countries that recently published a Demographic Health Survey (DHS) to provide additional context. A copy of this report was shared with USAID and profiled on the M4M website.

Upon completion of the secondary analysis, M4M designed client exit surveys to be conducted at identified franchise clinics in two geographic regions within the greater Nairobi area. In October to December 2016, interviewers will conduct rapid interviews with all patients who received care during one randomly selected eight-hour day. Surveys will include the new equity tool questions, augmented with a short number of demographic indicators and a limited selection of reasons for visit/care received at the facility.

The equity tool was developed by PSI, M4M, USAID and a wide range of stakeholders in year two of SIFPO2. Below is a recap and progress report on the Equity Tool:

Simplified tool to measure relative wealth.
The Equity Tool is a simplified method to measure the relative wealth of program beneficiaries. During the last year, PSI, M4M, and a collaboration of seven other organizations have focused on dissemination and implementation of the Equity Tool methodology, which maintains high agreement (Cohen's Kappa Statistic of ≥0.75) with the full DHS wealth index. The methodology was published in *Global Health: Science and Practice* in March, 2016. This article is supplemented by technical factsheets on the development of each individual country survey, available on the Equity Tool website (www.equitytool.org).

The tool was generated under the belief that the reduced survey is easier to answer than the full wealth index, and can be used in a household-based survey, client intake, or client exit interview. Given the

uptake of the tool to date, there is evidence this is happening. Through 17 trainings and webinars, the tool is promoted as an option for routine measurement of beneficiary wealth, such that programs can adjust their service delivery models after viewing the instantly calculated results on the mobile application.

Mobile-based tool. Led by M4M, data collection has been further simplified through the creation of a mobile phone/tablet-based survey format that aggregates and analyzes results for both national and urban-only populations. The tool works online and offline, and is currently available for 31 countries. By the end of 2016, the Equity Tool will be available for at least 35 countries, and for four countries, an updated survey, benchmarked to a more recent DHS survey, will be available.

Substantial uptake and use. Launched in December, 2015, the Equity Tool has more than 350+ users who have completed 37,000 surveys in 31 countries. The Equity Tool has been used by organizations such as Helen Keller International, the International Rescue Committee, and Blue Square to measure program performance and by research institutions such as the University of California, San Francisco (UCSF), BRAC University, and the Liverpool School of Tropical Medicine for technical projects.

Broad dissemination. The Equity Tool has been presented globally at conferences and meetings including the African Health Economists Association and the Global Health and Innovation Conference, and the World Bank, USAID, Norad, HANSHEP, the Gates Foundation, and many others through webinars supported by both PSI and the SFMWG. Visit www.equitytool.org.

1.1.8. Conduct a Francophone West Africa regional training-of-trainers (ToT) in YFHS

Anticipated year-two outputs:
A. Francophone West Africa training-of-trainers in YFHS conducted
B. French YFHS curriculum and tools revised as needed based on pilot experience and shared with francophone West African network members

Year-two progress on outputs (October 2015 to September 2016):
SIFPO2's efforts to scale up mainstreamed YFHS included a ToT for Anglophone and Lusophone Africa in 2015. This trip to Benin served as the Francophone version of the YFHS ToT (1.1.8.A).

PSI translated its YFHS TOT curriculum and tools into French and added time for participants to review and discuss the global consensus statement on Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception and the Evidence to Action project's publication, "Thinking outside the separate space: A decision-making tool for designing youth-friendly services." (1.1.8.B)

In Cotonou, Benin, from February 8 to 12, 2016, SIFPO2 hosted a five-day regional workshop to prepare PSI staff and partners to plan effective programs for and with youth and train healthcare providers in YFHS. This training provided an opportunity for country-to-country technical assistance. One of the two lead facilitators was a PSI Madagascar host country national who leads trainings of providers in YFHS in rural Madagascar.

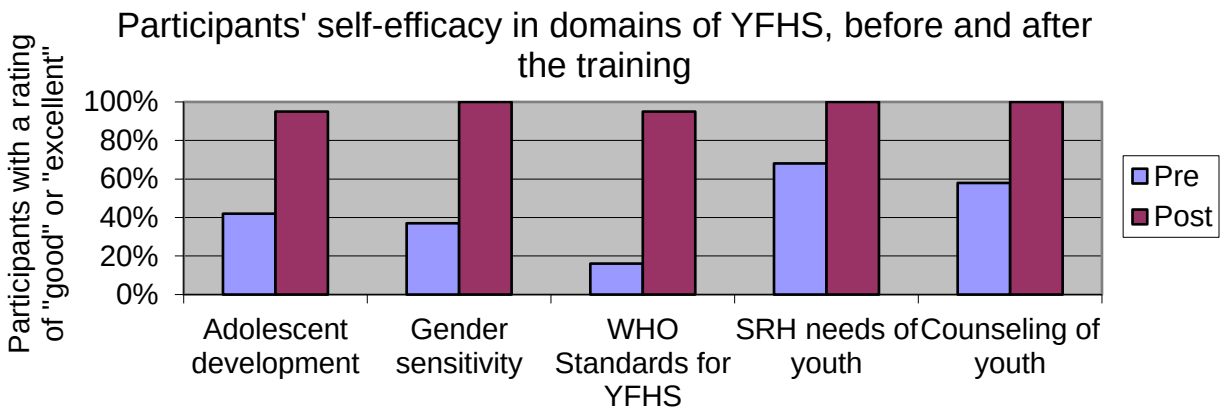
The workshop's 18 participants represented PSI's Francophone network members and three partners: the Senegalese and Beninese Ministries of Health, the International Planned Parenthood Federation (IPPF) Member Association in Benin. Participants came from the following eight PRH priority countries as well as Cameroon, which used KfW funding to attend: Benin, DRC, Guinea, Haiti, Mali, Niger, Senegal, and Madagascar (co-facilitator).

Youth from Benin played an active role in the training. Five adolescent and youth peer educators joined the training for all five days to share their perspectives on YFHS. The adolescent and youth participants included two young men and three young women, including an out-of-school youth.

Participants experienced all of the provider training activities, which utilized interactive training methods such as role plays, case studies, debates, small group work, and other participatory approaches. The training addresses providers' questions about young people and method choice and shares the global consensus statement on *Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception*. In addition, all participants practiced facilitating sessions and received feedback from their peers and instructors. Furthermore, participants separated into three groups to see YFHS and interview providers and staff at a PSI site, an IPPF network clinic, and a public sector site with mainstreamed YFHS.

Pre- and post-training assessments showed increases in self efficacy to train providers in the following YFHS topics (figure 1). Of the 22 participants (including youth) who filled out anonymous evaluation forms, 21 (95%) agreed that "The content was clear and easy to follow." All 22 participants reported agreement with the statements, "The workshop strengthened knowledge and skills that I will use," and "The facilitation techniques facilitated a good exchange of ideas and learning." Participants expressed that the values exploration exercises and site visits were particularly eye-opening.

Figure 1. Pre-/post-training responses to the question "How would you rate your level of knowledge and skills with regard to five YFHS topic areas"



Once the ToT was completed, PSI made minor revisions to the curriculum and disseminated it to Francophone network members (1.1.8B).

Following the ToT in Benin this year and Zimbabwe last year, participants returned to their countries, debriefed or trained their colleagues, and took steps using other funding sources to make contraceptive services youth-friendly. Results of the two workshops included:

- In 16 African countries, staff trained a total of 1,199 providers and 235 referral agents in YFHS.
- Staff assured the quality of YFHS through supportive supervision and, in some cases, quality audits that included youth standards, mystery client surveys comparing the experiences of younger and older mystery clients.
- The referral agents trained led activities to generate demand among youth and provided referrals that resulted in thousands of young people receiving a voluntary FP method of their choice from a youth-friendly provider.
- Staff in DRC provided technical assistance to their MoH to learn PSI's approach to YFHS and improve national provider training tools for YFHS. The team in DRC also worked with the MoH to incorporate tracking of age data for FP clients to allow better monitoring of programs.
- PSI/Mali trained providers from nine clinics in their social franchise in YFHS and organized a youth club associated with each clinic. Comparing the periods before and after the training, PSI/Mali saw a 30% increase in the number of FP clients aged 26 and younger per month. The largest gains were for LARCs, including a 50% increase in young implant clients and a 42% increase in young IUD clients.

- Staff improved their collection and analysis of client age data to allow better M&E.

An assessment of the effects of YFHS work is planned for the next year.

1.1.9. Disseminate the results of couple communication studies with a specific focus on men married to adolescent girls in Zambia

Anticipated year-two outputs:
A. Research report containing specific recommendations around approaches to increase male support for FP presented to PSI and other relevant stakeholders as well as disseminated electronically through global networks

Year-two progress on outputs (October 2015 to September 2016):
To complete this study, which began in year one, ICRW trained and supervised the field research team, which was led by SFH, PSI's network member in Zambia. Data collection, carried out in December 2015 in Central Province, consisted of 48 in-depth interviews with both members of couples in which women married before the age of 18 years, and four focus group discussions, two with young married women and two with men married to younger women.

One of the most striking findings to emerge from the analysis was that the majority of respondents (both men and young women), said that they got married before they were ready because of an unintended pregnancy. Many of these couples were forced by their families, or strongly encouraged by the church to marry. Men and women alike reported dropping out of school prematurely because of unintended pregnancies. This finding signals the clear need for FP programming that is inclusive of both married and unmarried youth.

ICRW used the desk review on the role of couple communication on FP use in the context of child marriages to inform the Zambia study protocol development and the background section of the study report (1.1.9.A), which is now available through PSI's and ICRW's websites. ICRW and SFH also used other resources to develop a research manuscript for publication.

In Zambia, SFH presented the findings to the Mission and MoH, and then held a wider dissemination event on October 11, 2016, for an audience of 50 people. Participants included the MoH, USAID, UNFPA, implementers, and the media. The Mission FP focal point attended and spoke at the dissemination event, as did the MoH. The dissemination was covered in a Zambian print media story and in two radio interviews.

In Washington, ICRW presented the findings of the formative research to representatives from the USAID Global Health Bureau at a brownbag in June, 2016. Additionally, ICRW presented the research findings at the annual conference of the American Public Health Association in Denver in early November.

1.1.10. Mainstream YFHS certification and supervision through integrated QA systems

Anticipated year-two outputs:
A. YFHS certification incorporated into PSI's global QA system
B. YFHS supervision, youth mystery client surveys or client satisfaction surveys, and certification of clinics conducted by network members in at least two PRH priority countries

Year-two progress on outputs (October 2015 to September 2016):
The SIFPO2 team identified a need to integrate a minimum standard regarding youth inclusiveness into PSI's global QA system for all FP programs, regardless of whether the program includes youth-focused funding. SIFPO2, including PSI's Global Medical Director, developed a standard under the heading, "Services are inclusive of adolescents and youth," and fleshed out its definition. SIFPO2 gained the buy-in needed from stakeholders within PSI to include this standard in QA audit tools, starting with an external QA audit in DRC in July 2016. PSI added the same youth inclusiveness standard and two associated

indicators in HNQIS that will be used for tablet-based supervision. After successfully piloting the youth-related standard and criteria in DRC, PSI updated all QA staff globally on the requirement to measure this standard in quality audits and provided them the tools to do so (1.1.10.A).

In addition, SIFPO2 developed a youth-focused mystery client tool to check the quality of YFHS. PSI network members in Mozambique and Madagascar piloted the mystery client tool to identify areas for improvement of the quality of YFHS (1.1.10.B). The survey process includes two scenarios designed to push at the limits of providers' comfort with regard to YFHS:

- One set of mystery clients played the role of an unmarried 16-year-old girl who wants to delay pregnancy until married;
- One set of mystery clients played the role of a married 18-year-old woman with no children who wants to delay pregnancy for three years.

PSI Madagascar, which used bilateral funding to scale up YFHS training in their social franchise, received support from SIFPO2 to adapt and pilot the youth mystery client study protocol. PSI Madagascar conducted 114 youth mystery client visits for contraceptive counseling from franchise providers in 57 Top Réseau clinics in the north, center, and south of the country. The analysis of 26 criteria showed that young mystery clients found the providers to be friendly, trustworthy, and respectful, and used language they understood, resulting in clients feeling more comfortable. Areas for improvement included verbally assuring the client of their confidentiality and explaining which methods protect against HIV and sexually transmitted infections (STIs). PSI Madagascar is using these findings to improve services for youth across the franchise network.

Before undertaking a mystery client survey, PSI Mozambique took steps to mainstream YFHS in the PSI-operated "Tem Mais" network. In January and February 2016 in Mozambique, SIFPO2 and the Dutch co-funded YFHS training for 15 nurses and five IPC coordinators. PSI Mozambique then integrated key YFHS standards and provider behavior change communication messages into the routine supervision of the Tem Mais nurses, who have demonstrated competency in YFHS during client visits and achieved YFHS certification. Inspired by the YFHS training, several Tem Mais nurses have established partnerships with school districts and provide weekly counseling sessions in nearby schools. The schools refer students interested in contraception to the Tem Mais facilities.

In September 2016, PSI Mozambique carried out 15 youth mystery client visits and 10 adult mystery client visits at 5 clinics within the Tem Mais network. The youth mystery clients reported positive feedback on staff friendliness, informed choice, and the wide range of methods offered. Mystery client surveys also revealed areas for improvement that PSI Mozambique is working to address, such as gaps in counseling on HIV/STI protection and dual method use. PSI Mozambique also translated posters and brochures from HC3 into Portuguese to inform youth about LARC options. From June through August, 2016, Tem Mais nurses served 8769 young FP clients, including 515 girls and 107 boys under age 15, 3325 girls and 285 boys aged 15-19, and 4233 young women and 304 young men aged 20-24.

After receiving positive feedback from Mozambique and Madagascar on the YFHS mystery client tool, SIFPO2 made it available to other countries in the PSI global network.

1.1.11. A feasibility assessment: World Health Partner's telemedicine model as part of a social franchise network wasn't this activity cancelled in the revised work plan

As per the updated work plan of January 29, 2016 and communications of January 14, 2016, this activity was removed from the year-two work plan.

1.1.12. Align PSI client-based record system via DHIS2 with a national health management information system (HMIS) to enable strengthened multi-sectoral HMIS

Anticipated year-two outputs:
A. Private sector indicators in one country aligned with the national HMIS

Year-two progress on outputs (October 2015 to September 2016):
DHIS2 is currently used in more than 40 countries as governments' national HMIS. By using the same software, PSI is able to more easily align indicators for increased reporting efficiency. This process helps to ensure that key indicators match the MoH's and facilitate data sharing, while also making sure that PSI's DHIS2 configuration meets its own donor and program decision-making needs.

In the spirit of information and data-sharing, PSI's local platforms in Nepal, Laos, Cambodia, Myanmar, DRC, Mali, and Senegal are sharing program data from DHIS2 with the local MOH. This is accomplished through quarterly review meetings at the district and regional levels and ensuring data is readily available to the MOH (ex: in some countries, the MOH is able to access PSI's dashboards). PSI will continue its commitment to making high quality data available to local MOHs through report sharing and ensuring alignment of key indicators as much as possible, which should eventually lead to increased evidence-based FP programming decisions.

1.1.13 Disseminate the results of SIFPO-funded PSI research through peer-reviewed publications, research briefs, and other channels

Anticipated year-two outputs:
A. At least two peer-reviewed publications

Note: Due to the departure of PSI's Research Advisors for other positions in early in 2016, only one peer-reviewed publication was published during year two. However, several reports on SIFPO2 funded PSI research were published on the PSI website in conjunction with other implementing partners.

Year-two progress on outputs (October 2015 to September 2016):
A peer-reviewed publication was published in June 2016 on the impact of SF on FP use in Kenya: Chakraborty, N., Mbondo, M., and Wanderi, J. 2016. Evaluating the Impact of Social Franchising on Family Planning Use in Kenya Journal of Health, Population and Nutrition 35:19 DOI: 10.1186/s41043-016-0056-y.

A report on results from a study on understanding factors affecting referral uptake to improve access to FP services was published on the PSI website: Population Services International. 2016. What facilities uptake of referrals for family planning? Results of a study in Mozambique. Research Highlights 2016.

A report on the relationship between wealth and the use of health services in the private sector was prepared and published by M4M for PSI: Chakraborty, N. and Sprockett, A. 2016. The relationship between wealth and use of health services in the private sector: A literature review and secondary data analysis focusing on family planning and common childhood illness.

A brief on results from research in Zambia on couple communication was published on the ICRW website and the PSI website and findings were presented at an internal USAID meeting: Lydia K. Murithi, et al. 2016 Understanding Couple Communication and Family Planning in Zambia Formative Research Study Finding and Recommendations.

A report on an effective model for the integration of modern FP services into community-level HIV programming for female sex workers in Ethiopia was published on the PSI website: Population Services International. 2016. An Effective Model for the Integration of Modern Family Planning Services into Community-Level HIV Programming for Female Sex Workers in Ethiopia. Washington, DC: PSI.

The following presentations, derived from work of SIFPO1 and SIFPO2, were conducted at ICFP in January 2016:

- Leading with Evidence: Implementing a Global Management Information System to Improve Evidence-Based Decision Making
- A Comparison of Case-Mix, Client-Volume, and Revenue between Franchised and Non-Franchised Providers in Kenya
- Task Shifting to Auxiliary Nurses as an Opportunity to Expand Delivery of LARC: PASMO Guatemala's Experience
- Improving Family Planning Interventions through the Movercado Eco-System in Mozambique
- Improving the Access to Family Planning Services in DRC
- Role of the Private Sector in Health Systems Strengthening and Workforce Training in Family Planning in the DRC
- Integrating Family Planning into PSI-Ethiopia's MULU/MARPs HIV Prevention project

1.1.14 Data to Action: Using a low-cost retail panel to overcome condom market failures

Anticipated year-two outputs:
A. A low-cost option for conducting a retail panel in low-resource settings
B. Robust and actionable data about Mozambique's condom market
C. Engagement with the private sector about how to best intervene in the market
D. A case study that can be used to convince other USAID missions to make similar investments in TMA and market strengthening.

Critical to the HIV prevention response in Mozambique is universal accessibility to and a steady supply of condoms to those at risk. Evidence suggests that there is a substantial gap in Mozambique's condom market. The goal of the Condom Retail Panel study is to assemble data on the current state of the condom market from the private retail sector in Mozambique and pilot a rapid approach to better inform decisions by key stakeholders.

In August 2016, a draft of the study protocol with questionnaire and indicators was submitted to USAID. The study protocol is still undergoing refinement and is expected to be finalized in October 2016. The study intends to collect key information on the breadth and depth of the condom market in two select sites: Maputo and Nampula. The indicators measured and tracked by this retail audit include: stock, sales volume, consumer price, and value of condom brands and variants.

The retail panel will test the accuracy of two rapid approach retail panel methods: phone surveys and SMS surveys. By structuring the panel to use combinations of in-person surveys, phone surveys, and SMS surveys, the study will compare phone and SMS surveys to in-person surveys. This will answer whether it is possible to rapidly and continuously monitor the performance of the overall market using lower cost solutions than in-person surveys with highly trained enumerators. By directly comparing the accuracy of these methods to traditional in-person retail audits, this study will inform future decisions on implementing retail panel methods to continuously fill gaps in market performance information for multiple actors. Initial data collection is expected to begin in Q1 of FY17 with follow up data collection occurring monthly for the three months following the initial data collection.

Sub-Result 1.2: Innovations, tools and approaches for delivering FP services to target groups tested, implemented and disseminated.

1.2.1. Provide ongoing technical assistance to PSI DRC to roll out Sayana® Press

Anticipated year-two outputs:
A. Communication campaign conducted
B. Sayana Press services provided

Year-two progress on outputs (October 2015 to September 2016):

In year one, PSI's network member in DRC, Association de Santé Familiale (ASF), conducted qualitative research with women, community health workers, and providers on perceptions of injectable contraceptives and the potential for community-based distribution of Sayana Press. ASF used the results to inform the development of a market introduction plan, including a communication strategy, during a marketing planning workshop with the MoH and other key stakeholders. ASF then coordinated with Tulane to successfully pilot the introduction of Sayana Press through community-based distribution by nursing and medical students.

In year two, following the pilot, ASF continued to participate in technical meetings with partners in DRC to plan for the introduction of Sayana Press. Pfizer registered the product in May 2016. The shipment of commodities from USAID is expected to arrive in late 2016. ASF has requested field support funding for the introduction, including the communication campaign and service delivery, once the product arrives.

1.2.2. Pilot a constructive male engagement intervention that utilizes mass media in Kinshasa, DRC

Anticipated year-two outputs:
A. Write an article on the qualitative study of gender and FP from year five of SIFPO1 and submit it for publication by a peer-reviewed journal
B. Gender transformative communication campaign involving mass media produced and aired in Kinshasa

Year-two progress on outputs (October 2015 to September 2016):
Based on the results of formative research and marketing planning in year five of SIFPO1, ASF designed a SIFPO2 core-funded male engagement campaign to complement field supported communication activities, which focus on reaching women as the primary audience for FP messages. Behavioral objectives for the campaign are for young married men like Pablo, the audience archetype, to:

1) raise the topics of fertility intentions and FP with their partners,
2) seek accurate information about contraception, and
3) provide social and/or financial support for voluntary contraceptive use by their partner, or use a method themselves.

Campaign messages aligned with the overall positioning statement: "Couple communication about FP is the best way for Pablo and his wife to make informed decisions for the protection and the flourishing of their family" (1.2.2.B).

ASF set up a partnership with a television journalist who attended ICFP with SIFPO2 field support as part of ASF's strategy to engage the media in covering FP issues. For one hour each week, the journalist hosts a popular national TV program called "Libala ya Bosembo" ("Peaceful Wedding") in the Lingala language that is prevalent across DRC. The show brings together four real newlywed couples. The host asks each individual questions while his or her spouse is out of the room. When the spouse returns, he or she tries to guess the answers. ASF integrated FP content at three points in the show to promote the campaign's three behavior objectives:

- Questions for newlyweds included those relevant to FP, such as, "Where do you get information about contraception?" and "What is your preferred method of contraception – for now or in the future?" The purpose of including these questions was to signal that couples should discuss these topics and seek information about contraception from credible sources instead of believing myths and rumors.
- At the end of the show, one of ASF's senior FP staff gave a brief talk about the wide range of FP methods available and asked viewers to go to a health center or call ASF's FP hotline for more information. He provided the hotline number.
- During the show, ASF aired FP spots with the hotline number.

- Three episodes of "Libala ya Bosembo" with this FP content aired in October 2016, just after the end of year two, thanks to preparatory efforts in year two. Reruns will continue over the next year.

ASF is monitoring calls to the hotline to see if the show affected the number of callers in general, male callers in particular, and callers who say they heard about the number through the television show. Since the show has national reach, ASF expects to see an increase in callers from across the country.

One of the episodes supported by SIFPO2

To complement the mass media intervention, ASF developed a strategy for mid-media and interpersonal communication (IPC) tailored to men. In Kinshasa, ASF identified men's soccer fan clubs that play and watch soccer together. The club doctors and presidents have agreed to participate in a brief training to become champions for constructive male engagement in FP. At the invitation of the club leadership, ASF will send one of its existing male community health workers to lead an FP discussion for each soccer club. Soccer match calendars with FP promotional content will be distributed to men, who commonly use such calendars for the rhythm method but may be inspired to seek information about modern methods (including CycleBeads) after hearing the FP talk and seeing the reminder of FP advertisements on the calendars. The calendars also show the FP hotline number.

ASF included the continuation and monitoring of constructive male engagement communication activities in their year three workplan for field support.

Previously, SIFPO2 planned to develop a publication based on the formative research (1.2.2.A) for the male engagement campaign. However, upon the advice of the Editor-in-Chief of the journal Global Health Science and Practice, SIFPO2 will await program evaluation results before writing a journal article regarding male engagement in DRC. As an alternative, PSI may share the data with the Institute for Reproductive Health (IRH) to analyze the Passages Project's male engagement work in DRC. If IRH and PSI-ASF develop a publication together, SIFPO2 will be credited.

1.2.3. Support roll-out of dedicated post partum intrauterine device (PPIUD) inserter in Mali to expand the range of methods available to post-partum women

Anticipated year-two outputs:

A. PPIUD inserter launched
B. Provider and client sensitization activities conducted

Year-two progress on outputs (October 2015 to September 2016):
Under SIFPO2, PSI Mali launched a demonstration pilot to introduce a PSI-designed dedicated PPIUD inserter into a subset of public and private health centers (1.2.3.A). The aim of the intervention is to increase access to post-partum LARCs in Mali through a simplified IUD insertion procedure that eliminates the need for specialized equipment in the delivery room. As the first intervention using the dedicated inserter in Sub-Saharan Africa, the Mali pilot is providing important lessons for the introduction and scale up of PPIUD services throughout the region.

Since the arrival of the inserters in late February 2016, trainers trained 23 midwives and one obstetric nurse in 17 public sector sites (three reference facilities and fourteen community health centers) (1.2.3.B). From October 2015 to September 2016, more than 1,400 women opted to receive PPIUDs following counseling and eligibility screening. There were two phases of the project, the initial pilot phase after the

first trainings, and a larger phase after the first four-month experimental period. During the initial experimental phase from March 2016 to June 2016, 10 expulsions were observed from 343 insertions. These expulsions were primarily associated with two health care providers, who have since received additional coaching. The majority of women who experienced expulsions have since chosen other methods.

Participating providers have been very enthusiastic about the dedicated inserter, citing ease of use and convenience. PSI Mali is conducting supportive supervision for trained staff every quarter, as well as whole-site orientations every month for other facility staff to explain the importance of birth spacing and post-partum FP and to encourage them to discuss post-partum FP (PPFP) with clients and refer interested individuals for additional counseling and services.

1.2.4. Assess demand for the IUD as emergency contraception (EC)

Anticipated year-two outputs:
A. Internal recommendations for how PSI network members can increase demand for and provision of the IUD as EC
B. Findings disseminated to internal and external audiences

Year-two progress on outputs (October 2015 to September 2016):
In order to contribute to the goal of expanded method choice, with SIFPO1 support, PSI developed provider guidelines and tools for providing the most effective form of EC, the copper IUD. In year two of SIFPO2, PSI collaborated with its network members in Uganda (PACE) and Cambodia (PSK) to assess the demand for this form of EC, and developed a set of internal recommendations for all PSI service delivery programs on how they can increase access to this method (1.2.4.A).

Through this assessment we learned that PSK provided the IUD as EC to 50 clients through 33 PSK network clinics in 2015, the first year offering this method. This is a much lower figure than the number of EC pill packs (46,000) distributed in that same year. In Uganda, PSI supported PACE to revise its management information system (MIS) collect data on when the IUD is provided as EC as the MIS system did not have this capability. PSI's PACE determined that there is still a large amount of bias against any form of EC among women, as well as their IPC agents, and as a result conducted refresher trainings for IPC agents to provide accurate information on EC.

Based on what PSI learned working with PACE and PSK, PSI developed a set of internal recommendations for how PSI can increase access to the IUD as EC including:

1) Revise a country's data collection system to include the IUD as EC as a reporting option;
2) Include the IUD as EC in a program's next update of their communication outreach materials;
3) Orient communication agents to the IUD as EC (increasing their capacity to share accurate information about the method); and
4) Orient providers to the IUD as EC checklist.

These recommendations will be shared via the "Emergency Contraception Strategic and Technical Guidance" document (mentioned in activity 1.2.5 below), disseminated to all countries in the global PSI network. PSI also contributed the blog, "Promoting the most Effective form of EC: The Copper IUD" to the Knowledge For Health website, which provides insight into some of the barriers to increasing demand for the method in Uganda (https://www.k4health.org/blog/post/promoting-most-effective-form-emergency-contraception-copper-iud) (1.2.4.B)

1.2.5. Develop a strategy for increasing the distribution of socially marketed EC products at PSI

Anticipated year-two outputs:
A. Strategy developed with recommendations for how PSI FP programs can expand method choice and increase access to socially marketed EC products

Year-two progress on outputs (October 2015 to September 2016):
EC is an essential component of any comprehensive FP program; however, in a number of countries where PSI works, EC is largely unavailable or not accessed. There are several reasons for this, including; EC not being included in the National Essential Medicines List in some counries a lack of high-quality affordable drugs in the market; an absence of comprehensive training and information on EC for both public and private healthcare providers; and generally low knowledge about EC among the intended audience, along with many myths and misperceptions.

Yet the women PSI seeks to serve benefit greatly from having access to a broad range of contraceptive methods, and EC is unique in that it is the only contraceptive method that gives a woman a second chance to prevent pregnancy. Additionally, PSI programs can also increase their sustainability by introducing a product that can recover costs. Despite the benefits of socially marketing an EC pill product, only a third of PSI programs do so, and yet there is evidence of gaps in markets. Therefore, PSI researched and developed guidance to motivate more PSI network members to assess market failings in EC access and to consider socially marketing EC products. The final product is an "EC Strategic and Technical Guide for PSI Network Members." (1.2.5.A) It includes the public health rationale supporting access to EC, and the opportunity to create a sustainable EC product using targeted communication.

The analysis includes a review of DHS data, Performance Monitoring and Accountability 2020 (PMA 2020) data, current literature, as well as insights from interviews conducted with PSI program managers who oversee PSI programs to learn about how they were able to secure funding and overcome barriers to providing EC in their country context. The guidance emphasizes that PSI's social marketing programs can play a key role in increasing access to and use of EC by addressing key barriers to EC, including:

- **Create a sustainable, affordable EC product:** Formative consumer research on pricing of existing EC products and ability and willingness to pay allows programs to design a deliberate cost-recovery approach at the outset. Programs as varied as Cambodia, Cote d'Ivoire, Nigeria and Paraguay have all used program income or initial donor funding to establish a full or partial cost-recovery model of distribution. Generally, the strategy consists of launching a product with donor funding and then achieving sustainability through yearly revisions of price, always balancing this with ensuring access and affordability for our audience.
- **Identify the opportunity:** The first step is to evaluate the opportunity to launch an EC product. PSI's portfolio management process guides this course of action from identifying the gap in the market to designing the best approach to launch. The next step is to conduct a market landscape to understand how the market for ECs is currently performing, what existing products are and learn about the consumer (e.g. knowledge about EC, ability / willingness to pay, and barriers to use). This analysis will then help build the best solution for the market.
- **Build a business plan to assess the financial feasibility:** The five-year business plan will outline all your assumptions of sales volumes, pricing, COGs and promotional support required. The business plan will identify what investment is required to launch the product and when financial sustainability can be achieved.
- **Emphasize social and behavior change communication:** Without marketing or communications programs to support EC, clients rarely seek out EC and healthcare providers rarely discuss EC with clients during routine visits. Additionally, the public discourse around EC is often misguided. As a consequence, many women do not know that EC is available, effective, and safe. Programs must provide behavior change communication (PBCC) activities directed towards at-risk populations (including youth and couples) and providers (especially pharmacy or drug shop-based providers) to enhance awareness, increase knowledge and change norms and behaviors around EC.

PSI's FP/RH Department in conjunction with the Global Social Marketing Department will be disseminating the EC Guide to all PSI senior leadership across the PSI network in November, 2016. This strategic guide comes at an opportune time as PSI's marketing department is exploring options for launching a global EC brand in order to maximize procurement and marketing efficiencies and increase access to EC across the global network.

1.2.6 Conduct a research study to understand the impact of franchising on quality of services in Uganda

Anticipated year-two outputs:
A. Research protocol finalized
B. Research protocol submitted to Institutional Review Board (IRB)
C. Select research firm for data collection
D. Design and pilot data collection forms

Year-two progress on outputs (October 2015 to September 2016):
At the global level, PSI is exploring the impact of integrated service delivery on health outcomes, with quality as a central focus. Quality is both a pillar of SF, and one of the promises that we make to clients and providers when promoting franchised services.

PSI has worked closely with the SFMWG to identify quality indicators that can be standardized across franchises in order to make more effective comparisons. The purpose of the study is to develop a streamlined and common measure of quality across social franchise agencies, to identify elements of service delivery that are associated with improved behavioral outcomes and to design better clinic and provider strategies that promote re-engagement and method continuation.

This study has two main components:

- A cross-agency component called "Assessing Service Quality and contraceptive Discontinuation," (ASQ-D) to assess the relationship between service quality and contraceptive method continuation among clients in 26 clinics in Uganda. Metrics for Management will lead this study and PSI will participate by providing readiness measures from facilities and collecting data among clients.
- A PSI-led provider trust and re-engagement component, which will focus on assessing the level of trust clients have in ProFam clinics and providers. The goals of the study are to assess the relationship between service quality and contraceptive discontinuation among clients in the social franchise networks, and to better understand the relationship between clients and ProFam providers along with the role that trust plays in encouraging re-engagement with ProFam and FP method continuation in Uganda.

This study will provide information to: develop a streamlined and common measure of quality across social franchise agencies, identify elements of service delivery that are associated with improved behavioral outcomes, and design better clinic and provider strategies that promote re-engagement and method continuation.

In August, the study design and protocol was drafted and submitted to the Uganda IRB for initial feedback (1.2.6.A and Output 1.2.6.B). The survey instruments, including the facility assessment and initial and follow up client exit interview questionnaires, are also being finalized (1.2.6.D). A Request for Proposal for the research agency for data collection was also released (1.2.6.C). Testing of the survey instruments and the resubmission of the study protocol to the IRB is planned in the first quarter of FY17.

1.2.7. Expand method mix and build local partner capacity through the roll-out of the LNG-IUS in Senegal

Anticipated year-two outputs:
A. Providers trained
B. Product launched
C. Consumer and provider materials developed

Year-two progress on outputs (October 2015 to September 2016):

The anticipated year-two outputs of this activity in Senegal were delayed by regulatory challenges in 2016. However, extensive work was done to overcome those obstacles and facilitate the successful introduction of LNG IUS into Senegal in 2017. In the first quarter of year two, PSI concluded a regulatory agreement with M360, which enabled PSI ADEMAS to act as the local market authorization authority, and begin product registration, whereupon M360 prepared the dossier in English and transferred it to ADEMAS. ADEMAS subsequently hired a consultant to perform a regulatory assessment, provide a registration timeline and prepare the dossier/application for submission.

At the same time, PSI learned that the regulatory authorities in Senegal required almost the entire dossier to be in French (unlike the regulatory authorities in Madagascar). Therefore, pending the results of a call for translation quotes, the dossier will likely be translated into French in Q1 FY2017, which will also be available for future registrations in other francophone countries.

Senegal will use the results from their 2015-2016 Total Market Assessment for Family Planning, also conducted under SIFPO2, to guide marketing planning. ADEMAS will also be able to learn from PSI-Madagascar's marketing planning under the EECO project and adapt Madagascar's *Avibela* client and provider materials, which will be developed in French. A final marketing plan will be completed once the dossier is submitted and the timeline is clearer, currently estimated for mid-2017. In addition, Senegal will use standard PSI research protocols for IUS providers and users, to contribute to the global IUS learning agenda and allow cross-country comparisons.

ADEMAS service delivery capacity has not expanded significantly in 2016 as previously anticipated, and so it is likely that the primary recipients of the product when it is registered shall be MSI and the local IPPF affiliate providers. At the same time, ADEMAS shall continue to work closely with all stakeholders so that this introduction may in the long term facilitate availability of LNG IUS through all channels i.e. including the public sector.

In addition, following approval in June 2016 that SIFPO2 could begin the process of introducing LNG-IUS in PSI Network Members in Zimbabwe and Nigeria, both countries have successfully applied to the ICA foundation for product donation. PSI Zimbabwe is collaborating with the University of Zimbabwe, whose OB/GYN department currently holds a waiver for the ICA foundation product and is looking to increase clients in their acceptability study by including six New Start clinics. The ICA foundation has approved a donation of 750 units and they should be available in-country before the end of 2016. PSI Zimbabwe has also identified trainers within the OB/GYN professional association in-country, who have already had experience with the product.

In Nigeria, where the product is already registered, PSI and Society for Family Health (SFH) Nigeria are in discussions with ICA foundation about acquiring product, which is also expected to be in-country before the end of 2016. Both SFH Nigeria and PSI Zimbabwe will also use PSI's standard research protocols for IUS providers, and SFH Nigeria will also use PSI's protocol for LNG-IUS users, to contribute to the Global Learning Agenda. Zimbabwe will have access to data from University of Zimbabwe's user study, which includes similar questions to PSI's user questionnaire.

1.2.8 Enhance the capacity of providers to respond to adverse events (AEs) through the improvement and dissemination of PSI's AE drill toolkit prototype

Anticipated year-two outputs:

A. Adverse event toolkit graphically designed and translated to French and Spanish
B. Adverse event toolkit disseminated to all PSI FP service delivery programs, as well as externally
C. Webinar for PSI staff conducted to provide guidance on using the toolkit

Year-two progress on outputs (October 2015 to September 2016):

PSI encourages all FP/RH programs to conduct an annual "drill" to test its ability to report an AE to PSI Washington and to manage it appropriately. An AE drill is a simulation of an AE using a scripted scenario.

In order to provide programs with guidance on how to conduct a drill, PSI developed a "toolkit" with essential information.

PSI's AE drill toolkit has been translated to French and Spanish (1.2.8.A) and disseminated across the global PSI network (1.2.8.B). PSI made the decision not to graphically design the document so that changes in the future could easily be made (for example, adding in scenarios that countries have successfully used to implement their drills.)

In lieu of a webinar (1.2.8.C), PSI's Clinical Advisor communicated with all QA Regional Leads to ensure they were familiar with the tool and capable of supporting countries in their regions to conduct AE drills. QA Regional Leads then checked in with each country in their region individually to find out if they had conducted a drill and what type of support they need to implement one in the coming year. Based on the results of this inquiry, all FP/RH medical meetings held over the next 18 months will include a session on building QA managers capacity to implement a drill. Additionally, QA Regional Leads are leading webinars in their regions during year three to give an update on PSI's global QA system and will include guidance from the AE Drill Toolkit. Finally, the AE drill guidance was shared externally with MSI and IPPF.

1.2.9. Advance the global permanent method (PM) agenda and expand method choice in PSI FP programs

Anticipated year-two outputs:
A. PSI local clinical staff participated in one MSI-led regional workshop on PMs
B. Workshop learnings shared across the PSI global network
C. Landscape assessment of QA approaches across PSI PM programs conducted

Year-two progress on outputs (October 2015 to September 2016):
PSI currently provides tubal ligation services through its network members in Uganda, Malawi, Guatemala and Pakistan; and vasectomy services in Guatemala. (PACE Uganda initiated its tubal ligation services through SIFPO1 support in 2015.) In year two, PSI conducted an assessment to determine how each network member modified its QA system to launch PM services to help PSI determine where gaps in QA for PM service delivery exist among network members (1.2.9.C).

PSI's QA Managers in India, Uganda, Malawi, Pakistan and Guatemala completed the checklist and provided feedback to inform the second iteration of the tool. As a result of the assessment, a "Permanent Method Pre-Launch Checklist" was developed for any PSI program across the global network that has been awarded funds to add voluntary tubal ligation or vasectomy service to their program. The checklist was utilized by PSI-Tanzania and successfully provided them with a road map to strengthen and revise their QA system prior to launching tubal ligation services at the end of 2016. Additionally, QA gaps were identified among current PM programs and will inform the content of the QA regional meetings that PSI will hold over the next 18 months.

PSI also supported three local staff from PSI-Tanzania, PSI-Malawi and PACE Uganda to attend the MSI/Engender Health regional PM workshop held in August, 2016 in Malawi (1.2.9A). There were several concrete outputs from their participation including:

- Shared challenges in the region identified;
- Recommended actionable strategies for overcoming challenges to quality voluntary permanent method access based on lessons learned;
- Champions to lead the action in each country; and
- A National Strategy Action Plan to increase access to quality voluntary permanent methods of contraception in each country.

The participants have shared their trip reports and will be future resources for other PSI programs working on PM programming (1.2.9.B).

1.2.10 Enhance the youth-friendliness of pharmacies in Mozambique

Anticipated year-two outputs:
A. Pharmacies identified and assessed using youth-friendly criteria
B. Pharmacy staff trained
C. Numbers of referrals tracked using Movercado

Year-two progress on outputs (October 2015 to September 2016):
Pharmacies are an integral part of health systems with the potential to serve many FP clients—especially adolescents and youth, who may prefer the convenience and privacy of pharmacies as a source for short-acting methods. A review of DHS data from 57 countries showed that 18% of FP users in sub-Saharan Africa access their method through "private specialized drug sellers," which includes private pharmacies, private drug stores, and private dispensaries (Campbell et al., 2015). In Mozambique however, private pharmacies serve only 7% of contraceptive users (DHS, 2011). In urban Maputo, PSI seeks to improve young Mozambicans' access to contraception by mainstreaming elements of youth-friendliness in private pharmacies that offer condoms, oral contraceptives and referrals for other methods.

This activity builds upon the foundations laid a decade ago by USAID's PSP-*One* project's partnership with pharmacies in Latin America and utilizes PATH's Youth-Friendly Pharmacy Program Implementation Kit. The activity objectives are to:

- adapt and replicate successful approaches of the past in a setting with high unmet need among youth,
- test whether vouchers magnify the effect of the intervention since cost is a common barrier for young people, and
- generate global learning to revitalize efforts to partner with pharmacies in the interest of meeting the contraceptive needs of youth.

On April 26, 2016, the Mission sent concurrence for this activity, which was added mid-year.

PSI Mozambique conducted a pre-intervention assessment to confirm the feasibility of establishing youth-friendly pharmacies that provide young people with information on sexual and RH and contraceptive methods. The assessment was led in peri-urban locations in Maputo to identify potential barriers to youth-friendly pharmacy services, the locations of pharmacies, the willingness of pharmacy staff to participate, and other efforts to increase young people's access to RH services. As part of the assessment, PSI Mozambique carried out in-depth interviews with pharmacy staff and owners to assess the willingness of pharmacy staff to participate in such a project. In addition, the team trained young mystery shoppers, who visited the pharmacies in September and reported back on issues to address through the intervention. Through the assessment, PSI Mozambique identified 18 pharmacies with a potential to participate in the intervention or as comparison sites (1.2.10.A). All of the selected pharmacies are near secondary schools, where PSI plans to focus efforts to generate demand and refer young people to the intervention pharmacies.

In October, PSI Mozambique conducted two separate on-the job trainings (1.2.10.B) for a total of seven pharmacy staff covering five pharmacies – starting small in order to allow for improvement before involving the other pharmacies.

PSI Mozambique also refined plans for the continuation and assessment of this activity in year three. There will be three groups of pharmacies, with six pharmacies in each group:
1. **Control group:** no intervention.
2. **Basic intervention group:**
    - On-the-job training for pharmacy staff to become more youth-friendly,
    - Pharmacy branding as youth-friendly if quality standards are met, to help identify that they are part of a network that welcomes adolescents,

- Referrals from promoters' school-based communication activities to the pharmacies for short-acting methods, and to PSI's network of nurses for a wider range of method choices (1.2.10.C).

3. **Intervention with price reduction**: Same components as the basic intervention group, plus a youth voucher that reduces the price of contraceptives at pharmacies and gives the pharmacy a partial rebate when the voucher is redeemed.

These groups of pharmacies will be as similar as possible for all factors besides the intervention components. In year three, the assessment methodology will include:

- Comparison of the numbers of male and female condoms, EC pills, and oral contraceptives sold before, during, and after the intervention in intervention and control pharmacies.
- Qualitative methods such as in-depth interviews and focus group discussions to understand the perspectives of pharmacy staff, promoters, and young clients on the intervention.

Result 2: Increase sustainability of country level FP and other health programs

Sub-Result 2.1 Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged.

2.1.1 Develop and disseminate findings on financial sustainability and social franchising analyses
Anticipated year-two outputs:
A. Follow-up financial sustainability action plan developed for two PSI network members
B. Outcomes and lessons learned disseminated to targeted PSI audiences and key external stakeholders

Year-two progress on outputs (October 2015 to September 2016):
During the first year of SIFPO2, R4D worked with PSI's social franchise platforms in Tanzania and Uganda to landscape domestic health financing options that may support quality, equitable, and sustainable delivery of FP services. Under these analyses, PSI and R4D implemented a novel *Framework for Analyzing Health Financing Options for the Financial Sustainability of Social Franchising Networks* to determine key challenges to the sustainability of FP networks and identify mitigating options. These options included leveraging public sector health insurance schemes, local government contracts, and private health insurance schemes.

In year two, R4D worked collaboratively with the PSI country platforms and local government agencies in Tanzania and Uganda to advance priority options for the sustainable financing and delivery of FP services (2.1.1.A). The governments of Tanzania and Uganda are stepping up efforts to advance public-private partnerships (PPPs) for primary health care at the regional and district levels. PSI and R4D took concrete steps to develop formal contracting arrangements between a) district governments in the Morogoro Region and PSI in Tanzania, and b) the Kampala Capital City Authority (KCCA) and PACE in Uganda, so that people can access government-supported maternal, reproductive, and child health services at PSI-supported facilities.

To achieve this in Tanzania, PSI and R4D provided the PPP Unit in the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) with technical assistance to launch a regional chapter of the national Public Private Health Forum (PPHF) in Morogoro. Working with members of the Morogoro PPHF, PSI-Tanzania (PSI-TZ) and R4D developed a proposal for a PPP that lays out terms for public-private collaboration on service delivery and performance management, and outlines the operational and coordination challenges that PSI can alleviate for both the government and private sector providers in its role as an intermediary. PSI-TZ and R4D will continue to engage with public and private sector stakeholders in Morogoro to finalize and implement the PPP in Q1 of year three.

In Uganda, R4D and PSI affiliate PACE worked with the KCCA to launch a public-private contracting arrangement to ease congestion in public sector health care facilities and improve the delivery of maternal health and FP services. Only seven of the 10 KCCA-run health care facilities offer maternal health services, leading to congestion and bottlenecks in the public sector in delivering key services for women and girls. The KCCA also lacks systems, funding, and capacity for engaging the ubiquitous private health care sector in Kampala. The R4D-PACE collaboration with KCCA under SIFPO2 aims to design a workable partnership for harnessing private primary care facilities, such as those supported by PACE, to deliver maternal and preventive/promotive health care services to women and girls. The partners reviewed examples of public-private partnerships for health in East Africa, and developed a concept note that details the implementation and evaluation plan for a contracting arrangement that will strengthen maternal and child health service delivery and improve the uptake of FP methods across Kampala. In Q1 of year 3, this team will present the concept note to a broader stakeholder group within the KCCA and to other private and donor sector partners for their buy-in and support for launching the project.

During year two, PSI and R4D also embarked on an ambitious dissemination phase (2.1.1.B) to:

- Inform practitioners, researchers, and funders of the experience of SIFPO2 health financing options analysis
- Create visibility for USAID POP RH and SIFPO2 in broader efforts to align the financing and delivery of FP and primary health care services between the public and private sectors
- Receive feedback to further hone the analysis and make it useful to the work of partners advancing UHC and stewardship of mixed health systems.

In March 2016, R4D presented the SIFPO2 framework and country analyses in a webinar to the UCSF-led Social Franchising Community of Practice, where it was received as a forward-looking vision of growth for franchisors looking to diversify sources of financing. R4D also presented this framework in an interactive session at the Global Health Mini-University in March to a mix of development professionals who offered input on diverse uses for the framework. In early April, R4D participated in a consultation hosted by UNFPA in New York on the integration of FP programs into mechanisms for UHC, where it engaged a cross-section of FP and UHC partners on defining financial sustainability, given the SIFPO2 FP experience. In May, R4D participated in a panel hosted by USAID at the Women Deliver Conference in Copenhagen, offering insight on the power of social franchises to advance UHC for women and girls in countries across the globe. Throughout the year, R4D has remained engaged with PSI platforms in India, and other countries interested in advancing sustainability for their SF networks and strengthening financing and delivery of FP and RH services.

One clear outcome of this dissemination work has been that connections between the SIFPO2 work and broader health financing and health system reforms initiatives and discussions have begun to emerge. For instance, follow-up work with the PSI country platforms will actively engage with plans and processes for the rollout of the Global Financing Facility for Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH), where the inclusion of the private sector in “mixed delivery models” is emerging as a major theme. The SIFPO2 work has emerged as an important contribution to the mixed health systems space, providing relevant country experiences, data, and options to advance implementation.

2.1.2. Support PSI social franchise networks to increase their domestic financing opportunities and improve their performance and contribution to health systems strengthening

Anticipated year-two outputs:
A. A customized framework and strategy developed for increasing franchise platform’s and franchisees’ access to sustainable financing in one country

Year-two progress on outputs (October 2015 to September 2016):
R4D worked with PSI-affiliate Society for Family Health (SFH) in Nigeria to analyze health financing options to enhance the financial sustainability of its SF network. As the largest health care NGO in Nigeria

with more than 650 providers, and a key supplier of SRH commodities in the country—SFH maintains a strong value proposition for its franchisees, but often lacks dedicated financing for social franchising. SFH also focuses on higher level providers (hospitals and pharmacies) and urban areas, and could reach more effectively the poorest populations most in need of preventive/promotive health care services.

Under SIFPO2, R4D worked with SFH to help rationalize its franchise structure and develop options for sustainable domestic financing for franchising (2.1.2.A). R4D's work proposed an evolution in SFH's role as a health market intermediary in Nigeria to take advantage of the growth and service opportunity in the country provided by a renewed focus on primary health care (for instance, through initiatives such as 'Primary Health Care Under One Roof' and making 10,000 PHC centers functional) and new federal funding for the supply and demand sides under the 2014 National Health Act. This work tied into the strategic thinking of the SFH team at an opportune time as the organization was beginning to develop a business case to better target franchising support to providers and draw revenues from a mix of grants, franchise and insurance fees, and contract revenues. Under options developed by R4D, SFH can be cost-effective and yield self-driving revenues where possible, access (domestic/donor) third party financing to improve equity, and add new clients to the service provision network. These options will help SFH refocus the franchise on lower level providers who are the most in need of better organization and more intensive support, leverage new opportunities for domestic and donor financing in Nigeria (such as PPPs, state-led insurance, and the Global Financing Facility for RMNCAH), and enhance access to and impact of FP and other preventive/promotive services.

The SIFPO2 team left SFH managers with a clear vision for evolving the franchise model to reach poorer, underserved clients, and playing a key role as an intermediary between public and private sector actors involved in health care financing, delivery and policymaking. In the next step, in SIFPO2 year three, R4D and PSI will aim to engage SFH to further develop and implement priority options.

2.1.3. Strengthen regional approaches and efficiencies for social franchising in East Africa

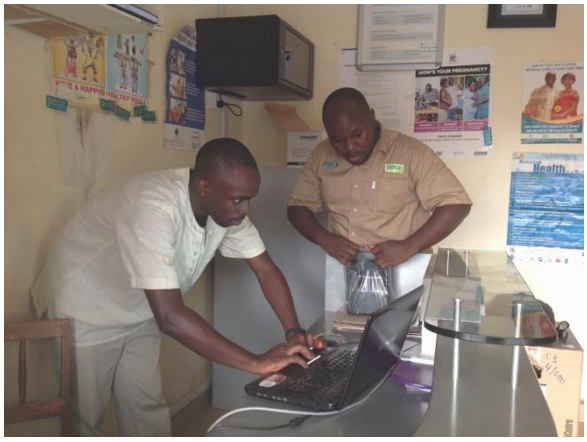
Anticipated year-two outputs:

A. Enhanced East Africa regional pooled procurement mechanisms applied for FP products/services
B. A new marketing initiative implemented to support the recommendations of year one

Year-two progress on outputs (October 2015 to September 2016):
With the goal of improving the financial sustainability, quality, cost effectiveness and impact of social franchising, PSI examined whether a multi-country pooled procurement strategy could address stock outs and fake drugs while reducing pricing in social franchised health clinics.

In East Africa, where PSI social franchises were typically receiving goods from multiple sources at varying prices, franchisees were paying more for products, and missing the opportunity to pay lower bulk rates. PSI is currently working to solve this challenge by finding a central supplier to offer pooled procurement that will be flexible enough for small clinics to access credit, and for large clinics to have access to an attractive range of drugs. To test this, PSI used one drug supplier for PS Kenya's social franchise over six months and found important gaps in the supply chain that will help inform and develop stronger business and pooled procurement strategies in the region. PSI identified an expert in the international pharmaceutical industry, I+Solutions, to complete a pooled procurement analysis to develop the formularies and quantification of essential drugs and consumables to be used with Tunza providers in Kenya, Uganda, and Tanzania.

After the pilot, PSI found that there was not a wide enough range of generic and branded drugs offered to the clinics; smaller clinics were not able to secure enough credit from the local supplier; and the lack of linked inventory and financial systems meant that it was difficult for Tunza to track the quantities and discounts across the franchise. This information will be used to influence the formulary and the business strategy of the pooled procurement next year. PSI will then develop a business case outlining the capital, business model, and supply chain strategy that would allow for a multi-country pooled procurement of essential drugs and consumables for franchises (2.1.3.A).


CMS Set Up

Since April, social franchises in Kenya, Uganda, and Malawi have been testing the acceptability of the Tunza Business Model, which was developed during these past 18 months. A key core value proposition for both the franchisee and the Tunza Franchisor is the Tunza Clinic Management System (CMS). The CMS will address client flow, health area protocols, financial, inventory, human resource issues and overall data management. This is critical to the Tunza business model, as it is not possible to measure revenue gains at the clinic level until financial and health service information is captured consistently. Learnings from the initial essential procurement test with Transwide demonstrated that the CMS will also be a key tool in managing the pooled procurement mechanism. It allows direct links to re-order stocks and gives a more effective way to manage credit, and efficiencies in the entire financial side of the supply chain.

Some of the key findings from the initial acceptability testing of the Tunza Business Model are;

- Franchisees want a CMS that will improve the overall business management of their facility but will need financing for the equipment.
- Some franchisees are concerned that the tax authorities will have access to the financial data.
- Franchisees are not used to annual license fees and need to be convinced that the CMS will pay for itself in other business savings.
- The franchise incremental revenue share concept is a very foreign concept. It will require more selling and modeling.
- The preferred value propositions are; improved business systems, quality improvement, marketing and demand creation, affordable quality drugs, consumables, and equipment with affordable financing.

PACE Uganda launched the Tunza CMS with eight early adopters in October 2016, and PSI will be able to demonstrate some of the dashboards showing performance trends as early as January 2017. The CMS will allow the franchises to demonstrate how increasing business skills and financial sustainability of both the franchisee and the franchise can contribute to increased quality FP-RH services.

While Tunza marketing plans were developed for Kenya, Malawi, Tanzania and Uganda, year two has focused on the first step, testing the acceptability of the value proposition (2.1.3.B). After two months of testing acceptability of the different elements through visits with 45 franchisees, PS Kenya determined that all of the elements of the value proposition and the revenue share are too complex to get providor's buy-in while still delivering current donor deliverables. PS Kenya are thus redesigning the strategy for Kenya using a staged approach that begins with a focus on improving the product supply chain, then adding an element of financing and identify a medical record keeping system that is an off the shelf one

time purchase. Malawi, Tanzania and Uganda found the value proposition needed to be simplified by focusing on improved business management and systems, quality improvement, provision of quality products and increased client flow. PSI will continue to establish a regional social enterprise that will have Tunza franchisors in Uganda, Tanzania, and Malawi. In Uganda, an important milestone has been achieved: Five clinics have signed agreements and two have gone live with the CMS. More learning and refinements will happen as additional franchisees sign on in the coming year.

2.1.4 Support PSI's network members to evaluate the impact of the business skills trainings on franchisee performance

Anticipated year-two outputs:
A. Dissemination strategy developed for future business skills offerings to network

Year-two progress on outputs (October 2015 to September 2016):
In 2015, PSI contracted Open Capital to review PSI's business skills activities. Their recommendations included: consolidating the classroom training content and adding more practical exercises; providing one-on-one in-person support to clinics on a monthly basis to operationalize the learnings through business advisors and; creating a standardized business assessment and development plan that is implemented across all franchises.

To date, all of the Open Capital recommended materials used for business skills trainings have been aggregated. They have been edited and all now include pre/post tests and have been tested by the business advisors in Kenya. Additionally, a consultant has been working to investigate the best type of e-Learning platform to measure franchisee progress with business and health area skills, as well as to house in person supplementary materials, online course material, and suggested resources for in person/online paid courses that franchisees might choose to take. This may include integration with PSI University online courses.

Based on the success of the business advisors in Kenya, additional business advisors have also been hired in Malawi, Tanzania and Uganda. The job descriptions are available on PSI's internal website and other countries are showing interest in this model. The business advisors focusing on Tunza in Kenya and Uganda are currently focused on ensuring the pilot clinics are ready to implement the CMS. The business advisors are preparing the clinics with the computer hardware and power back-up. They will also be responsible for working with the clinics to get all the medical, stock and financial information updated in the system.

In Uganda, PACE is experimenting with two kinds of business support with their different franchise networks, ProFam, GoodLife and the nascent Tunza network. PACE has hired dedicated business advisors for the Tunza network who, as mentioned above, are recruiting new clinics and once signed on, to implement a CMS. The ProFam network has continued to build off the work from SIFPO1 by continuing to implement the business skills training with other donor funding. While they understand that dedicated business advisors would help make the recommendations from their trainings stick, one of their challenges has been in finding sufficient funding to hire these advisors that can focus on this network. To address this challenge, with other donor funding, PACE contracted the Private Sector Foundation of Uganda (PSFU) to provide some of the trainings and mentorship to the clinics. After holding business skills classroom training sessions, PSFU mentors conducted at least one follow-up visits for each of the trained facilities. In addition, 70 of the facilities will continue to receive quarterly business support mentorship visits from PACE staff, while another 40 are receiving four extra follow-up visits from the PSFU mentors. As many of PSI's networks may struggle to find funding for dedicated business advisors, PSI would like to learn more about the impact of the different follow-up support visits. In year three, SIFPO2 will provide resources to assess the impact of three models and share these lessons across the network.

2.1.5. Structure and launch a development impact bond (DIB) focused on improved maternal and child health in Rajasthan, India

Anticipated year-two outputs:
A. DIB concept refined and updated with stakeholder agreement
B. Outcome funders committed to funding the DIB
C. Payment metrics chosen and financial modeling to price outcomes completed
D. Legal structuring of the DIB including the signing of binding contracts between various stakeholders on the DIB completed
E. An external neutral impact evaluator selected, and baseline data collection initiated
F. DIB launched

Year-two progress on outputs (October 2015 to September 2016):
PSI has been working closely with USAID and other partners to structure and launch a DIB. DIBs are a nascent innovative financing mechanism through which upfront funding is provided to implementers by private investors, who are then remunerated by donors or host-country governments—with both a principle and a return—if evidence shows that the programs achieve objectives. The DIB currently in design is focused on reducing maternal and neonatal mortality in Rajasthan, India, through an intervention that will enroll women in a program that will give them access to high-quality antenatal care, institutional delivery and PPFP services. USAID will likely be an outcome funder, PSI will likely be the main implementing partner, and UBS Foundation will likely be the main investor.

During the design phase, from May to October 2016, USAID and PSI have contracted with Social Finance, an organization with predominant expertise working as an intermediary, to structure this DIB. Given that this mechanism is new and that the DIB will likely be under a lot of scrutiny when it is launched, it has been particularly valuable to have a neutral and experienced intermediary group like Social Finance working with all the stakeholders to develop a strong business case for the DIB, choose and define appropriate payment metrics, properly align incentives, and identify and mitigate structural and management risks to the extent possible. In this way we hope that when this DIB is taken to conclusion, key learning from this pilot can be drawn and shared widely to determine the scope for taking the DIB mechanism to scale to address maternal and child health and other development issues globally. Specific deliverables that have been met by Social Finance to date include:

- Financial budget input sheets for service providers to populate for the DIB financial model
- DIB outline term sheet prepared based on stakeholder engagement
- Summary note on DIB legal and contracting structure, incorporating input from Reed Smith LLP
- Summary note to outcomes funders on pricing of outcomes (amount and methodology)
- Attendance and presentation at all-parties meetings to review term sheet and intervention model
- Draft financial model – including provider cost projections and outcomes payments
- Production of a slide deck summarizing the DIB
- Summary note prepared on performance management, operational and reporting processes
- Attendance and participation at all-parties calls and meetings to finalize MoUs

Sub-Result 2.2: Capacity of local partners to provide quality FP and other health services built.

2.2.1 Provide technical assistance to PSI network members to design, build, improve, and expand high- quality FP service delivery including through social franchising

Anticipated year-two outputs:
A. At least two QA audits supported including participation of host-country national staff
B. Technical assistance (remote and in-country) provided to at least three countries

Year-two progress on outputs (October 2015 to September 2016):

While no QA audits were undertaken in the first half of year two, SIFPO2 supported a QA audit in Tanzania (Q3) and in DRC (Q4) (2.2.1.A).

TA trips (2.2.1.B):

- SIFPO2 Project Director traveled to DRC in March/April 2016 to provide technical assistance to DRC Field Support Program.
- SIFPO 2 Deputy Director traveled to Ghana in February 2016, supporting the new Field Support Program.
- Co-executive Director of ADEMAS, visited PSI Benin to learn strategies on expanding FP services through SF in October 2015.
- SIFPO2 Technical Advisor for RH, traveled to Mozambique in September 2016 to lead trainings in provider behavior change communication (PBCC) and informed choice in support of young people's FP access and assist PSI-Mozambique to adapt and pre-test PBCC and informed choice tools.
- SIFPO2 Communications and Knowledge Management Advisor traveled to Mozambique to document youth FP work (including efforts funded by SIFPO2) in a program brief and to provide co-facilitation assistance for trainings in PBCC and informed choice.
- SIFPO2 Senior Program Manager traveled to Uganda in August to bring PACE, PharmAccess and UHF together to discuss SafeCare roll-out progress and begin developing a detailed workplan for year three that focuses on cost-effectiveness.

2.2.2. Train PSI local QA auditors and QA Regional Leads on revised QA model for integrated services

Anticipated year-two outputs:

A. Training conducted

Year-two progress on outputs (October 2015 to September 2016):

PSI facilitated a four-day QA strategy meeting for PSI's QA Regional Leads where PSI's global approach to QA was refined. An integral part of the meeting was the QA Regional Lead's orientation to PSI's new QA model for integrated service delivery (2.2.2A). The workshop served as an opportunity to garner their input and buy-in to the framework so that they can be PSI's ambassadors and on-the-ground support as the framework is disseminated across PSI's global network over the coming year. There was a lot of energy and enthusiasm generated in discussions around utilizing integrated service delivery as a way to bring more efficiency to PSI programming. As a result of the discussion, PSI will develop a program brief that describes current PSI programs operating integrated service delivery in order to disseminate learnings across PSI's global network and with the wider community. PSI also took advantage of having all QA Regional Leads in D.C. to ensure that PSI Washington staff are familiar with their role in ensuring QA and integrated QA at PSI.

2.2.3. Continue the development of QA Regional Leads

Anticipated year-two outputs:

A. Post-QA audit follow-up provided to at least two countries per region by the QA Regional Leads
B. Leadership role played by two QA Regional Leads at the PSI Global QA Manager Meeting
C. Two Adverse Event and Complications Review Board virtual meetings held

Year-two progress on outputs (October 2015 to September 2016):

Under SIFPO2 year one, PSI developed an initiative to elevate and train six local PSI clinical staff to serve as focal points for QA in their respective regions. These "QA Regional Leads" are now tasked with providing ongoing QA support to all FP/RH service delivery programs in their region. Shifting responsibilities to local leaders and developing greater expertise within each region has allowed quality to be assessed with more rigor, and with a greater understanding of the local context. Having regional QA leaders also allows PSI staff in countries to develop relationships that yield more frequent contact when

issues of concern arise or simply questions that lead to learning and quality improvement. For example, PSI-Tanzania staff reached out directly to the QA Regional Lead for East Africa when they began planning to initiate tubal ligation service delivery in 2016.

In this reporting period, PSI:

- PSI's Global Medical Director mentored QA Regional Leads as they developed clinical and programmatic responses to audit findings and supported programs to implement quality improvement action plants. Each QA Regional Lead provided audit follow-up or remote technical assistance to at least two countries in her or his region (2.2.3.A).
- QA Regional leads led external QA audits in other PSI FP/RH service delivery programs in Tanzania, Nepal, Mozambique, and Nigeria.
- QA Regional Leads traveled to Washington DC to contribute to a five day internal global QA strategy meeting. QA Regional Leads also gave presentations about QA in their respective regions to PSI HQ's staff, helping to raise the profile of QA within the organization (2.2.3.B).
- PSI implemented two Adverse Event (AE) and Complication Review Boards, led by PSI's Global Medical Director, with all leads joining in remotely to assess the root cause of AEs and evaluate a PSI program's response (2.2.3.C).

2.2.4. Hold capacity building workshop on integrated service delivery for PSI Social Franchise leaders

Anticipated year-two outputs:
A. Workshop held for PSI social franchisors

Year-two progress on outputs (October 2015 to September 2016):
SIFPO2 co-funded a meeting of social franchise managers in Nairobi, Kenya with 47 managers from 16 country platforms (2.2.4.A). At the meeting, each platform demonstrated how it had advanced the use of the global SF metrics to inform its decision making.

The group also worked on its franchise value proposition (to providers) and created work plans to further develop value propositions in 2016. A day visiting several Tunza franchisees helped cement franchise segmentation and the importance of creating an evolving value proposition. Lastly, PSI launched its new standardized QA (mobile) tool and gained consensus on the roll out across the franchises in 2016 and 2017.

2.2.5. Develop mobile health (mHealth) application for e-referrals in one USAID PRH priority country

Anticipated year-two outputs:
A. mHealth application developed for e-referrals
B. mHealth application tested in one PRH priority country

Year-two progress on outputs (October 2015 to September 2016):
PSI began developing an e-referral system in Nepal designed to send data to DHIS2. During the year, the mobile application designed specifically to handle e-referrals was developed in a local DHIS server and PSI was able to send and receive messages that are linked to DHIS2 seamlessly (2.2.5.A). After developing the initial model in Nepal, PSI decided to further test the application in Tanzania (2.2.5.B).

PSI Tanzania employed two different e-referral programs (Greenmash and Movercado) to test efficiency and effectiveness. After analyzing outcomes, PSI Tanzania has made significant progress in improving the e-referral system based on lessons learned to improve efficiency. There is a particular emphasis on improving communication and follow-up with potential FP clients. PSI Tanzania is also concerned with promoting sustainability by developing an in-house solution built on DHIS2 which will be more flexible and responsive to country needs and cost considerably less. This e-referral prototype is currently being refined

and will be field tested in Tanzania in October-November 2016. Based on field experience and feedback, a final version will be completed and deployed. This version will be available for replication in other PSI networks. PSI is already considering ways to make future versions even more user friendly for potential clients, and is exploring introducing voice recognition via phone for client identification.

2.2.6 Participate in international FP meetings, conferences, and working groups to share PSI lessons learned and best practices with the broader FP/RH community

Anticipated year-two outputs:
A. Key FP technical working groups, consultations and meetings attended by PSI SIFPO2 staff
B. Social Franchise Metrics Working Group lockdown meeting in October 2015 attended by PSI
C. Reproductive Health Supplies Coalition Annual Meeting and on-going working group meetings attended by PSI
E. Women Delivery Advisory Committee meetings and Women Deliver Meeting in 2016 attended by PSI
F. USAID-UNFPA led TMA working group meetings attended by PSI

Year-two progress on outputs (October 2015 to September 2016):

- In October 2015, PSI participated in the technical consultation "What Works in Adolescent Contraceptive Service Delivery" in Washington, DC.
- In December 2015 and June 2016, PSI participated in meetings of the FP and Immunization Integration Working Group in Washington, DC.
- Throughout the year, as a member of the FP Task Sharing Technical Working Group, PSI participated in working group teleconferences and contributed to the development of tools, such as the FP task sharing Call to Action.
- In February 2016, PSI participated in the UNFPA-USAID TMA working group, presenting findings on the application of the PSI approach to Total Market Approaches in Senegal.
- At Women Deliver in May 2016, PSI organized and facilitated a session on Overcoming Barriers to Young People's Access to Contraception.
- At Women Deliver in May 2016, PSI helped co-organize a session on Health Systems as Employers
- PSI Madagascar’s National Social Franchise Coordinator traveled to Denmark to speak about youth vouchers at the Women Deliver conference in Copenhagen in May 2016.
- Social Franchise Metrics Working Group lockdown meeting in October 2015: PSI co-facilitated this meeting in Bellagio Italy. The focus was on quality measurement. PSI has since started designing a protocol with PACE/Uganda to pilot a shortened list of quality measures at social franchises and determine if improvements in quality are correlated with method continuation. PSI is also working with M4M and an editor to publish a series of papers on quality that were written prior to the meeting and have since been revised.
- PSI's Technical Advisor and EC lead participated in the International Consortium for Emergency Contraception's (ICEC) annual meeting held in Washington D.C. in September, 2016, along with the follow-up Gates/USAID EC consultation where the price of EC and re-positioning EC as a peri-coital method was discussed.
- SIFPO2 Technical Advisor for RH, participated in the July 2016 working meeting in Switzerland hosted by WHO for the development of a tool to integrate adolescent considerations in broader sexual and reproductive health programs.
- In April 2016, SIFPO2 Technical Advisor for RH, traveled to London to participate in the USAID Task Sharing Technical Working Group meeting hosted by MSI and FHI360.
- PSI’s Technical Advisor for Youth and Girls, went to Amsterdam, Netherlands to chair and attend the 2016 Sharenet meeting on adolescent and youth SRH, in September 2016.
- In September 2016, the Long-Acting Reversible Contraceptive and Permanent Method Community of Practice (LARC/PM CoP) Secretariat, PSI, along with FHI 360, Pathfinder International and its Evidence to Action Project (E2A), *Consensus to Action: Developing Solutions to Expand Method Choice for Youth* (2.2.6.A). *See activity 2.3.2 for more information.*

- In July 2016, the LARCs/PM Cop/PSI hosted a meeting, " Streamlining Service Delivery to Expand Access: Innovations in IUD Insertion Technology," to learn about two innovations supported by Saving Lives at Birth and designed to simplify IUD insertion, including immediate PPIUD insertion, and expand the number of providers with the ability and confidence to offer clients this important option. (2.2.6.A) *See activity 2.3.2 for more information.*
- In July 2016, the LARC/PM Cop Secretariat/PSI hosted a technical consultation to address expanding access to LARCs and permanent methods through task sharing. (2.2.6.A) *See activity 2.3.2 for more information.*
- In September 2016, PSI presented the SIFPO2 year one study of FP referrals in Mozambique at a technical consultation on community-based FP referrals hosted by the USAID Advancing Partners and Communities project.

2.2.7 Participate in 2016 International Conference on FP (ICFP) in Nusa Dua and hold capacity building pre- meeting for PSI network staff

Anticipated year-two outputs:
A. Participated in the international steering committee and relevant sub committees
B. One-day pre-meeting hosted for PSI affiliates attending the conference
C. Abstracts submitted for panels and presentations to contribute to global learning
D. PSI implementation successes and learnings presented at a conference

Year-two progress on outputs (October 2015 to September 2016):
PSI SIFPO2 staff attended the ICFP in Bali, Indonesia to contribute to and learn from the collaborative global knowledge on FP efforts around the world.

On January 24, 2016, global PSI staff gathered for a one-day pre-meeting (2.2.7 B). The day began with a discussion of PSI's strategic priorities with PSI's Director of Family Planning and Reproductive Health, and its President and CEO. PSI's Global Medical Director then led a discussion on current research in contraception and voluntary FP. There were also facilitated dialogues on the importance of quality communication around voluntarism, informed choice and method-specific language. Two of PSI's technical advisors conducted a values exploration activity to highlight the importance of self awareness in FP topics. The day ended with a session on the importance of informed choice, and resulted in a collaborative knowledge exchange.

With support from SIFPO2, PSI presented research on various topics (2.2.7.C and D), including:
- Leading with evidence: Implementing a global management information system to improve evidence-based decision making
- A comparison of case-mix, client-volume, and revenue between franchised and non-franchised providers in Kenya
- Task shifting to auxiliary nurses as an opportunity to expand delivery of LARC: PASMO Guatemala's experience
- Improving FP interventions through the Movercado ecosystem in Mozambique
- Improving access to family planning services in the Democratic Republic of Congo
- Role of the private sector in health systems strengthening and workforce training in family planning in the DRC
- Integrating FP into PSI Ethiopia's MULU/MARPs HIV prevention project (The word "MULU" when translated from Amharic, means complete, while MARPS is the acronym used for "most at-risk populations.")

SIFPO2's Technical Advisor on RH co-organized and introduced the IBP Concurrent Session entitled, "Reaching Young People with Contraceptive Information and Services" on January 27, 2016 (2.2.7.A). PSI and other partners also launched a consensus statement supporting the expansion of contraceptive choice for young people to include LARCs. More than 50 leading global health and development organizations have endorsed the statement. At ICFP, PSI co-led an event to celebrate the global consensus statement.

2.2.8. Develop PSI's guidelines for gender based violence (GBV) response based on pilot experiences

Anticipated year-two outputs:
A. Clinical and programming standards and guidelines for responding to GBV revised and disseminated within PSI's global network
B. GBV research and programs at PSI: Checklist for program design and start-up developed and disseminated within PSI's global network
C. Webinar for PSI staff conducted to provide guidance on using the checklist and guidelines

Year-two progress on outputs (October 2015 to September 2016):
To improve PSI's clinical and programming standards and guidelines for responding to GBV based on experience in the field, SIFPO2 gathered input from PSI network members, including those in Guatemala, Madagascar and DRC, who have begun to use the guidelines with other funding. With funding from the Embassy of Sweden in Guatemala (SIDA), PASMO Guatemala is partnering with five local organizations to develop integrated and effective programs to prevent and respond to GBV. PASMO identified a need for an information sharing policy template, which SIFPO2 added to the guidelines as an annex.

Several countries expressed a need for a provider handbook to accompany the programming guidelines. In response, SIFPO2 developed a provider handbook called "Responding to Gender-Based Violence in Social Franchise Health Care Settings." The handbook content is an adaptation of the "Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A clinical handbook developed by the World Health Organization (WHO), UN Women and UNFPA" (2014). SIFPO2 translated the provider handbook into French and disseminated both the French and English versions to network members with funding to address GBV (2.2.8.A). In March, PSI shared the French version of the handbook with MoH and Ministry of Women, Family and Children stakeholders in DRC during a Passages Project ToT. The DRC MoH's National Adolescent Health Program adopted the use of the French version of the handbook.

SIFPO2 seeks to ensure that PSI network members consider all critically important factors—such as their capacity for GBV program evaluation—before seeking funding and embarking upon GBV programs. To further this goal, SIFPO2 developed an internal tool: Gender Based Violence Research and Programs at PSI: Checklist for Program Design and Start-Up (2.2.8.B). In March, PSI's network member in Haiti piloted the use of the tool when designing a GBV project with local partners. SIFPO2 will disseminate the tool within PSI's global network pending approval by the senior management team. Through SIFPO2, PSI's Director for HIV and TB delivered an internal presentation and webinar on PSI's GBV tools and approaches took place in September 2016 (2.2.8.C).

Also through SIFPO2, ICRW provided remote technical assistance to PSI's team in Haiti to guide the development of a GBV research protocol. Haiti is ranked second in the Global Slavery Index and has close to half-million unpaid child domestic workers, called "restavèks"—the majority of whom are girls. These children frequently experience profound physical, sexual, and psychological abuse at the hands of the families for whom they work. A philanthropic partner in PSI's Maverick Collective recently committed funding to enable PSI OHMaSS (PSI's network member in Haiti) to address the needs of vulnerable girls, including restavèks, in Haiti. To inform the approach, PSI OHMaSS plans to engage vulnerable girls in mapping exercises to locate existing services within identified safe zones (also called 'safescaping'), in order to build a referral network that is accessible to them. SIFPO2 enabled PSI OHMaSS to leverage ICRW's expertise in participatory action research involving adolescent girls and GBV survivors. In March 2016, ICRW's Director of Gender Violence and Rights held a call with PSI OHMaSS to discuss the project's conceptual framework, ethical safeguards for the study, and examples of studies using the safescaping approach.

Sub-Result 2.3 Innovative partnerships to strengthen service delivery networks pursued.

2.3.1. Conduct TMA analysis in two additional PRH priority countries

Anticipated year-two outputs:
A. FP TMA analysis completed in at least two countries

Year-two progress on outputs (October 2015 to September 2016):

Senegal: In 2015, at the request of the Senegalese Department of Reproductive Health and Child Survival (DSRSE), PSI and ADEMAS conducted a total market landscaping analysis for family planning commodities and services, to feed into the National Action Plan for FP 2016-2020. PSI and ADEMAS conducted a secondary analysis of existing surveys, a literature review, and collected data through government documents, in-depth interviews with key market players and influencers, and an outlet survey. In January 2016, a technical working group of key government players, development partners including ADEMAS, PSI and MSI, professional associations and private sector actors completed an initial validation of the marketing landscaping, identified priority market constraints, and shared a report from this with USAID Senegal. In August 2016, the group held a second workshop to outline activities and key indicators.

Elements of the new DSRSE strategy that can be attributed to the results of this work include:

- Emphasizing the need to address the absence of LARCs in public facilities
- Ensuring that services are designed for and cater to youth
- Addressing the legal framework that does not allow services provision in pharmacies
- Recognizing that private sector data go unaccounted for in the national health system
- Strengthening the private sector's capacity to provide LARCs

Going forward, the DSRE's strategy will work to strengthen the regulatory framework around private sector contribution by increasing the number of private providers and encouraging distribution of contraceptives by private sector actors. Examples of this work includes lifting facilitating registration of providers and new products, and allowing pharmacies to provide oral contraception without a prescription. The DSRE has also committed to improved coordination as part of a multi-sectoral TMA. PSI will share the final report with the MoH, USAID, and other partners in October 2016. The National Family Planning Technical Committee will take responsibility for monitoring each of these indicators during quarterly meetings, and will also establish a mechanism for collecting distribution data from the private sector, so that the volume and value of the public, NGO and private sectors can be tracked over time.

Mozambique: Supported by the SIFPO2, PSI Mozambique started a total market analysis for FP in March 2016. The platform hired an external consultant to conduct the desk review and secondary data research, while the in-country team coordinated market research interviews that examined the market players and functions, stakeholders and relationships within the health market (with an emphasis on the private sector players and channels). The questionnaires were conducted by an external agency who also worked on preliminary analysis of the information gathered. The landscape was finalized in June 2016 and helped identify the role of the private sector in health products and services delivery in Mozambique, the current players involved in performing the core demand and supply functions as well as the current state of the market environment that influences (positively or negatively) the core functions and role of stakeholders influencing that. The key findings from the TMA landscape were used to develop further analysis of how the current market failures and constraints affect health seeking behaviors of adolescents and youth. The landscape helped guide PSI's decisions on how to respond to the needs of the beneficiaries. Preliminary information has been shared with key stakeholders such as UNFPA, USAID, and the Dutch government. A formal dissemination workshop with key government and other stakeholders that were engaged on this piece of work has been discussed and most likely will happen during the first quarter of 2017. Further dissemination will be done to the newly-formed social marketing technical working group (composed of MoH, donors, and other NGOs) to introduce social marketing and the concept of TMA to government stakeholders. This technical working group is seeking to help frame the legal framework of social marketing

in Mozambique. Developing a legal framework for social marketing in Mozambique would improve service delivery and PSI's ability to strengthen the market with products and services.

Cambodia: In Cambodia, PSI began its TMA work through two external workshops attended by the National Maternal and Child Health Centre (NMCHC), USAID, commercial and NGO partners. These and other partners were also engaged through in-person interviews in order to fully capture their knowledge of the market. Following the TMA process, PSI-Cambodia (PSI-C) and PSK first analyzed data from the Cambodian Demographic Health Survey (CDHS) 2014 to understand who the market was failing, and considered equity lenses such as age and wealth to identify segments of the market that were being disproportionately underserved. For the family planning market in Cambodia, the TMA analysis identified girls and women between the ages of 15 to 29, traditional method users, urban wealthy women and discontinued users as being failed by the market, which was confirmed by the external partners. When considering *how* the market was failing, PSI-C, PSK, and partners identified the following key market constraints: motivations and bias of providers that lead to low quality of service and counseling, and negative belief of clients; and lack of promotion along value chain, promotion is relying on NGOs. PSI-Cambodia and PSK are now finalizing the results of the TMA by developing a root cause analysis of the market constraints and disseminating results to partners. Follow-up actions are underway, for example: discussions between UNFPA and PSK about collaborating on research on young people; PSI-Cambodia and PSK preparing the launch of a new generation oral contraceptive to fill a product gap identified; NMCHC incorporating the results from the TMA into their Reproductive Health Commodity Security Strategy due to be completed by the end of 2016; and the USAID Mission in Cambodia using the TMA results to inform their on-going mid-course review of their Country Strategy.

2.3.1.1 PSI TMA for FP workshop in Asia (added in November 2015)
Anticipated year-two outputs:
A. A workshop report will be provided to USAID

Year-two progress on outputs (October 2015 to September 2016):
In June 2016, SIFPO2 supported a TMA workshop in Thailand. A three-day workshop was held in Bangkok to: Increase awareness and understanding of PSI's market development approach and to analyze current and future work by PSI in Asia for adapting this work to family planning; increase understanding of how and when the market development approach can be used; and Increase ability among participants to effectively communicate PSI's market development approach to other PSI team members as well as external partners.

Participants included: representatives from PSI's network members from Nepal, India, Pakistan, Cambodia, Laos, Vietnam, Myanmar, Papua New Guinea, and Bangladesh; PSI's regional research and marketing advisors from Asia, East and West Africa; and representatives from PSI's Evidence for Implementation, and Family Planning/Reproductive Health teams. The workshop was led by the Global Social Marketing team with support from the Asia Regional Support Team. The three-day workshop was kicked off with a presentation by SIFPO2 Director who presented on TMA as a tool to address unmet family planning needs and reach FP2020 goals. I also included an overview of the market development approach and practical examples of how it is being implemented for family planning in India. The workshop was organized around the four questions PSI seeks to answer when using the market development approach:

1. **Who is the market failing? (Set the Strategic Framework)** PSI considers potential consumers (the total need for a product or service) and actual consumers (total use of a product or service) in a market. This initial analysis of the gap through equity lenses such as age, gender, geography, wealth quintile and risk behaviors help determine who the market is failing among users and non-users.

2. **How is the market failing? (Understand the total market)** PSI conducts a robust market mapping and landscaping exercise to determine the key players in the relevant health market, the functions they are or are not performing, and how the enabling environment influences their capacities and incentives to perform. We also measure market performance in terms of health trends, quality of use of health products and services, as well as the availability of quality, affordable products and services in the market.
3. **Where do we work in the market? (Design the Intervention)** PSI determines this based on where PSI is best positioned to further market development, and design interventions to influence the incentives and/or capacities of relevant market players as well as create a conducive environment to improve overall market performance.
4. **How will we get there? (Work plan and Monitoring and Evaluation Plan)** PSI determines the steps to achieve our interventions' goal and metrics that will track our progress in getting there. The structure of workshop included: presentations on the Theory of Change; Use/Need Analysis; Market Trends; Market Performance - Breadth and Depth; Market Structure - Production-to-Use Spectrum; and Market Functions; illustrative examples (from India) for each step of the market development approach; and for each major concept an activity. The activities were developed to help simulate the experience of the market development approach process. Participants were encouraged to review and analyze data and present their findings for discussion. At the end of each day, presenters held a panel question and answer session to address any lingering questions and clarify concepts.

On the final day, the Global Social Marketing team presented a quick overview of how do approach market landscaping with the market development approach in mind. In other words, not every network member will be able to apply a full market development approach due to funding or other constraints but it is a way of thinking and understanding our markets we work in.

2.3.2. Serve as secretariat for LARC & PM Community of Practice and co-chair of Vasectomy Sub-Working Group

Anticipated year-two outputs:
A. Two technical consultations organized by the LARC/PM Community of Practice held
B. Two global webinars organized by the LARC/PM Community of Practice conducted
C. Resources on Community of Practice website updated
D. Three Vasectomy Sub-Working Group meetings held

Year-two progress on outputs (October 2015 to September 2016):
PSI has continued to play an active role as secretariat of the LARC/PM CoP.

In December 2015, PSI supported a meeting of a USAID consultative group for the LNG-IUS that brought together donors, implementing partners, and suppliers to discuss strategies around LNG-IUS introduction and identify areas for collaboration, including development of training materials. PSI has continued to co-lead a sub-working group of partner organization that has convened to map and share information on individual country introductions, share lessons and discuss common challenges.

As co-chair of the voluntary vasectomy sub-working group, PSI helped to organize and facilitate two Vasectomy Working Group meetings, and also helped organize a global webinar titled *What Do Men Have to Do With It? An Update on Vasectomy Trends and Program Successes*. Eighty-three participants joined the webinar and engaged in active discussion following the presentations.

On July 13, 2016, PSI hosted a technical meeting in Washington DC called *Streamlining Service Delivery to Expand Access: Innovations in IUD Insertion Technology*. The objective of the meeting was to share information about two new IUD insertion technologies supported by Saving Lives at Birth:

- A reusable IUD inserter designed by Bioceptive to make interval IUD insertions simpler, safer, and more intuitive
- A PPIUD inserter designed by PSI, Pregna International Ltd., and the Stanford Program for International Reproductive Education (SPIRES) to allow for a standardized, easy-to-learn insertion technique in the immediate postpartum period

The 29 meeting participants represented USAID, the Bill & Melinda Gates Foundation, the MoH of Nigeria, two academic institutions, a private company (Bioceptive), and five cooperating agencies involved in strengthening FP service delivery. The meeting report highlights key messages delivered by the speakers and provides links to the presentations and resource documents. The report is available here: http://www.psi.org/publication/streamlining-service-delivery-to-expand-access-innovations-in-iud-insertion-technology/ and was distributed through the LARC & PM CoP website.

On July 14, 2016, PSI hosted a one-day technical consultation in Washington DC called *Expanding Access to Long-acting Reversible Contraceptives and Permanent Methods through Task Sharing.* The 68 meeting participants represented USAID/Washington, USAID/Ethiopia, USAID/Nigeria, the Bill & Melinda Gates Foundation, the World Health Organization (WHO), the World Bank, the Ministry of Health of Nigeria, two academic institutions, four private industry partners (Bayer, Bioceptive, Merck, and Laerdal Global Health), and 16 cooperating agencies involved in FP programs. During the meeting, participants refreshed their knowledge of the WHO guidelines for FP task sharing as they relate to LARCs and PMs, learned from cases of task sharing research and scale-up including a presentation by the Nigerian MoH on community-based provision of LARCs, heard about seven tools or resources related to LARC/PM task sharing, and formulated recommendations in small groups. The meeting report is forthcoming.

On September 20, 2016, PSI along with Pathfinder International, E2A and FHI360, hosted a technical consultation entitled *Consensus to Action: Developing Solutions to Expand Method Choice for Youth*. The one-day meeting was held in Washington, D.C and brought together 66 participants from USAID, FP2020, and a number of implementing partners working across adolescent and youth sexual and reproductive health. The purpose of the meeting was to develop a series of recommendations for how to put the global consensus statement, which was developed by this consortium and is being promoted worldwide, into action. The key themes focused on addressing provider values and perceptions; improving contraceptive counseling; creating demand; strengthening advocacy initiatives; measuring and using data; and getting to scale. A follow-up meeting was held on October 19, 2016 at PSI with a select group of technical experts from USAID, PSI, Pathfinder, E2A, FHI360, MSI, FP2020, and HC3 to refine recommendations surrounding the cross-cutting themes of messaging, task-shifting and quality of care.

PSI has also planned a LARC removals webinar that will take place in January 2017.

2.3.3 Lead sub-group on social franchising research, within the private sector in Health Thematic Working Group of Health Systems Global

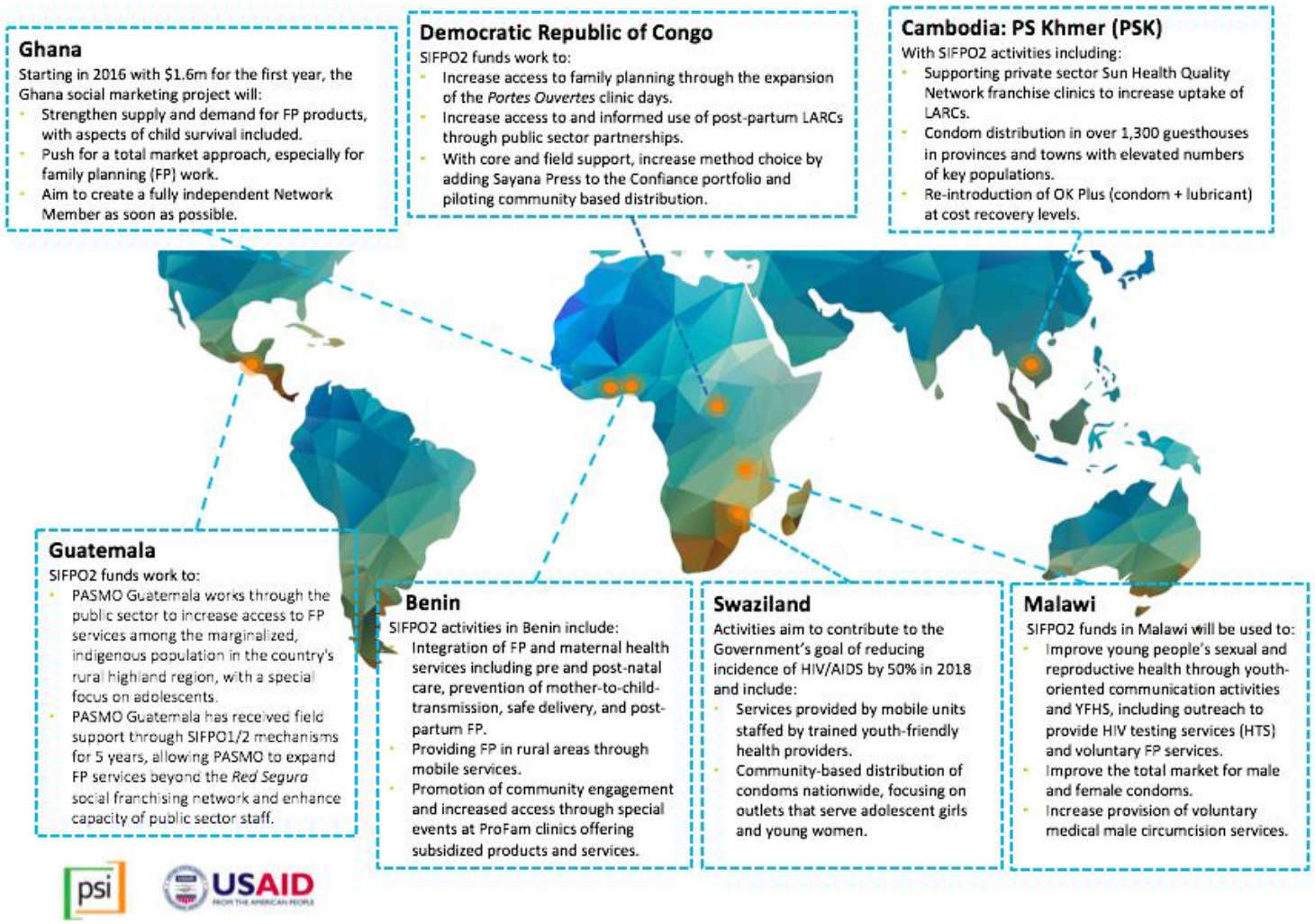
Anticipated year-two outputs:
A. Initiation and effective functioning of the sub group

Year-two progress on outputs (October 2015 to September 2016):
Health Systems Global, the association of health systems researchers, has created a number of working groups based upon member interest. The Private Sector in Health working group, of which PSI is a member and has previously participated through pre-conference meetings, is a broad and diverse array of researchers with many interests. Among these, several researchers are interested in SF, and PSI has offered to lead a group of these researchers to share ideas, discuss study designs and findings, and collaborate on future work. The sub-group is housed under a Harnessing Non-state Actors for Better Health for the Poor (HANSHEP)-funded platform known as “The HUB” (www.healthsystem shub.org/group s/16).The delivery of this activity was impacted by the absence of the SIFPO2 Research Advisors for the second half of 2016. This was conveyed to USAID and with the permission of USAID with additional efforts

made instead to engage and support the activities of the Social Franchise Metrics Working Group (activity 1.1.6).

SIFPO2 Field Support

- Benin
- Cambodia
- DRC
- Ghana
- Guatemala
- Malawi
- Swaziland



Benin

In October 2015, ABMS/PSI Benin was awarded funding from SIFPO2 to increase the use of modern FP methods among sexually active women of reproductive age through the application of social marketing and SF in key intervention zones throughout Benin.

The program seeks to:

- Increase contraceptive access through the private sector;
- Increase demand for integrated voluntary family planning and maternal health services and products; and
- Improve the quality of the ProFam social franchise network.

Additionally, ABMS/PSI worked to prevent and control Ebola Virus Disease (EVD) and to raise awareness about the dangers of purchasing, using, and selling counterfeit or substandard artemisinin-based combination therapies (ACTs). Implementation of the activities started in October 2015 and achievements for each result area are as follows:

Objective 1: Increasing contraceptive access and voluntary utilization through the private sector

Under this result, ABMS/PSI maintains efforts to address Benin's FP needs by increasing informed access to and use of integrated voluntary FP and maternal health services and products. ABMS/PSI uses multiple distribution channels to ensure availability of FP products for intended beneficiaries.

Key activities and results:

From October 2015 to September 2016, ABMS distributed and sold voluntary FP and child health products in both private health clinics and pharmacies. Distribution and sales figures for the fiscal year 2015-2016 are indicated in the table below.

Figure 2: Sales and distribution (Objectives for October, 2015 through September, 2016)

Products	Oct.2015-Sept.2016 Sales/Distribution	Annual objectives	% Achieved
Laafia® Oral Contraceptive	193,538	196,500	98%
Laafia® Injectable	45,517	43,000	106%
Laafia® IUD Kits	27,360	20,000	137%
Laafia® Implant	27,656	26,000	106%
Prudence Plus® Condoms	5,012,513	9,485,500	53%
Laafia® Cycle Beads	2,746	2,700	102%
Orasel/Zinc® kits	457,256	383,000	119%
Aquatabs®	7,510,420	7,200,000	104%

- 50 ProFam clinics offered integrated services, including: voluntary FP, antenatal and postnatal consultations, delivery services using active management of the third stage of labor (AMTSL), prevention of mother-to child transmission (PMTCT), HIV counseling and testing, STI treatment and cervical cancer screening
- 37 providers were trained on integrated services to address challenges linked to clinic staffing turn-over
- 15 voluntary FP promotion days were conducted in which free counseling and services were offered at ProFam clinics. During these days, 348 FP clients were served; of them 154 chose an IUD or implant

- 32 outreach sessions in five Health Zones were conducted by the mobile service team. During these sessions 1,272 new FP clients received services
- 528 medical detailing visits were conducted in ProFam clinics and pharmacies in order to assure availability of quality products
- Four medical detailers received refresher trainings on PBCC
- 161 pharmacy assistants received refresher trainings on Laafia brand contraceptive products
- ABMS provided support to ProFam clinics on the development of the association "ANC ProFam." ABMS gave technical and financial support to this association to set up the management committee in each local area and to hold their first General Assembly. 70 providers and clinic managers attended the first Assembly.
- Twelve providers received training on business skills and project design. These 12 trainers will train their peers in the next quarter. The objective is to ensure they have the capacity to design and implement business improvement projects. One of the first topics the clinic managers want to tackle is the development of better waste management systems in their own clinics by building incinerators.

Objective 2: Increase demand for integrated family planning and maternal health services and products

In order to increase demand for integrated FP and maternal health services and products, ABMS/PSI continued demand generation for FP use and promoted Laafia brand, *Prudence Plus* condoms, *Aquatabs,* and *Orasel-Zinc* through radio campaigns and a variety of media such as television, Facebook, and the toll-free hotline (*Ligne Verte)*.

Key activities and results:

- Promotion of *Laafia* products: Promotional activities were conducted to increase awareness of the advantages of FP methods. ABMS continues to use multiple channels to provide informed choice of FP methods. ABMS's hotline and Facebook page provided information on the location of the nearest ProFam clinics for women interested in FP counseling and services.
- As part of the introduction of Sayana Press in Benin, representatives from ABMS, Advancing Partners and Communities (APC), and Maternal Health Department from the MoH conducted a joint study visit in Burkina Faso in July 2016 to learn about experiences in launching Sayana Press at community level. ABMS, in collaboration with APC under the leadership of the MoH developed training materials (trainer's guide, participant workbook). A communication plan was also developed and materials will be pretested and finalized before the launch of the product.
- ABMS continued to implement communications campaigns to raise awareness about the dangers of purchasing, using, and selling counterfeit or substandard ACTs. The first campaign was designed to reach family members responsible for purchasing anti-malarials, including pregnant women and mothers of children under five, to raise awareness about the dangers linked to purchasing and using counterfeit and substandard anti-malarials; the second reached small business owners and entrepreneurs to raise awareness about the dangers of selling such substandard medication. Different strategies were used to disseminate messages and sensitize the the intended beneficiaries. ABMS used multiple communication channels to disseminate messages linked to the campaigns, including mass-media, the *Ligne Verte*, a mobile video unit (MVU), informational stands located in markets, and IPC agents. During this reporting period, ABMS:
    - Reached 14,624 women and caregivers via 8521 IPC sessions;
    - Distributed 11,510 informational flyers;
    - Received 2549 calls regarding questions about ACTs;
    - Sensitized 776 entrepreneurs of small businesses and 2,036 clients regarding the dangers of selling, purchasing, and using counterfeit or substandard ACTs; and
    - Broadcast 5,789 radio spots on the dangers of purchasing, selling, or using counterfeit or substandard ACTs.
- With the support from the MoH and USAID, PSI organized a workshop in September 2016 to capitalize on what has been achieved during the campaign. The objective was to analyze the results and to develop the recommendations. Approximately thirty participants from different entities

participated at the workshop: USAID, MoH, Ministry of Interior and Public Security, Ministry of Justice, Quality Control National Laboratory, representatives from the entrepreneurs and the peer educators.

- As part of the National Ebola Communications Committee, ABMS/PSI developed and implemented a communication plan designed to engage with and educate the public on EVD. The communication activities were focused on increasing the public's general knowledge of EVD (causes, signs, symptoms, addressing myths/misconceptions); EVD prevention and risk reduction actions for individuals /households /communities; actions needed in case of suspected EVD or other hemorrhagic fever cases: The plan has helped reach critical rural and urban areas. From October 2015 to September 2016, ABMS:
    - Reached 56,730 people through 5632 IPC sessions with messages about EVD;
    - Trained 1,426 people (ABMS staff, IPC agents and supervisors, community volunteers from Peace Corps, Non-governmental organizations (NGOs) and young scouts)
    - Broadcasted 15,469 radio on 17 local radio stations in support to the IPC activities; 430 broadcasts bands scrolling on TV
    - Created 91 road signs for EVD prevention
    - Received 11,225 calls with questions about EVD

Objective 3: Improved quality of the ProFam social franchise network

Under this result, ABMS/PSI continued to reinforce the provision of high quality services through training, regular supportive supervision visits and refresher trainings to the ProFam network providers. During the period of October 2015 to September 2016, ABMS/PSI recruited 13 new ProFam clinics in addition to the 57 existing clinics in the network and continued to provide support to the total 70 clinics of the ProFam network through supervisions, trainings, and evaluations.

Key activities and results:

- ABMS received an external audit during the second semester to evaluate compliance with the 21 standards and five norms of the ABMS/PSI quality assurance plan. Fifteen selected clinics were visited during this visit. It is expected to receive the report of the external QA audit this coming month. An action plan will be developed based on the recommendations and findings.
- ABMS/PSI conducted an evaluative supervision among ProFam providers. The evaluation is ongoing. Results will allow ABMS to identify high performing clinics and providers among which the top 10 will be rewarded. Low performing clinics and providers will receive more intensive supervision to improve performance.
- In order to strengthen capacities of clinics to prevent and detect suspected EVD cases, eight training sessions were organized, reaching 260 providers and clinic managers from ProFam, youth centers and affiliated clinics. Clinics were also equipped with EVD supplies and equipment to meet minimums standards for infection prevention control. These supplies included electric thermometers, sterilized gloves, and alcohol for disinfection.

Challenges

ABMS encountered the following difficulties throughout the year, especially during the first semester: *ProFam* clinics have faced provider turnover due to the fact that the government of Benin has recruited thousands of service providers from the private sector. Providers often prefer to work for the government system due to the benefits provided. While a strong public sector is a good thing for the total market, users will still often use and rely on the private sector, so it is essential that the private sector continues to provide quality, affordable health products and services. To address this problem, ABMS/PSI will consider the motivation of the providers in the selection criteria for the network. Additionally, ABMS will require that two providers are trained in each ProFam clinic, to minimize disruption caused by turnover. Work to improve business skills of private providers will also be reinforced, so as to increase their financial sustainability.

ABMS/PSI was unable to complete the activities related to the launch of Sayana Press during this reporting period due to a delay in registration and arrival of the product. ABMS/PSI is in charge of the

communications and the roll-out of the communication tools is pending the availability of Sayana Press in country.

Success story

Mrs. Hoonon is a former retailer of fake ACTs. She was part of hundreds of illegal vendors in the Dantokpa market, one of the biggest medicine markets in Cotonou. For nearly eight years, she worked there steadily growing her business. She owned land and could easily feed her family with the income from the sale of these fake medicines.

One day, listening to the radio she heard about the adverse effects of fake anti-malarial medication, including kidney failure. ABMS/PSI was conducting a communication campaign to raise awareness about the dangers of purchasing, using and selling counterfeit or substandard ACTs. The campaign reached small business owners and entrepreneurs like Hoonon.

"I was very touched by this message. I don't want to contribute to the death of some of these children who die innocently. I had to abandon the sale of fake drugs despite the benefits I made with them." Today, Hoonon only sells other products (children's diapers, toothpaste, cookies etc.) and she says "I am proud of my current work despite the difference of the income. I have a clear conscience, and I pray that other vendors one day stop this dangerous activity."

Cambodia

The following highlights the achievements during the reporting period from October 1, 2015 to September 30, 2016 of the SIFPO2 project.

During fiscal year, PSI-Cambodia and local implementing partner Population Services Khmer (PSK) provided support for Sun Quality Health Network (SQHN) members through supportive supervision, quality assurance, refresher trainings and analyses of provider data using DHIS2; stimulated growth of the commercial sector for FP commodities, including a focus on ensuring condom access at high risk locations; and engaged the public sector to support reproductive health commodity access and security. PSI-Cambodia and PSK undertook a total market assessment to better understand the FP market in Cambodia and where it fails consumers. PSI-C and PSK worked with a network of 115 registered acute respiratory illness (ARI)/pneumonia providers to generate demand for and ensure an accessible, high quality supply of services and supplies to treat pneumonia, ARI, and diarrhea. PSI-C also provided training and technical assistance to strengthen PSK systems and ensure PSK's sustainability as a national leader in FP services. PSI-C also received funding under SIFPO2 to conduct a survey on bed net preferences, the findings of which were disseminated to the government and partners in August 2016.

Objective 1: Increase the supply of and demand for modern methods of voluntary family planning and reproductive health services

Under this objective, PSI-C and PSK increased the use of modern FP methods among sexually active women of reproductive age, with an emphasis on LARC methods, using a Total Market Approach.

Activities and Results:

Support to SQHN providers: PSK conducted supportive supervision visits (SSVs) to 13 SQHN providers in Q1, eight in Q2, and 12 in Q3. In Q4 one SQHN provider resigned for personal health reasons, so at the current time, SIFPO2 supports 13 SQHN providers. PSK conducted 15 SSVs to the 13 SQHN providers in Q4, with all providers meeting minimum quality standards.[1]

In addition to providing a quality check and on-the-job skills coaching, these visits used PBCC to encourage providers to initiate their own clients for LARC methods and to continue to provide post-abortion FP services. As a result of this effort, walk-in FP clients have increased from 209 in the last reporting period (December 2015 to February 2016) to 262 in Q3.

Community mobilizers (CMs): During year two, CMs successfully referred 530 women (out of 6,323 clients contacted), who all visited a SQHN provider for services. In order to help CMs develop their monthly visit plan, the project mapped households in 38 villages and rolled out the use of a new IPC tool called the "IPC algorithm," which helps CMs categorize potential beneficiaries so that they can customize their messages. The categories of intended beneficiaries are postpartum women, post-abortion women, traditional method users, women who more than five children, and non-users of FP.

Stimulate growth of the commercial sector: PSK continued to support major distributor Mega Lifesciences to expand their coverage to new outlets within their current provinces in order to increase FP product availability. From September 2015 to August 2016, Mega expanded to 232 new outlets, reaching a total of 2,749 outlets (September data not yet available).

PSK's supply of Eva Marvelon (480,000 units ordered at $1/cycle) is expected to last until mid-2017 at the current sales level. The projections for product sales have been surpassed, showing an increasing demand for this product, which is not subsidized and offers a mid-level price point in the pill market.

[1] SIFPO started with supporting 15 SQHN providers. 1 provider passed away in 2016 and the 2nd resigned in Q4.

Using its own funds, PSI-PSK are developing a third generation oral contraceptive brand and launch plan (in collaboration with other PSI countries also interested in this product) and are planning to introduce the new product to the market in Cambodia at a price accessible to wealth quintiles two and three. This product will be priced between the OK Pill and Eva and will not benefit from any subsidy. In Q4, PSI and PSK began the registration process for the new OCP called Meuri, which is expected to be approved by the end of December 2016. The launch of Meuri will help to fill a gap identified in the FP TMA process, where it was found that 95% of the current OC market is the same older generation of pills as OK pill and Srey Pich, the public sector brand.

PSK also conducted a qualitative study to assess the feasibility of introducing a monthly injectable contraceptive into the Cambodian market. The purpose of the study was to: assess the acceptability of a monthly injectable contraceptive; assess the willingness of consumers to pay and the willingness of providers to purchase a monthly injectable; and determine an optimal price point for a monthly injectable. To respond to the objectives, the study reached 260 women of reproductive age and 110 providers (both pharmacies and clinic providers) within the Phnom Penh area.

Key findings included:

- A high interest from consumers and providers in a monthly Injectable (83% of consumers and 85% of providers expressed their interest).
- Optimal price point for providers to purchase was 2,400 Riel ($0.60) with an acceptable range of 1,400 to 4,700 Riel (0.35-1.20).
- Optimal price point for consumers to purchase was 5,000 riel ($1.25) with an acceptable range of 2,300 to 10,200 Riel ($0.57 - $2.55).

However, PSK also found that PSK would need to sell the product at 6,000 Riel to be reasonably cost recoverable, which is higher than the results found for the optimal price point. Further, even if the price was set at a higher price point with an intended smaller market, then we would likely not meet minimum order quantities for manufactures. Therefore, PSK does not intend to pursue this product at this time.

Total market approach: PSK and PSI engaged in the FP TMA assessment during this reporting period including completing *Step 1: Who is the Market Failing?* and *Step 2: How is the Market Failing?* and holding two external workshops (in June and September) and one internal workshop (in September) with facilitation support from PSI/Washington and the regional team. PSI also introduced the “Production to Use Spectrum” which is part of the TMA framework and a way to understand the total FP market from end to end. In between the two workshops, PSK completed primary data collection through interviews with over 40 market players and then analyzed and synthesized the data, along with information from a literature review, into proposed key market constraints. The second workshop included presentation of market data including market depth, breath, and information on various FP products, including the Four Ps (product, price, place, promotion). The proposed key market constraints were also presented, and the group reviewed and discussed their own ideas about the key market constraints. The workshop also covered participants’ vision for a health FP market, ways to address the market constraints, and proposed ideas for the way forward.

Public sector engagement: In June, PSK participated with the small group of partners including United Nations Population Fund (UNFPA), USAID, National Maternal and Child Health Center (NMCH) and Reproductive Health Association of Cambodia (RHAC) to continue working on the draft of the Cambodia Reproductive Health Commodity Security Strategy Action Plan and Forecast 2016-2020 developed by John Snow International. As of the end of September 2016, the NMCH is still finalizing the strategy.

Key activities for October to December 2016: PSK will continue to engage with the commercial sector for joint demand creation activities for FP among young people at universities and within the catchment areas of garment factories.

Objective 2: Increase sustainability of commodity supply for HIV prevention and FP

PSI-C and PSK are working to increase the capacity of the commercial and public sectors to participate in and strengthen the condom market as a part of a broad range of FP options in Cambodia, as well as to ensure the availability and visibility of condoms at high risk locations.

Activities and results

Ensuring condoms and lubricant at guesthouses and other high-risk venues: PSK's three full-time merchandizers and seven sales representatives target guesthouses and other high-risk venues such as karaoke bars and massage parlors through the HIV Flagship Project's Center of Excellence organizations. The results for each quarter are as follows:

Figure 3:

Period	Guesthouses covered	% covered	Total Condoms Sold	Condoms sold to high-risk venues	% to high risk venues
Q1	1,288/1,351	95%	3,036,828	815,454	27%
Q2	1,348/1,351	99%	3,727,638	670,236	18%
Q3	1,348/1,351	99%	1,879,638	568,236	30%
Q4	1,346/1,351	99%	4,035,696	703,008	17%

Re-launch OK Plus Condom with lubricant at cost recovery level: Using its own funds, PSK procured 500,000 units of a new version of OK Plus (condom + lubricant). Despite a price increase to Riel 1,500 ($0.37 USD) as opposed to Riel 800 in the previous years, PSK sold more than 125% of its projections, which reflects a higher pipeline and higher demand than expected. In Q4, PSK's direct sales team worked with distributor Mega to ramp up efforts to ensure availability and accessibility of OK Plus in key outlets with marketing support activities at both the consumer and trade levels. PSK also continued its OK Plus Facebook marketing campaign, sponsored a boxing program on Bayon TV with a large male audience, joined with SMARTgirl to conduct two Condom Plus events targeting Entertainment Workers in Phnom Penh and Siem Reap, and partnered with local NGO Men Health Cambodia to hold a promotional event for lesbian, gay, bisexual and transgender (LGBT) in Siem Reap.

Increase capacity of commercial sector to engage in the condom market: Through outreach to major commercial sector players, PSI-C and PSK noted that one main concern regarding high-risk venues is the reluctance of many owners to carry and display condoms – which may be seen by law enforcement as a sign that their venue allows sex trafficking. PSK met with National Center for HIV/AIDS, Dermatology and STD (NCHADS) and National Aids Authority (NAA) separately to identify way to motivate high-risk venue owners to stock and sell condoms at their venues. NAA agreed to an endorsement recognizing entertainment establishment owners in the agenda/work plan of the government's 100% condom use program.

During the last week of April 2016, PSK organized a family planning event in three locations (Phnom Penh, Battambang, and Siem Reap) with the purpose to of further stimulating growth of the commodities market in Cambodia by sharing with key customers on product features and benefits, encouraging them to carry broader range of products for their clients, and ordering more products to increase availability. PSK invited condom companies like Okamoto, Romantic and Durex to join the FP events free of charge, where they can gave out free samples, highlighted their products in a joint presentation, and carried out promotional activities. This activity was just one example to show commercial players that there are many opportunities for low-cost and successful joint demand creation activities and we can do it together successfully with minimal cost.

Increase capacity of the public sector to conduct TMA condom market analysis: In September 2016, PSK organized a National Condom Core Group (CCG) quarterly meeting at Phnom Penh hotel with 37 key decision makers from NAA, Ministry of the Interior, MoH, Department of Drugs and Food, NCHADS and UNAIDS in attendance. During the meeting, PSK presented the key achievements of the CCG related to

sustainability and supply of condom in Cambodia and Dr. Lan Van Seng, Deputy of NCHADS led the discussion on the way forward. As a result, NCHADS showed their commitment in leading the CCG included leading the CCG quarterly meeting.

In Q3, PSK's Executive Director and PSI-Cambodia's Country Representative met with the Secretary General of NAA, and Deputy Secretary General of NAA to reignite the efforts of the 100% condom use program by removing fears and worries from entertainment establishment owners who are afraid to stock/sell condom at their establishments. The results of the meeting included the decision by Senior Minister, Ieng Mouly, Chairperson of NAA, to publicly promote the 100% condom use program. As a result of the meeting, PSK agreed to print and frame 1,500 of Prakas 66 – a letter approved by Prime Minister Hun Sen in October, 1999 and endorsed by Senior Minister Ieng Mouly in 2016, which urges all Ministries and Provincial Governors to mobilize all possible resources to promote 100% condom use at all levels in their respective provinces or ministries and place them at high risk venues.

Key activities for October to December 2016: PSK will do a condom distribution survey to measure condom penetration by type of outlet and to see the progress since the previous one in 2015. In-depth interviews of outlet buyers – in particular of high risk venues – will also be conducted to better understand their purchasing habits so that PSK can design solutions that will better ensure condom availability. For example, topics will include: why they stock or not stock condoms; whether they recommend products, what drives their recommendation; whether the offer, margin, distribution model adequately ensure condom availability, among other topics.

Objective 3: Increase appropriate ARI/pneumonia and diarrhea treatment

PSI-C and PSK worked with the network of ARI/Pneumonia clinics to generate demand for and ensure an accessible, high quality supply of services and supplies to treat pneumonia, ARI and diarrhea. PSK conducted SSVs and QA assessments, conducted refresher trainings on pneumonia and diarrhea case management, and aired local and national radio spots on treating pneumonia and diarrhea.

Activities and Results:

Ensuring availability of and access to correct treatment: In Q1, PSK held training for and registered 118 providers in their ARI network; as of Q4 there were 155 providers in the network. The team revised the QA checklist and began conducting QA at the end of Q1. This table illustrates this work during the year.

Figure 4:

Period	# of Cases of AR reported (# severe)	% Correct Diagnosis	QA assessments conducted / total providers	Providers meeting standard QA score of 80%
Q1-2	1,969	94%	115/118	100%
Q3	2,644 (122)	92%	48/117	100%
Q4	1,434 (47)	91%	105/115	100%

In September PSK organized a half-day close-out workshop to officially inform the PSK network providers and Public Health Departments (PHDs) about the conclusion of the project and to have an opportunity to share the project's achievements for the past three years, share research findings, as well as discuss how providers can sustain practices for correct case management of ARI/Pneumonia that they have built. Total participation included 111 guests hosted from all five intervention provinces, and included PHDs, ARI providers and USAID. The event included group discussions on looking toward sustainability after the SIFPO2 project.

Increase demand for and correct use of ARI/pneumonia/diarrhea treatment and services: In Q1-Q2, 6,369 one-minute radio spots on diarrhea treatment were aired (on one national and 13 local radio

stations) to promote the importance of using effective oral rehydration salt and completing a 10-day course of zinc for treating dehydration and preventing diarrhea, and 2,385 one-minute spots on pneumonia were aired on five local radio stations which explained pneumonia symptoms, and the importance of seeking treatment from a trained provider and completing full dose of the MoH-recommended antibiotics. In Q3, 7,476 diarrhea treatment spots and 2,800 pneumonia spots were aired. In Q4, 7,700 diarrhea treatment and 1,890 pneumonia spots were aired.

Objective 4: Ensure PSK has systems and capacity to implement multi-year projects with funding from local and international donors, including USAID

PSI continues to provide technical, financial and managerial capacity building assistance to PSK to continue its long-term investment in PSK systems, processes and people as well as ensuring achievement of the SIFPO project work plan and deliverables.

Activities and Results:

Capacity building for PSK leadership: The PSK Executive Director attended the PSI Country Representative Financial Training and Global Governance Summit in Washington, DC in July 2016. The financial training deepened the ED's capacity to provide oversight on finance with the focus on program budgeting, donor compliance in relation to financial management, sub recipient management, fraud detection and prevention, monthly project financial performance reviews, financial audit including internal and external audits, ethical considerations, and financial reporting. This training came at an opportune time, as in PSK's new structure, in effect as of October 1, 2016, the Executive Director directly oversees the finance department and, in accordance to its strategic plan, will lead efforts to strengthen PSK's its internal control system.

Ten PSK staff attended two trainings provided by the PSI regional new business development adviser. The training focused on donors' priorities and regulations, strategy and steps for grant bidding and proposal development. This training directly supported one of PSK's priorities, to develop a new funding model, under PSK's strategic plan.

Strengthen internal systems and controls: The internal audit manager developed the audit charter and the internal audit plan for 2015-16 which were all approved by the board. According to the audit plan, the internal auditor has done the first round of audits for the procurement/logistics/administration/IT and finance departments, and no major findings were identified. He also conducted an audit of PSK sub awardees looking at their finance system and management as well as compliance issues. There was no major finding among the sub-awardees. The internal audit manager resigned in Q4, and PSK anticipates that the position will be replaced by January 2017.

Implement PSK's new strategic plan: On March 31, 2016, PSK officially launched its first strategic plan, covering 2016 to 2020. The launch was the culmination of nearly one year of work on the strategic plan, which all members of PSK's senior management team have been actively working on. Key initiatives being implemented under the strategic plan include: mapping all provider networks to understand options for strategic integration across networks; re-launching of OK plus to reposition the brand to improve sales and profitability; developing executive and sales and marketing dashboards for management team to monitor and make decisions on program implementation; training of PSK MIS team by PSI's regional DHIS2 support team on DHIS2 troubles shooting and new configuration; organizational restructuring that will enable PSK to meet the strategic plan goals as well as be more integrated, lean, and cost-effective.

Key activities for October to December 2016: PSI's Global Internal Audit team will conduct an audit of PSK in October 2016. PSK plans to move its financial system from Lawson to Quick Books by December 2016.

Bed net preference survey

PSI-C and PSK received funding under SIFPO2 to carry out a malaria bed net preference survey. The results from the Bednet Preference Study will be used to a) inform a PMI funded follow-on crossover

quantitative study, linking preference and use; b) influence Global Fund procurement by providing more customized specifications; c) explore prevention products that better meet the needs of Cambodian beneficiaries."

Study operations: Data collection for the bed net preference study was completed by early May; from June to September 2016 activities included transcribing, coding, data analysis, dissemination and report writing. Data coding and analysis was done by a consultant from late May till end of July. All 24 focus group discussions and 29 in-depth interviews with different target groups were reviewed and coded into different frames in order to answer research objectives. Dissemination of the findings from the bed net preference study was conducted in August 2016, with participants from different relevant stakeholders including the Malaria National Program, USAID and NGOs.

Key findings:

- Bed net usage in Cambodia is driven by the desire for protection and comfort. When users perceive fewer mosquito threats, they will prioritize comfort first, leading to inconsistent usage or non-usage.
- Users consider specific product attributes and types of bed nets for specific uses and settings. This is reinforced by the variety of options for untreated conventional nets available from local markets. When distributed long-lasting insecticidal nets (LLINs) are added into this product eco-system, users have variety of options for achieving comfort and protection.
- While purchasing power may constrain the type of bed nets a household can acquire, there is wide-spread aversion for distributed LLINs. This reinforces aspiration, purchase and continued use of conventional nets.
- A combination of product attributes drives aversion for LLINs:
    - Small interior size: Too small for co-sleeping and have trouble fitting existing sleeping product such as sleeping mat, beds and mattresses.
    - Low height: LLIN height is considered inadequate, causing psychological and physical discomfort to users. Low height is also associated with untucking.
    - Polyethylene fabric material: While considered strong and durable, polyethylene is uncomfortable to the touch and associated with shrinking, wrinkling, inward bowing, and hole-size deformation, thus further constraining interior space.
    - Mesh-hole size: LLINs feature large mesh-holes which users associate with increased likelihood of insect breach. This drives purchase and continued use of conventional nets.
- Product attributes and distribution strategy influence each other. While polyethylene LLIN product attributes are not considered valuable for home bed net use (distribution campaigns focus heavily on households), they do provide unique value for alternative uses and income generation activities. Households not driven by this value can count on the cash-savings that participation in bed net distribution brings. These households will forego repairs or replacements while the household awaits the next round of bed net distribution.
- In conclusion, users have access to a variety of bed net options, both from local markets, and via free distribution programs. Despite wide-spread distribution, the product attributes of LLINs confine them to a narrow spectrum of preferred usage:
    - Single occupant users, often men
    - Utilization in remote settings such as forest, mountains, and plantations where chemical protection is highly valued.
    - Utilization in settings where versatility is important.

Democratic Republic of Congo

In January 2016, the Association de Santé Familiale (ASF) received approval from USAID DRC for voluntary FP and maternal and child health (MCH) activities under SIFPO2. In July 2016, USAID DRC approved ASF's use of PEPFAR funding through SIFPO2. SIFPO2 activities build upon the foundation laid by SIFPO1 in DRC.

With SIFPO2 funds in DRC, ASF uses a total market approach to contribute to the achievement of USAID's 2015-2019 Country Development and Cooperation Strategy for the DRC, as well as the DRC's MoH strategic goals as outlined in the National Strategic Plan for FP 2014-2020 and National HIV/AIDS Strategic Plan 2014-2017.

ASF seeks to improve the health for groups of people with the greatest unmet need for products and services. The FP market in DRC is failing many groups, especially adolescent girls and post-partum women, who have high rates of unmet need for FP and face high health risks associated with early and closely spaced pregnancies. Caregivers of children under age five are a priority audience for ASF's MCH work because these children are more susceptible than older groups to mortality from diarrhea and malaria. The HIV epidemic in DRC primarily affects key populations. Priority groups for PEPFAR through SIFPO2 include truck drivers and adolescent girls at high risk while the LINKAGES Project led by FHI360 focuses on other key populations in DRC.

ASF identified and prioritized health market failures in DRC to address through SIFPO2. These include: frequent stock-outs of FP and MCH products at the level of facilities and pharmacies, a shortage of health care providers with the skills and motivation to offer a wide range of methods including LARCs, low quality information provided in pharmacies, and misconceptions in communities about FP methods, correct treatment of diarrhea and malaria, and HIV/AIDS.

ASF dovetails SIFPO2 efforts with those of the National Program for Reproductive Health (PNSR) and other projects to achieve three objectives:

- Increase the availability of quality health services and products related to voluntary FP, MCH, and HIV/AIDS
- Increase the knowledge of and demand for health services and products related to voluntary FP, MCH, and HIV
- Strengthen the capacity of local organizations in behavior change communication, community mobilization and distribution of health products

This report presents highlights of the activities completed by ASF/PSI and results obtained during the reporting period from October 1, 2015 to September 30, 2016 of the SIFPO2 project.

Objective 1: Increase the availability of quality health services and products related to voluntary FP, MCH, WASH and HIV/AIDS

ASF worked to strengthen FP and MCH product distribution, improve the quality and breadth of voluntary FP services offered in health facilities through social franchising, expand FP service delivery to the community level, integrate post-partum FP services with antenatal care and delivery services, and strengthen the quality and availability of child health information in pharmacies.

Key activities and results:

- Following the WHO's 2015 update to the FP medical eligibility criteria, ASF advocated for policy change within DRC and received authorization to introduce post-partum implants. With PNSR, ASF trained 60 public sector providers who provide PPFP including PPIUD to also offer PP implant insertion at 10 facilities in Kinshasa and Lubumbashi. Trained service providers in the *Confiance* social franchise network performed 2,262 voluntary PPIUD and 1,237 voluntary PP implant

insertions as part of a broad range of PPFP options made available within the context of informed choice.

- In collaboration with PNSR, ASF refreshed 232 private and public sector providers in ASF's social franchise on FP counseling and service delivery, including waste management, infection prevention, and how to address common myths.
- With complementary funding from the USAID Passages project, ASF trained and supported all 80 Kinshasa-based providers in its *Confiance* social franchise to offer youth-friendly services.
- With complementary funding from DFID's DEFEAT Malaria project, ASF provided training, equipment, and quality assurance to integrate malaria testing and treatment services into 40 *Confiance* clinics and pharmacies in Kinshasa.
- In collaboration with the heath zone management teams, ASF conducted supportive supervision visits to all *Confiance* providers for quality assurance monitoring, including compliance with USAID's FP Regulations. The visits were guided by a new supervisory checklist, updated in partnership with the Programme National la Santé de la Reproduction (PNSR).
- PSI-Washington organized and conducted an external quality audit in July 2016, with recommendations for quality improvement integrated into the SIFPO2 workplan for fiscal year (FY) 2017. The quality audit included new criteria to assess the extent to which providers and clinic staff are respectful and inclusive of adolescents and youth.
- ASF organized quarterly technical meetings with FP/MCH providers and community health workers in each province to discuss distribution and communication approaches, data collection tools, supervision checklist review, status of previous quality audit recommendations; compliance with USAID FP requirements and sharing of experiences and lessons learned.
- ASF organized 527 special service days ("Open Door Days," or "Journées Portes Ouvertes") in public and private facilities to promote and provide free voluntary FP products and services, registering 44,721 new clients through this approach alone.
- During the year, franchised providers introduced 65,191 clients who were not using FP at the time of the visit to voluntary FP services.
- To wholesalers (and directly to clients in the case of Open Door Days), ASF distributed branded and generic male and female condoms, in addition to a wide range of other FP and MCH products. As a result of the distribution of Aquatabs point-of-use tablets and packets of PUR®/P&G® for water purification, 166,944,540 liters of water were treated.

ASF's FP activities generated 264,450 CYPs through the contraceptive services provided by franchised providers and products distributed through clinics and pharmacies, as shown in Figure 5.

Figure 5: Product Distribution and Service Delivery Projections and Results

Product	Projected distribution/ service delivery	Results	% of FY 16 projection achieved	Comments
Copper IUD	4,750	4,914	103%	
5-year implant (Jadelle) and 3-year implant (Implanon)	37,500	34,618 (20,242 Jadelle and 14,376 Implanon)	92%	
DMPA–intramuscular (Depo Provera)	250,000	118,926	47.6%	Distribution was suspended in early 2016 pending re-registration of the product by Pfizer, and was restarted in August and September 2016, with a 2-month MoH waiver provided.
DMPA–subcutaneous (Sayana Press)	100,000	5,448	5%	Stock currently unavailable pending registration by Pfizer of 200-pack shipments.
Combined Oral Contraceptives (COMBI 3)	870,000	690,101	79.3%	
CycleBeads	4,900	7,500	153.1%	
Emergency contraceptive pills	40,000	216	1%	Stock currently unavailable pending delivery in Q4 2016
Branded male condoms (Prudence Classic & Sensuelle)	-	2,231,453		Stock remaining from SIFPO 1
Branded female condoms (Prudence Femme)	500,000	400,839	80%	
Diarrhea treatment kits (Ora-Zinc)	180,000	8,162	4.5%	Distribution will recommence pending delivery of new stock in Q4 2016.
Water purification packets (PUR/ P&G)	1,516,000	791,326	52%	Distribution supports diarrhea prevention activities
Water purification tablets (Aquatabs)	6,466,000	7,951,564	123%	
Liters of water treated through distribution of water purification packets and tablets	144,480,000	166,944,540	115.5%	

Objective 2: Increase the knowledge of and demand for health services and products related to FP, MCH, WASH and HIV

ASF engaged priority audiences in discussions about their FP options, diarrhea prevention and treatment, and HIV/AIDS. ASF's efforts to generate demand for services are linked to service delivery through referrals, on-site services, and the activities described under Objective 1.

Key activities and results

- In the community and at clinics, community health workers reached 413,711 people with IPC sessions on FP and diarrhea prevention and treatment. Key FP messages included the benefits of voluntary FP, the client's right to informed choice, and correct information about side effects to dispel myths and misconceptions. Health promoters offered referrals to nearby FP providers. In

partnership with the MoH, health promoters also sensitized caregivers of children under age five to the concepts of safe water treatment, drinking and storage, hand washing during key moments of the day, use and cleaning of latrines, and diarrhea treatment with ORS and Zinc.

- *Confiance* clinic providers held group counseling sessions during ante- and post-natal care (immunization) sessions. Providers referred women interested in adopting modern methods towards the FP unit on-site for individual FP counseling and voluntary services or to schedule an appointment.
- ASF provided RH and FP information through the existing toll-free hotline via well-trained operators in four national languages; a total of 15,787 calls from people seeking information about FP were received over the reporting period, of which 12,879 were from men.
- Three ASF staff members presented three abstracts at the ICFP that took place in Indonesia from January 25-28, 2016.
- Two strategic partners participated in ICFP with SIFPO2 support. One was the mayor of Limete Commune in Kinshasa, who officiates a hundred weddings each month. The other was a journalist who hosts a famous show called *Libala Bosembo* ("Peaceful Marriage") every week on the national television station. The two partners were chosen due to their role as influencers and opinion leaders, and both now serve as advocates for the promotion of voluntary FP. This partnership provided the foundation for the core-funded SIFPO2 activity to include content about couple communication on FP in the journalist's popular television program.
- The ASF communications team produced and distributed the *100% Jeune* Magazine with educational messages about FP, MCH and HIV/AIDS, in a format attractive to youth. After discussions with PEPFAR team regarding *100% Jeune Magazine*, ASF is developing plans to better use this tool to achieve project objectives.
- ASF organized youth outreach events to communicate HIV/STI prevention and FP messages, and to promote the FP hotline and the social franchise clinics as resources for more information on voluntary FP. This *100% Jeune* activity reached 500 adolescent boys and girls aged 14 to 17.

Figure 6 shows the key communication achievements during the reported period.

Figure 6: Communication indicators achievement

Indicator	Projection	Results	% of FY 16 Projection Achieved	Comments
Number of individuals reached with FP messages through IPC	439,560	413,711	94%	FP and MCH messages were integrated during IPC sessions by trained CHWs
Number of mothers or caregivers of children under five reached with information on diarrhea prevention and treatment	360,000	413,711	115%	
Number of hotline calls received	N/A	15,787		Of these, 12,879 calls (82%) were from men
Number of truck drivers reached with HIV prevention, counseling and testing information through IPC	2,540	2,440	96%	
Number of individuals who received HTC services and received their test results during the reporting period.	1,950	1,586	83%	

Objective 3: Strengthen the capacity of local community-based organizations in behavior change communication, community mobilization and distribution of health products

ASF reinforced the functions and actors that underpin the health market by building the capacity of local organizations to communicate with their communities about health, and by collaborating with the government to jointly implement and supervise activities.

Key activities and results

- In collaboration with the MoH in Kinshasa and former Katanga provinces, ASF organized a refresher training for 21 trucker peer educators and four supervisors from local partner community-based organizations (CBOs) in IPC, monitoring, data reporting and data quality control. The peer educators reached a total of 2,440 truckers with messages, and 1,586 received testing and knowledge of their serologic status.
- To reach adolescent girls and young women at high risk for HIV, ASF trained 22 peer educators and four supervisors from CBO partners focused in Kinshasa and former Katanga to conduct IPC sessions focused on HIV/STI prevention, correct and consistent use of condoms, condom negotiation with male partners, HIV testing and linkages to care and treatment including negotiation with the partner to do the same. The trained peer educators and their supervisors will start peer education in early FY17.
- ASF provided refresher training to 116 community health workers on how to conduct communication activities related to FP, as well as MCH messages on safe water treatment, drinking and storage, handwashing during key moments of the day, and use and cleaning latrines along with correct diarrhea management with oral rehydration salts and zinc.

Challenges

Final approval for FP and MCH activities was received at the end of January 2016. The reduction in anticipated funding and changes to the workplan delayed implementation. ASF was able to maintain key staff and its relationship with clinic and community-based partners, but could not proceed with trainings, packaging procurement, commodity procurement for Ora-Zinc, or large scale distribution prior to approval of the budget. This delay affected the percentage of projected distribution that ASF was able to achieve for some products.

HIV activities also began later than anticipated. At the Mission's request, ASF revised proposed HIV activities to reflect PEPFAR's new global approach and to take into account the introduction of the LINKAGES Project. In July 2016, ASF received approval for its revised HIV workplan.

ASF had to suspend distribution of Sayana Press and Depo Provera, pending re-registration of these products by Pfizer. ASF has maintained close communication with the MoH, USAID, Tulane in the DRC, and Pfizer at the global level, to better understand the status of each dossier and offer assistance to move the process forward as appropriate. At end of March 2016, Sayana Press was granted market authorization, which not cover the Sayana Press packaging already procured by USAID at global level. As such, PSI and ASF are still consulting with partners to help resolve this issue.

Success story:

Integrated Health Services Key to Scaling Family Planning in DRC

"They call him Prophet Elie." Chantal Kilembe breaks into a wide smile when she mentions her five-year-old son, Elie Muaka. She gestures to show how he lines up chairs in their home to play "church." He corrals his friends to come in and sit as preaches enthusiastically, waving a small Bible in his hand for emphasis.

Nothing would make Chantal and her husband happier than for their son and his two siblings to realize their

dreams. But she lives on little income in Kinshasa, Congo and she knows if she can't afford to send them to school, they will have little chance.

"Life is difficult," she says. Her husband can't find work and the little money she earns selling fish and maize is all she has to feed her family, meet their basic needs, and cover school fees. Having more children would mean having to spread resources even more thinly. "If I give birth regularly, I don't have time to work," she says.

She learned she had FP options two years ago the day she took her son to get treated for diarrhea at Bomoi, a clinic supported by the ASF, PSI affiliate network member in the DRC. Gathered in a crowded circle at the front of the clinic, women listened to a community health worker from ASF discuss and show the mix of voluntary FP methods available to them. Chantal joined the group as she waited for her son's turn to be seen at the clinic. "While I was there, I listened to women talk about using family planning," she said. "They didn't get pregnant and were well."

After her son was treated for the diarrhea, Chantal asked the nurse, Papa Zebika as he's known by patients, about the FP options she had just heard about. She went home and decided with her husband that she would go back the next day and get an implant which can be used for up to five years. Chantal was enthusiastic to talk about how happy she was with the decision. She has told women in her community about the clinic's services and how they can learn about and get FP there. Chantal, says with conviction, "My desire is to see my children grow up in a good way, to go to school, finish, and get good jobs. Family planning is an important part of that."

Papa Zebika, the nurse who served Chantal, signals to the graph in front of him. It shows that his clinic has seen nearly as many women for voluntary FP services in the first quarter of 2016 as it did in the whole of 2015. He claps, "That's growth."

In the first quarter, 344 women who came to his clinic voluntarily chose LARCs from among the wide range of contraceptive options available. "When we first started 10 women came a month. But that started climbing to 50 women. And now, it's even more." ASF attribues the increase in client choosing LARCs at Papa Zebika's clinic primarily to two factors:

1. The work of ASF's community health workers to integrate messages about the wide range of family planning methods available with messages about child health, including diarrhea and malaria treatment;
2. The "Open Door Days" supported by ASF at Papa Zebika's clinic, when clients can receive any family planning method for free.

Papa Zebika continues, "We tested a family planning program before. But it didn't work. When we aligned with ASF, it was a different story. We received training. They gave us supplies. And they have worked with the community to lend credence to the program." Papa Zebika's Bomoi clinic is part of ASF's social franchise network. He relies on ASF and PSI for training, quality assurance and marketing support. In exchange, Papa Zebika delivers specified health services, including FP, within established standards. He grins, "Women in our community know about the program now. They know they want to space their births. That's why we are here."

Ghana

This year-two report highlights the achievements from October 1, 2015 to September 30, 2016 of the SIFPO2 project. Please note that some activities may have begun prior to the work plan.

PSI-Ghana launched a social marketing project in 2015. The work plan was formally approved by USAID in February 2016, detailing the foundational and startup activities the team aimed to implement in year one.

Year one focused heavily on program start-up activities: The team established contacts with key partners and relevant stakeholders to create a presence within the FP community. PSI-Ghana commenced community activations and promotions to test the market for acceptability and recognition of the inherited FP commodities. In concurrence with these activities, the majority of key staff were recruited and a warehouse was secured to appropriately store the commodities per USAID's guidelines.

PSI-Ghana identified the need for collaboration with key distribution partners, in particular the main distributors of Secure, Protector, and Famplan. A Total Market Approach process is also underway, which will inform the state of FP commodities within the various markets. PSI-Ghana has begun work on a key deliverable: establishing a local social marketing organization (SMO). A local consulting organization has been hired to lead the process of registering the organization and headhunting for board members. As a result of these activities, PSI-Ghana has strongly positioned itself as a key player in FP and is on track to implement the social marketing program, improving access and creating a significant health impact in Ghana.

Objective 1: Increase the availability of quality health products in the private sector within Ghana's 10 regions, with a focus on the Northern and the Volta regions

PSI-Ghana joined a working group that regularly participates in the Commodities Procurement Table Meeting. These meetings ensure that PSI-Ghana's procurement projections are accurately captured in the pipeline. Another major activity that PSI-Ghana undertook was to set-up a warehouse to secure the USAID donated commodities that were being held in trust by the DELIVER PROJECT for USAID for onward transfer to PSI-Ghana. The 385-square-meter warehouse currently holds 3,045,780 Protector condoms, 2,499,524 quantities of Depo Provera (Famplan) and 5,252,988 quantities of Combination 3 OCPs (Secure). The warehouse was developed based on the terms of reference from the Ghana Food and Drugs Authority.

PSI-Ghana reviewed the distributor options available to identify the most experienced and networked vendor to ensure consistent availability of the commodities. VicDoris was chosen to distribute FP commodities to pharmacies and over the counter chemical sellers nationally.

PSI-Ghana conducted several pricing surveys to determine an appropriate price point for the commodities to be introduced into the market. This process led to a price review based on the cost of goods sold assessment. With the aim of quickly entering the market, PSI-Ghana has opted to incur the packing costs for both Secure and Protector. The wholesale costs of commodities were increased for the distributor to not only improve the program income prospects, but to also ensure introduction into the market at a competitive price.

Recruitment of key team members was also the focus during this period. Currently the senior team is made of the Chief of Party, Finance Manager, Research, Monitoring and Evaluation Manager, Sales and Distribution Manager, Warehouse Manager, and the Social Media and Communications Manager.

The Total Market Approach landscaping is underway to ensure that PSI-Ghana has a rich and detailed overview of the FP ecosystem in Ghana. The results will provide the Ghana Health Service, the MoH, and the National Population Council detailed information on the gaps to address and the strategies to be

implemented to improve the FP uptake in Ghana. PSI-Ghana's contribution and leadership during this will firmly position the future social marketing organization (SMO) as a leader in reproductive health in Ghana.

PSI-Ghana launched a request for quotation (RFQ) for the production of packaging materials during year one. The team visited the selected supplier to conduct a vendor audit, and to ascertain first hand the company's ability to deliver quality packaging.

PSI-Ghana organized a soft launch of its commodities during a major festival in the Central Region of Ghana. More than 10,000 condoms were sold and distributed. Promotional assistants engaged the festival goers, counselling them on proper use and debunking negative myths and misconceptions. The brand was ultimately visible to over 350,000 potential customers. The team organized FP activities during the Family Planning Week celebrations in Kasoa, Winneba and the Mankessim townships, as well as the Ekumfi District, Elmina, Twifo Praso and Assin districts. Adisadel Health Centre, the Baiden Ghartey Hospital, the Ewin Polyclinic, and the Essuakyir compound also participated in the events. Health educators interacted with community members, educating them on SRH and rights, and introducing them to Protector condoms and Secure oral contraceptives.

Objective 2: Increase the knowledge of and demand for socially marketed health products

To meet PSI-Ghana's commitment to the 'last mile' connection, PSI Ghana the team engaged *Triggerise* to provide training for 60 IPC agents who will then work at the community level to improve visibility, create access and provide information. The *Triggerise* technology will enhance the interaction between clients, stockists, pharmacies, and over the counter medical sellers. PSI-Ghana is building connections with civil society organizations in the Volta and Northern Regions with the goal of having them assist with future educational programs, SBCC activities, and sales at the community level.

Objective 3: Identify or create a local organization to build technical and organizational capacity to independently carry out social marketing in Ghana

PSI Ghana launched international and local bids for consultants to lead the localization process. The bid specifically sought to recruit an agency or an individual that had experience setting up a local NGO/SMO, including registration, setting up a Board of Directors (BOD), instituting a constitution to govern the local organization, as well as the capacity to train and build board cohesion and a common sense of purpose. PSI-Ghana led a bidder's conference to brief the organizations and individuals interested and clarify the request for proposal. Based on the scoring scheme developed by PSI DC's procurement committee, CDC Consult, a Ghanaian organization had the strongest technical proposal.

Challenges

Though PSI-Ghana inherited FP brands well known to Ghana's FP landscape, its lack of access to prior marketing or communication background on the brands, can be used as an opportunity to conduct a new market landscape and position the brands based on tactical communication, announce their presence and availability in the market while repositioning the brand. A challenge for Secure OC marketing is that emergency contraceptive use has increased in lieu of oral contraceptive use. PSI-Ghana also views this as an opportunity to re-educate women on the difference between the two methods, as well as the features and benefits of the oral contraceptive.

Guatemala

The SIFPO2 initiative in Guatemala, known locally as PlanFam, aims to reduce maternal mortality and chronic malnutrition through increasing the use of modern voluntary FP methods among rural indigenous women of reproductive age (WRA). PlanFam works with interpersonal communication agents to increase information and education on FP for WRA and refers women to FP services. Furthermore, in order to

increase the number of providers offering high quality FP services, PlanFam trains health providers in FP counseling and services. As part of the maternal and child health interventions, and in line with the MoH´s strategy, PlanFam is focusing on strengthening the MCH services at the primary care level provided at health posts located in rural areas.

Implementation of project activities began in 2011. Key activities and results from October 2015 through September 2016 for each result area are as follows:

Objective 1: Improve intersectoral coordination for FP programs nationwide

Under this result, PSI/PASMO concentrates on improving intersectoral coordination for FP and MCH programs nationwide, with a geographic focus on the Western highlands of Guatemala. PlanFam facilitates information sharing, use of standardized norms and guidelines for service delivery, and advocates for increased FP and MCH support at the national and community level.

Activities and results:

- PlanFam monitored the use of national FP guides and adherence to national protocols across 30 prioritized municipalities and 61 health posts, including: 175 compliance visits, and 364 interviews with both users and health care providers, including 228 users and 136 FP and MCH providers.
- Provided technical assistance to the National Contraceptive Security Commission (CNAA) of Quetzaltenango and El Quiche, to regionalize functions, ensuring better monitoring of supply and provision of FP: PlanFam provided technical assistance to the National Reproductive Health Program in November 2015, sharing information about stock outs of health commodities and resulting unmet needs for family planning services due to lack of FP commodities. The intervention resulted in UNFPA making a purchase of additional commodities to address the gap.
- Provided technical support to the MOH during the revision and printing of the Perinatal and Neonatal Mortality Surveillance Guide. Guidebooks were delivered in December 2015.

Table 7: Access to FP by Method MOH, Official Health Area Direction MIS

MODERN METHODS PROVIDED	Q1 2016	Q2 2016	Q3 2016	Q4 2016	TOTAL
Hormonal implants	427	420	459	509	1,815
IUD	281	249	286	300	1,116
Permanent Methods (VSC)	432	272	346	632	1,682
Quarterly injection (Depo-Provera)	10,759	8,504	9,896	10,936	40,095
Oral contraceptives	3,164	3,739	3,305	3,164	13,372

Objective 2: Improve access to quality FP services

Under this result, PSI/PASMO focused on improving access to and ensuring the quality of FP and MCH services by building the capacity of providers to offer these services and by monitoring the quality of services under five standard services provided.

Key activities and results:

- 1,682 clients voluntary selected a permanent method from a range of contraceptive options. From October 2015 to September 2016, 1,667 chose tubal ligation (Minilaparotomy), and 15 chose NSV.

- Verified implementation of medical quality standards, including supportive supervision to assure consistent delivery of high- quality FP and MCH services: 245 medical supervision visits were conducted including on-site training and technical refresher training.

Table 8: Training and certification activities	
Activities	October 2016 -September 2016
FP Workshops, including contraceptive methods workshops and LARC Specific workshops for 30 Prioritized Municipalities and 61 Health Posts (MOH-Primary care Level)	21 workshops on LARCs, including IUDs and HIs, and 64 Local workshops on all contraceptive methods in each facility for Health Post personnel
Personnel trained (MoH) IUD-SHI	117[2]
No. certified (MoH) IUD-HI	35[3]
Compliance visits	175

- Supported the development of 17 youth- friendly spaces that facilitate improved access and utilization of SRH services. Developed a youth engagement strategy, in coordination with the Ministries of Health and Education, focused on SBCC activities designed to improve the health services response to adolescents.

Objective 3: Improve FP communication for indigenous women and men

Under this result, PSI/PASMO focuses on increasing the demand for voluntary FP methods and LARCs within the context of informed choice using IPC, community and edutainment activities, and communication campaigns.

Activities and results:

- IPC agents and coordinators were supervised, monitored and evaluated, ensuring the provision of high quality FP information and referrals.
- IPC agents implemented communication activities and follow- up actions in beneficiary communities of 30 prioritized municipalities to create awareness, promote informed and voluntary demand for FP services and adherence to their chosen method.

Table 9: Referrals to FP Services				
	October-December 2015	January-March 2016	April-June	July-September
Initial visits	3,309	2,592	2,534	2,563
Follow-up visits	4,830	3,638	2,666	2,707
Effective Referrals	548	471	540	560

- Continued to implement the “new masculinity approach” strategy to engage with men on SRH issues. This was done through the implementation of IPC activities, training local organizations and health providers on gender and progressive masculinity, and using community channels such as mobile broadcasting vans to disseminate the “New masculinity and Family Planning” campaign messages, for a total of 57 activities in this period.
- Continued implementation of SBCC activities with youth, including interactive activities designed to facilitate life planning, healthy decision-making, and sexual and reproductive health. Specific activities include the “Train” life planning tool, the contraceptive method lottery, “fishing” for SRH rights, and the apron of anatomy for sexual and reproductive health.

[2] New personnel
[3] Certification will be complete next quarter

Table 10: Reach of SBCC Activities					
Activities	Q1 2016	Q2 2016	Q3 2016	Q4 2016	TOTAL
Fairs	5	7	5	23	40
Adolescents reached	425	414	841	3,778	5,458
Adults reached	113	45	0	99	257

- Trained MoH staff, local organizations, and 15 out-of-school youth leaders to replicate the edutainment methodology with teenagers.
- Implemented edutainment activities for adults including community film screenings, and informative stands and kiosks, to promote FP, nutrition, and MCH messages.
- Designed the "2016 strategy to work with teenagers," to be implemented from April through September 2016. The strategy included: a) community activities such as community film screenings with teenagers and teachers to spark and facilitate discussions about adolescent SRH, health fairs using the successfully proven methodology/set of five games promoting adolescent SRH and healthy decision-making, and theater performances led by youth; b) a digital platform to reach youth and adolescents, and to provide access to information and games promoting SRH. Games currently used in live sessions were digitalized and made available through the "Club en Conexion" electronic platform launched in September 2016[4].

Table 11: Reach of Youth-Focused Activities			
Activity	Number	Youth Reached	Educators Reached
Community film nights (Film: Ixcanul)	31	7,533	346
Jacinto y Filomena (short film)	55	7,111	207
Health Fairs	57	6,880	227
Community Theater	37	5,560	217

- Development and distribution of communication materials for mothers regarding eclampsia and the management of hypertension, as well as job aids for health providers on LARCs and management of eclampsia, hypertension, and obstetric hemorrhage.

Success story

Dynamic SBCC strategies to reach youth and adolescents with comprehensive information on sexual and reproductive health:

[4] http://clubenconexion.org/

From January to July 2016, 13,727 births were recorded among girls ages 10-19 in the Western Highlands region of Guatemala[1]. Teen pregnancy affects the physical and emotional development of adolescents in Guatemala and perpetuates the cycle of poverty. In response, the USAID|PlanFam project in Guatemala implemented by PASMO developed a dynamic SBCC strategy to work with schools to incorporate comprehensive sexual and reproductive health education.

Launching in September 2016 and in close coordination with the ministries of health (MSPAS) and education (MINEDUC), activities were implemented across schools in the Western Highlands through September 2016, reaching 200 educators and 8,500 students across 56 schools and 30 municipalities prioritized by USAID in San Marcos, Huehuetenango, Quiché, Quetzaltenango and Totonicapán.

As a part of the strategy, PASMO took the film “Ixcanul” to participating communities, an internationally recognized Guatemalan film about the life of an adolescent, indigenous girl living in the Western Highlands. The casts consist of Guatemalan actors and the film closely mirrors the reality and challenges faced by many adolescent girls in the Western Highlands region. The film was a part of the film forum strategy, where the film doubles as both a social event and means to open the discussion about adolescent SRH and teen pregnancy prevention. Other topics include: cultural and linguistic barriers to services, gender-based violence, and the barriers faced by adolescents to receive comprehensive SRH education, all themes reflected in the film. The project shows the short film “Filomena and Jacinto, a Childhood Full of Questions without Answers,” to spark conversations about the challenges of adolescence and invite adolescents to be the owners of their own solutions.

Film forum activities are complimented by health fairs and community theater. During health fairs, youth, adolescents, and community members are invited to participate in interactive games previously validated with youth, such as the “Family Planning Method Lottery,” “Fishing for SRH Rights,” and “The Train Life Plan.” Community plays are developed and performed by students and educators around the themes of adolescent SRH. PASMO believes that adolescents have a right to comprehensive SRH education, which is a critical component in supporting individuals, communities, and societies to prevent teen pregnancies.

Malawi

In 2015, USAID Malawi began programming for SIFPO2 with funding from the PEPFAR and USAID Family Health team. In Q4 FY16, additional funding was obligated for activities through Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) and field support for condom social marketing and voluntary medical male circumcision. This report highlights the achievements during the reporting period from October 1, 2015 to September 30, 2016 of the SIFPO2 project.

With PEPFAR funds through SIFPO2, PSI-Malawi aims to strengthen access to youth-friendly HIV services in 10 districts. USAID is leveraging KfW Development Bank investments in PSI-Malawi's work by integrating HIV testing services (HTS) with existing outreach services and the Tunza social franchise network. HTS includes pre-test information, post-test counseling, linkages to appropriate HIV prevention, care and treatment services and other clinical and support services. The aim of this approach is to increase the number of youth under age 25 who are tested and know their HIV status, link youth living with HIV to care and treatment programs, and support risk reduction among youth. In addition, USAID's Family Health Team contributes funding through SIFPO2 to support youth-friendly, voluntary FP activities, including outreach. Beginning in July 2016, SIFPO2 funds also supported provision of voluntary medical male circumcision activities through mobile service provision and demand creation as well as condom programming including supply chain support for implementing partners, including those serving key populations, demand creation and SBCC and social marketing of male and female condoms. SIFPO2 funds are also supporting PSI-Malawi in reaching adolescent girls and young women (AGYW) in Machinga district through DREAMS to encourage uptake of HTS and FP services.

Objective 1: Provide HTS and voluntary FP services

PSI-Malawi focuses on various channels to increase access to HTS and voluntary FP service including private sector social franchise clinics (Tunza), integrated outreach teams and HTS stand-alone outreach teams. PSI-Malawi trains providers to ensure they provide YFHS without stigmatization or judgment. Data collected from Tunza clinics indicates that, on average, at least 30% of FP clients are youth.

Activities and results:

Provision of integrated SRH Services: PSI-Malawi provides voluntary HTS and FP services through outreach mobile teams as well as through member clinics of the Tunza social franchise network. In FY16, 22 Tunza providers were trained in HTS and a total of 17 Tunza clinics are currently providing HTS services. In Q4 of FY16Q, eight of 14 outreach teams were launched to offer integrated SRH services, including HTS, in 10 districts across Malawi. Integrated teams leverage funds from KfW and SIFPO2.

FP Services: Voluntary FP services include a broad range of methods and counseling to clients to help choose for a method that suits them. FP outreach teams began outreach services in December 2015, providing free short-acting and LARC methods in hard to reach areas in Lilongwe District. During the FY16, 16,380 clients voluntarily accessed a broad range of FP options through outreach services in Lilongwe District while integrated teams served 44,164 clients with a broad range of FP options. KfW and SIFPO2 funding contributed to 349,967 CYPs in FY16.

HIV testing services: PSI-Malawi has eight integrated SRH teams and six stand-alone HTS outreach teams. All outreach teams provide voluntary HIV testing services, in FY16 outreach teams and Tunza provided HTS to 32,996 clients. In order to provide services to individuals with a high risk of contracting HIV, PSI used National HTS HMIS data to identify high HIV prevalence areas and respective health facilities in those areas and mapped catchment areas to identify HIV hot spots. Outreach services targeted these hotspots and case finding increased from 4% to 6% in Q3 and a drop in Q4 using this strategy. PSI-Malawi is further exploring synergies and collaboration with treatment partners to increase case finding. It was observed that after launch of integrated teams in Q4, the yield for the project has decreased. The team plans to implement prioritization strategies so that HTS services should locate high risk clients rather than offering testing services to all clients requiring RH services.

Table 12: Summary of HTS service delivery, October 2015 to September 2016

Quarter	Q1 FY16	Q2 FY16	Q3 FY16	Q4 FY16	Total
Total Tested	4,517	11,454	7,127	9,605	32,703
Positive	171	608	461	361	1,601
Negative	4,338	10,829	6,665	9,242	31,074
Positive yield %	4%	5.3%	6.5%	4%	5%
Inconclusive	8	17	1	2	28

Treatment and care linkages: PSI-Malawi is working in collaboration with treatment, psychosocial and client education partners (Dignitas and Baylor) to support newly diagnosed clients and potential ART defaulters. The collaboration aims to facilitate voluntary linkage of clients after a positive result. In further efforts to improve linkage to care, PSI-Malawi will engage expert clients to provide psychosocial support to newly diagnosed clients and help them access voluntary treatment and care. During the reporting period, PSI referred 100% of the 1,276 HIV positive clients from outreach and Youth Alert! (YA!) Events for confirmatory test, treatment and care and 742 clients (58%) were initiated on ART.

Communication and demand creation: PSI-Malawi promotes social norms to reduce HIV vulnerability among youth in addition to increasing access to HIV treatment and care and voluntary FP services. PSI's trusted YA! program consists of YA! Mix, a radio magazine show, and is supported by YA! listener clubs. Under SIFPO2, PSI-Malawi is integrating HIV content with SRH topics in YA! Mix while expanding the number of radio listener clubs active in project districts.

Across 10 implementing districts, PSI-Malawi has 498 active youth listening clubs, 102 of which were added in FY16. PSI-Malawi YA! Teams conducted 42 SBCC activities (Open Days and Mega Shows) reaching 100,410 youth with SBCC messages. PSI will continue to expand geographically by establishing an additional two radio listener clubs against a target of 100 in Lilongwe district. YA! Messaging integrates HIV and FP messaging and is aimed at youth, with a view to promoting healthy social norms around HIV and increase uptake of HTS and FP services.

Objective 2: Increasing access to commodities for HIV prevention

With the awareness that accessibility is key to uptake, PSI-Malawi contributes to condom and lubricant availability and accessibility through various channels including social marketing, supply chain to key populations and free distribution in the public sector. PSI-Malawi works closely with a number of partners, including One Community, Linkages, HP+ and other USAID implementing partners to improve availability and accessibility of condoms and lubricant. In addition to providing supply chain support for free distribution and demand creation communications, PSI remains a key player in the paid-condom market in Malawi, distributing over 20 million male condoms in the last year.

Activities and results

Condoms and lubricant: PSI participated in numerous meetings in Q3 FY16 aimed at introducing a supply chain system to reduce stock out of condoms and lubricant for implementing partners serving key populations. A total of 1,803,323 condoms and 27,346 lubricants (for implementing partners serving key population) were transferred to PSI warehouses in Mzuzu, Blantyre and Mangochi districts in FY16. Implementing partners serving key populations will access these commodities for distribution, using peer educators and drop-in centers.

In addition to providing supply chain logistical support for implementing partners serving key populations, PSI-Malawi works with One Community project to deliver condoms to designated health facilities. One Community structures draw down condoms from health facility pharmacies and distribute in their respect communities. This system was introduced in Q4 FY16 and a total of 1,164,297 condoms were delivered to health facilities in catchment areas where One Community project is implementing activities.

Social marketing: PSI-Malawi introduced Chishango as a socially marketed male condom in 1994 to help develop the condom market in Malawi and offer affordable condoms outside the public sector. Beginning in July 2016, SIFPO2 funding is supporting the distribution and promotion of Chishango across Malawi. Similarly, PSI-Malawi introduced CARE as a socially marketed female condom in 2009 as an alternative condom for females available outside the public sector. Chishango sales are aimed at males aged 20 to 29 years. A total of 6,760,480 Chishango male condoms were sold in Q4 FY16, representing 132% achievement against the quarterly expectations. CARE female condoms are targeted at sexually active women aged 15 to 30 and their partners. Distribution also reaches many female sex workers and women engaging in transactional sex. A total of 6,860 CARE female condoms were sold FY16 representing 29%.

Objective 3: Provides VMMC services through routine service delivery, rapid response and campaigns

PSI-Malawi is implementing VMMC services (demand creation and service delivery) in Blantyre, Chiradzulu, Mangochi, Mulanje and Phalombe districts. Services are delivered in collaboration with Ministry of Health, through eight dedicated outreach teams. Beginning in Q4 FY16, SIFPO2 began supporting VMMC activities.

Activities and results

Demand creation: PSI-Malawi used various demand creation strategies to reach men, especially those 15 to 24 years of age, with demand creation messages. Demand creation strategies included community entry meetings, van mobilization, TOC mass shows, whistle stop activities, motivational talks, and football events.

VMMC service provision: PSI worked closely with District Health Management Teams (DHMTs) in the planning for campaigns and delivered services in collaboration with MoH. During Q4 FY16, PSI-Malawi organized a VMMC campaign in all five districts, reaching 12,705 men with an additional 665 men receiving VMMC services through routine service delivery. The campaign was estimated to reach 12,450 boys and men during the campaign and the teams surpassed the estimate by 2%. PSI monitors adverse events closely, in Q4 FY16 there were a total of 23 adverse events (AEs) and no serious AEs (SAEs). The majority of clients reporting with AEs had infections due to poor hygiene. All AEs were successfully managed on site and followed up until full recovery.

Figure 13: Summary of VMMC service delivery through outreach, July 2016 to September 2016

Month/Age Pivot	July	August	September	Total	% of Total
<14	1,686	2,962	154	4,802	36 %
15-24	2,167	4,521	329	7,017	52 %
25+	410	1,049	92	1,551	12 %
Total MCs	4,263	8,532	575	13,370	60 %
SAE	0	0	0	0	0%

Note: VMMC projection is 22,100 July 2016 to March 2017 under SIFPO 2. Currently, the team has achieved 60% of the projection.

Objective 4: Expand services to adolescent girls and young women through DREAMS

Through SIFPO2 funding for DREAMS, PSI-Malawi is expanding integrated SRH services to adolescent girls and young women (AGYW) in Machinga District. PSI will leverage the KfW/SIFPO investment by integrating key HIV services with reproductive health outreach services, increasing the number of AGYW and male partners who are tested and know their HIV status, linking youth living with HIV to care and treatment programs, and supporting risk reduction activities among youth. DREAMS funds will also support

the integration of messages related to HIV and gender-based violence through Youth Alert mass media and listening clubs.

Activities and results:
SRH services: PSI-Malawi has two integrated outreach teams providing SRH services to AGYW in Machinga district and two HTS stand-alone teams aimed at male partners and male teachers. All teams provide HTS and the integrated teams provide a broad range of FP options; all providers have been trained in youth friendly service delivery. Outreach teams provide male condoms to promote dual protection. In FY16, 15,700 condoms were distributed to 785 AGYW and 248,440 condoms to 12,422 males. In FY16, integrated outreach teams provided FP services to 15,810 clients and all outreach teams in Machinga provided 9,814 clients with HTS. 447 clients tested positive, representing case finding of 4.5%.

Linkage to care and treatment: PSI outreach providers conducted monthly follow up visits to health facilities to check if cases identified through outreach testing linked to care. Out of 447 HIV positive clients in FY16, 242 clients had successfully linked to care, representing a linkage rate of 54%. PSI has recently developed a linkage and case finding Standard Operating Procedure, which has improved strategies for linking clients to care. PSI anticipates that using these strategies, linkage rates will increase in FY17.

Table 14: Progress on PEPFAR and SIFPO2 indicators

Indicator	Results (Oct 2015 – Sept 2016)	FY16 Projection	% of FY16 projection achieved
Number of priority populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards	4,764	14,000	68%
Number of individuals who received HIV testing and counseling services for HIV and received their test results	32,703	59,370	55%
Number of HIV positive adults and children newly identified	1,601	1,507	106%
Number of YA! Listeners clubs consistently reaching young people	498	700	71%
Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary FP services	Integrated outreach to begin soon	100%	57%

Challenges
The MOH in Malawi experienced stock shortages of Unigold HIV test kits in Q3 and Q4 FY16. Due to these shortages, the MOH issued a statement suspending all community-based testing and prioritizing facility-based use of HIV test kits. PSI-Malawi was forced to suspend all outreach testing during this period, which affected reach in FY16. A number of trainings planned by PSI-Malawi were put on hold due to training suspensions. USAID Malawi has suspended a number of trainings, including Test and Treat and STI due to public sector health workers boycotting trainings over DSA guidelines. PSI-Malawi is waiting for high level dialogues to conclude and the green light be given to proceed with trainings in FY17.

Confirmed linkage of referred positive patients remains a challenge. In addition to increased communication and the introduction of expert clients, PSI-Malawi will work closely with treatment partners as well as participate in the DREAMS linkage/referral pilot planned to take place in November 2017.

Swaziland

PSI received funding from USAID through SIFPO2 in March 2016 to implement DREAMS and Condom Distribution and Priority Prevention Population (PP Prev) messaging projects. Under DREAMS, PSI collaborates with Pact and Health Communication Capacity Collaborative (HC3) to address structural drivers that directly and indirectly increase girls' risk of HIV acquisition and/or early or unintended pregnancy. PSI focused on distribution of condoms nationwide, particularly among youth, with innovative community partnerships and media campaigns, and communicated the core minimum package of standard prevention interventions to priority populations in Kwaluseni Inkhundla as well as in all Tinkhundla not benefitting from the DREAMS partnership.

Objective 1: Increase access to a core package of tailored, evidence-based interventions intended to increase uptake of HIV and SRH services for adolescent girls and young women.
Under this objective, PSI/Swaziland focuses on providing comprehensive, coordinated and youth-friendly mobile HIV and SRH services to high-risk populations, specifically AGYW 15 to 24 in 19 selected Tinkhundla. PSI operates five mobile units around the country that offer HIV testing services (HTS), referrals to anti-retroviral treatment (ART), prevention of mother-to-child transmission (PMTCT), TB screening, STI treatment, FP provision, prevention information and referrals, and condom education and distribution, while increasing risk perception and reducing vulnerabilities to HIV.

Objective 2: Increased access to and demand for condoms
Under this objective PSI/Swaziland conducts community-based promotion and distribution of free-issue condoms. Intended beneficiaries are youth 15 to 24 and key populations (MSM, sex workers, and people living with HIV). Using social, mass, and small media, as well as below-the-line events and interpersonal communication, PSI/Swaziland also supports demand creation, and promotes the use of condoms among youth through an integrated branded marketing strategy, known as 'Got it? Get it.' PSIs work in early 2016 has been informed by an evaluation of the condom strategy conducted in December 2015.

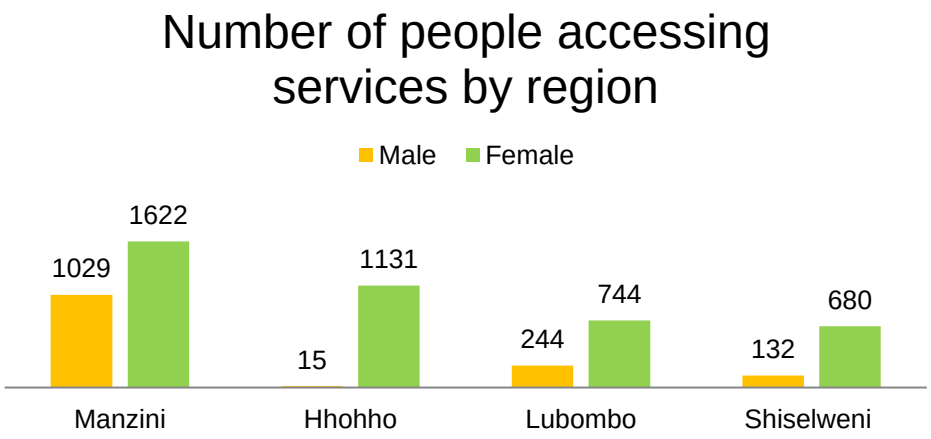
Objective 3: Improve access to effective information and support for behavior change to reduce risk and vulnerability to HIV
To complement the efforts of Objective 2, PSI/Swaziland utilizes the core minimum package of standardized prevention interventions with the above mentioned intended beneficiaries in 36, non-DREAMS Tinkhundla and the industrial town of Matsapha. PSI/Swaziland utilizes inter-personal communication with individuals or small groups, and conducts client-centered conversations using the principles and techniques of Motivational Interviewing.

Activities and results
DREAMS: PSI visited all DREAMS specific Tinkhundla to offer SRH/HIV services to AGYW. Since the launch of DREAMS in June 2016, of the 5,597 people who accessed services at the mobile units, 2,755 (49%) were AGYW. Of note is that 1,420 males, found mostly in Shiselweni and Lubombo regions, accessed SRH/HIV services at the AGYW mobile units. In Kwaluseni Inkhundla, PSI reached more males than females, which could be attributed to the fact that more outreaches were conducted to rural Kwaluseni areas where clients were found in sheebens and in fields. Community Health Promoters (CHPs), along with the counselor and nurse, conducted one door-to-door campaign in Kwaluseni in an effort to create awareness of the services offered at the mobile unit. A greater proportion (75%) of people accessing mobile unit services were females, with 2,755 (49%) being AGYW aged 15 to 24 years. The Figures 15 and 16 show the number of people reached by Inkhundla and by region.

Figure 15: number of people reached by Inkhundla

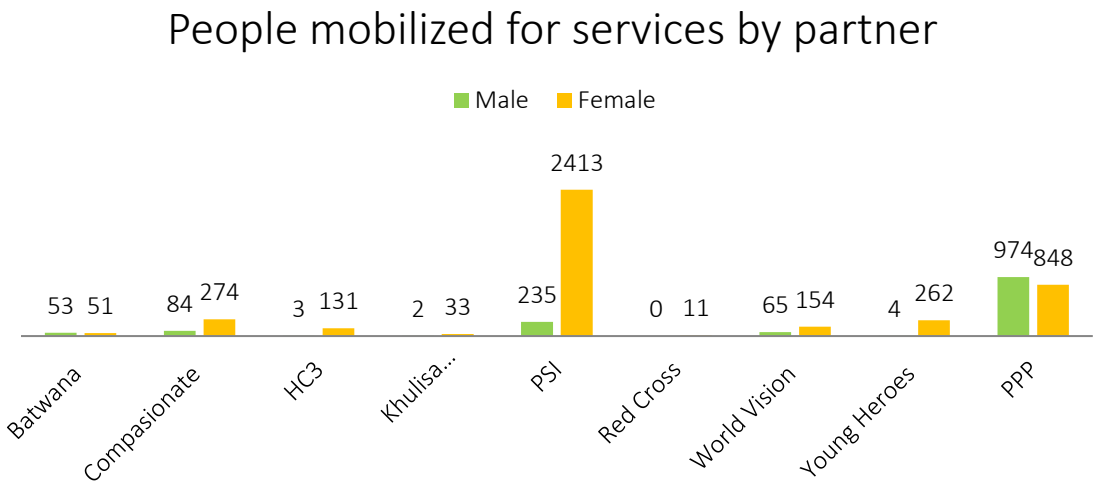
Dreams on Wheels (# people reached) by Inkhundla				
Region	**Inkhundla**	**Male**	**Female**	**Total**
Shiselweni	Maseyisini	83	296	379
	Mbangweni	49	384	433
Manzini	Kwaluseni	974	848	1822
	Lobamba Lomdzala	10	156	166
	Ludzeludze	3	85	88
	Manzini North	11	253	264
	Manzini South	4	91	95
	Mkhiweni	3	56	59
	Ngwempisi	24	133	157
Hhohho	Lobamba	1	250	251
	Mbabane East	1	195	196
	Mbabane West	5	218	223
	Motshane	4	267	271
	Pigg's Peak	4	62	66
	Ntfonjeni	0	139	139
Lubombo	Mpolonjeni	84	226	310
	Siphofaneni	50	248	298
	Sithobela	18	81	99
	Dvokodvweni	92	189	281
Total		1420	4177	5597

Graph 1: Showing number of people reached by region



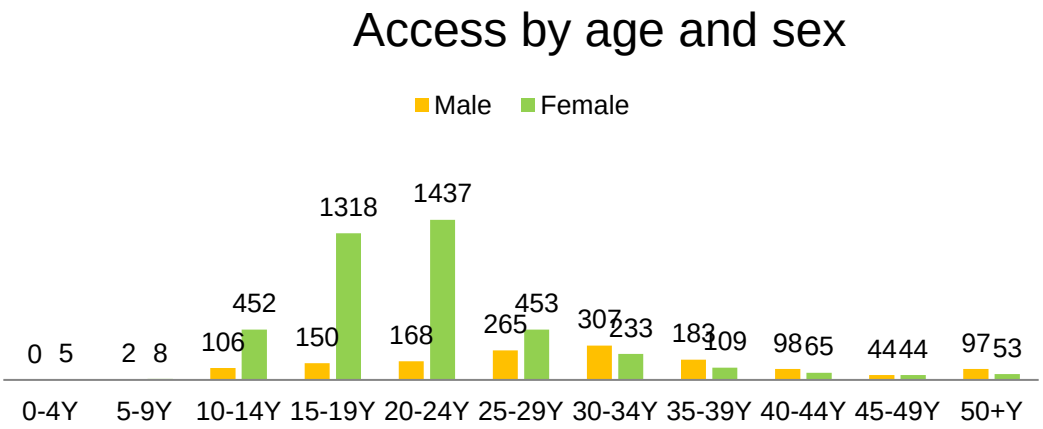
PSI works collaboratively with HC3 and Pact to offer services to AGYW at the selected Tinkhundla. Figure 17 shows the number of people mobilized by each partner working in the community. 47% of the clients who accessed services at the mobile units were mobilized by PSI CHPs; 18% by Pact partners, which include Bantwana, Compassionate, Khulisa, Red Cross, World Vision and Young Heroes, and 2% by HC3. PSI will continue to strengthen relationships with Pact and HC3 to mobilize the right population for the services. PSI will also participate at Pact and HC3 debriefings to encourage facilitators to refer clients for services at the mobile units for improved layering of services across partners.

Figure 17: People accessing services by partner



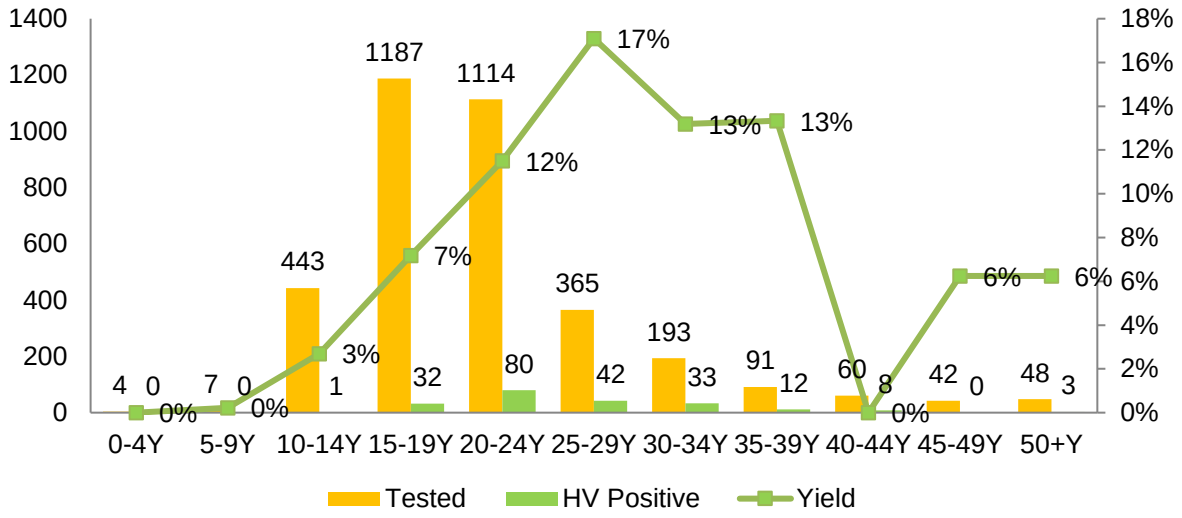
In general, AGYW have shown interest in the mobile services offered by PSI. 49% of AGYW aged 15 to 24 years, accessed various prevention services this reporting period. PSI does not turn anyone away from the unit who requests services, but services are tailored specifically for the 15 to 24 AGYW age group and messages are customized for them as well. Figure 18 shows service access by age and sex for all Tinkhundla and partners who mobilized clients.

Figure 18: Showing service access by age and sex



The yield by age amongst females is demonstrated through the graph below. Of the 4,947 individuals who tested for HIV, 3,554 (72%) were females, with the highest yield being amongst the age group 25-29 years at 17%. 15-19 and 20-24 recorded a yield of 7% and 12% respectively.

Figure 19: Females tested for HIV and yield by age



Referrals and linkages are a key part of the PSI DREAMS program and PSI has a fully-fledged referrals and linkages unit with expert clients and a coordinator to ensure that people who are referred are linked for services. HIV positive clients are followed-up by expert clients, and HIV negative clients referred for other services, such as VMMC and voluntary FP service refills, are followed-up by CHPs. PSI has capacitated CHPs and expert clients to follow-up clients and link them on the same day of the service, or call them and request to escort them to the facilities. Clients have expressed appreciation for the service that PSI offers. Figure 20 shows linkage rate by service for FY16:

Figure 20: Linkage by service

Service	Number referred	% Linked
BP	8	62%
TB Diagnosis	397	51%
HIV Care & Treatment	262	*71%
Breast CA Screening	1	100%
Cervical Cancer Screening	1	100%
Chicken pox	2	50%
FP Initiation (LARCs)	4	75%
FP Refill	732	**27%
Ovarian Scan	1	100%
SGBV Care /Treatment	3	66%
STI Management	21	80%
Ultra Sound Scan (Abdominal)	1	100%

VMMC	5	80%

*pending clients are followed-up by expert clients for linkages to care **clients not linked are not due for their appointments. Follow-up is conducted by CHPs

Condoms: Condom distribution and promotion is conducted nationally by PSI and other partners. PSI reached and surpassed targets for male condom distribution this reporting period. 13,134,100 million units of male condoms and 116,000 of female condoms were distributed nationally by PSI in FY16. Since April 1, 5,766,000 male condoms and 69,000 female condoms were distributed through 865 general population condom outlets, 33 key population outlets and 867 youth (GIGI) outlets.

Female condom distribution is still a challenge. Discussions with females at community events or outreaches reveal that women are still lacking empowerment to negotiate condom use with their partners. Some women would not take any of the condoms offered while others preferred male condoms, as they term them “easier” to use. IPC agents will continue educating the public on female condom benefits and the upcoming generic condom campaign will hopefully also improve uptake of female condoms in the country.

Figure 21: Reach for condoms annually

	Annual forecast	APR	%
Male Free Condoms	11,444,915	9,033,600	
Number 1		2,420,100	115%
Strawberry		841,700	
Vanilla		838,700	
Total Male Condoms		13,134,100*	
Female Condoms	170,200	116,000*	53%
Total Condoms	11,615,115	13,250,100	114%
Lubes	No forecast	186,000	N/A
Condom Outlets	1,500	1,765	118%

*Includes 3,593,000 male and 33,000 female condoms distributed under HC3 for the period Oct 15 – March 16

To complement SRH/HIV services, PSI reached a total of 19,863 (57% of the target) women and men with the minimum package of standardized prevention interventions in 36 non-DREAMS and Kwaluseni Tinkhundla. Specifically, PSI reached 6,233 AGYW and 4,986 men aged 20 to 34 years, with PP Prev messaging. PSI utilized IPC with individuals or small groups and conducted client-centered conversations using the principles and techniques of motivational interviewing (MI).

Challenges

DREAMS: PSI achieved 17% of the annual target of reaching 16,581 AGYW with services in selected Tinkhundla. Following a period of procurement and staff hiring and training, PSI only began implementing SRH/HIV mobile unit services in mid-June 2016. This meant there were only three and a half months of program implementation, which served as a period of observation and analysis of the program strategy. Therefore, it is too soon to determine which sites are working and which are lagging behind. The program will conduct an analysis of performance every month to understand performance of sites and beneficiaries reached, to better focus on sites that are lagging behind and on reaching intended beneficiary population.

PSI received SIFPO2 funding for COP (condoms/PP Prev) at the end of March 2016, so PP Prev results for FY16 are still in the process of being achieved. PSI achieved 57% of the set annual target for reaching AGYW and men with a minimum package of messages in non-DREAMS and Kwaluseni Inkhundla. PP Prev messaging initiated in February 2016 and was done jointly with condom distribution and health service delivery at designated areas.

Success story: The "DREAM" is a reality

The AGYW mobile health unit has proven to be a great success among the intended beneficiary population. The most common reason for its popularity, according to comments made by the clients, is the anonymity of the set-up, which, given the sensitivity of their needs, makes them feel more comfortable accessing health services in the mobile unit than in their local health facility.

Lihle looking at her results with her sister Nokwanda

According to 23-year-old Lenhle Dlamini from Kabhelina, a peri-urban area in Ezulwini, she would never go to the local facility because the nurses there are local residents and she doesn't trust them to keep their conversation confidential. When asked what attracted her to the DREAMS mobile unit, she said it was the nurse who was very friendly and easy to talk to. "She was not intimidating like the nurses she knows at her nearest facility," she said. According to Lenhle, the nurse gave her a flyer titled, "Am I at risk?" and asked her to answer the questions but not disclose her response. She said that experience was an eye-opener for her as it made her realize that she was at risk of contracting HIV. Lenhle admitted to having a boyfriend who is reluctant to use condoms and has not bothered to access services at a health facility.

After receiving the service at the mobile unit, Lenhle said, "I enjoyed the service very much," calling the staff excellent. "I don't even remember the last time I tested; I think it was some time last year. Today I did it and I also got contraceptives and condoms. They made it easy and comfortable." Another thing that she was quick to point out was the anonymity of the experience. "I don't know any of the people here," she says. "The only time I will ever see them again is if I visit the mobile clinic again."

Zika

PSI is pleased to submit the following highlight of activities against the proposed objectives of the USAID SIFPO2 project (AID-OAA-A 14-00037) for the reporting period of October 1st 2015 to September 30th 2016. This summary includes activities currently being implemented in the prioritized countries of the Dominican Republic, El Salvador, Honduras and Guatemala.

Introduction: In May of 2016, the USAID Bureau of Global Health invited PSI to submit a proposed supplementary work plan expanding the scope of activities being implemented under the SIFPO2 project to include interventions focused on addressing the rapid spread of the Zika virus within the LAC region. Four countries, including the Dominican Republic, El Salvador, Honduras and Guatemala, were selected as priority focus countries in which PSI would work in collaboration with other implementing partners to minimize the negative pregnancy outcomes resulting from Zika infections among women in key transmission areas. Under the USAID Zika response lines of effort framework, PSI was asked to support the improve capacity of countries affected by and at risk of Zika and other vector borne diseases to implement effective Zika related SBCC programming emphasizing community engagement and two way communication strategies.

In June of 2016, PSI's LAC Regional and technical teams based in the four target countries began to implement its SBCC Zika prevention strategy, focusing initial efforts on targeting key audiences including pregnant women and women of reproductive age, their male partners and families and private sector health providers.

Specific Result and Objectives included under PSI's LAC Zika Workplan: PSI has been requested to support improving the capacity of countries affected by and at risk of Zika and other vector borne diseases to implement effective Zika related SBCC programming emphasizing community engagement and two way communication strategies. PSI has established the following priority objectives in order to achieve this purpose:

(R1.1) Increased use of personal safeguards, including the voluntary use of FP and condoms to prevent unintended pregnancy and sexual transmission of Zika among WRA, pregnant women and their sexual partners;

(R1.2) Developed body of evidence regarding target communities´ knowledge about Zika transmission and prevention seeking behavior to strengthen SBCC messaging and program responses at the community, regional and national levels;

(R2.1) Increased provider knowledge about Zika and increased number of private health service providers who incorporate Zika counseling into integrated Sexual and Reproductive Health (SRH) services;

Key Activities and Results Acheived during this reporting period:

- Workplan for the period drafted, submitted and approved
- Established consensus with USAID on key program indicators for tracking project advances

- Identification, recruitment and onboarding of key regional and country level staff in each country, including Regional Coordinator, Regional Trainer, Regional Social Media Specialist, Country Project Managers and Clinical Master Trainers.
- Development and production of 40,000 Zika prevention kits targeting pregnant women in the four countries. 7,812 Zika prevention kits were delivered to the MoH in Honduras.
- Development of draft SBCC materials for pregnant women, male partners, CHWs and health providers. Validation of IEC materials by target audiences of pregnant women, women of reproductive age and male partners were conducted in four countries. Materials submitted to technical review committees in each country for revision and approval for use.
- Active participation in each of the four target countries by project staff in MoH technical working committees coordinating the Zika response in each country and in USAID implementing partner coordination meetings.
- IRB approval obtained for regional omnibus survey including 11 questions related to Zika prevention knowledge and behaviors to be conducted in seven countries in the region. A service contract was negotiated with service provider CID Gallup for implementation of this survey. Survey moved to the field level implementation phase in October with results expected for early December.
- Development of a draft training curriculum for training of private sector health care providers in the provision of Zika prevention counseling to pregnant women.
- Process of identifying private sector health care providers to be included in project was initiated. Providers include 87 private sector clinicians in Guatemala and 38 in El Salvador.
- Provider service reporting formats and client follow-up forms developed.
- A conference session on Zika and the management of high risk pregnancies was conducted by project Master Trainers in Guatemala during the national OB/Gyn conference. More than 200 providers were in attendance.
- A regional strategy and protocols for the provision of online prevention counseling via social media were developed. Airing of the first Zika prevention messaging via social media and affiliated websites was initiated in July and is ongoing. During the reporting period, more than 40 unique publications were developed and 6 educational video spots were posted to the platforms.
- Creative briefs were drafted and submitted to the McCann-Erickson advertising agency for the development of a regional SBCC media campaign in August. The first creative concept drafts were submitted for discussion and consultation with USAID technical team. Consultation on all SBCC education and training materials continues at the country and regional levels involving MoH and USAID staff.

Challenges: The development of SBCC materials for all target audiences has been prolonged as a result of intensive consultative processes at each stage of development and which involve a variety of institutional actors at the country and regional levels. Requests for revisions to draft materials continue to be received from MoH and USAID technical and program staff and it remains somewhat unclear as to what entity, technical office or cognizant program officers wield the ultimate authority to approve materials to be used in each country and across the region. Meanwhile, the lack of accurate information about Zika remains an urgent need among the vulnerable populations throughout the region.

PSI is working with USAID technical staff at the Bureau and Regional levels to clarify the lines of authority and continues to incorporate recommended revisions to materials.

Budget and Activity Summary

Result Area	Expenditures through September 2015	Oct 2015 - Sept 2016 Expenditures	Total Expenditures
Result 1: Strengthen the capacity of PSI's network of members to deliver high-quality FP and other health services to target groups	$1,357,608	$1,807,630	$3,165,238
Result 2: Increase the sustainability of country level FP and other health programs	$1,043,134	$929,530	$1,972,664
Subtotal Core:	**$2,400,742**	**$2,737,160**	**$5,137,902**
Benin (including Benin's central funds)	$83,951	$1,106,748	$1,190,699
Cambodia	$-	$1,208,140	$1,208,140
DRC	$400,000	$1,840,493	$2,240,493
Ghana	$-	$627,211	$627,211
Guatemala	$974,276	$1,913,456	$2,887,732
Malawi	$105,211	$1,967,963	$2,073,174
Swaziland	$-	$1,033,428	$1,033,428
Zika	$-	$244,968	$244,968
Subtotal Field:	**$1,563,438**	**$9,942,407**	**$11,505,845**
Grand Total	**$3,964,180**	**$12,679,567**	**$16,643,747**