Graduation and Phase-Out in the Health Sector: What Have We Learned?

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Spring 2012

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ACKNOWLEDGMENTS

The authors wish to thank the following colleagues for their valuable input: Dr. Ariel Pablos-Mendez (Assistant Administrator, Global Health Bureau), Paul Holmes (Senior Regional Health Advisor, Europe and Eurasia Bureau), Susan Thollaug (Team Leader, Latin America and Caribbean Bureau), Gary Cook (Public Health Officer, Asia and Middle East Bureau), Mary Vandenbroucke (Public Health Officer, Bureau for Global Health), Willa Pressman (Public Health Officer, Bureau for Global Health), Linda Howey (Africa Bureau), Katie Qutub (Health Advisor), Marguerite Farrell (Health Development Officer, Family Planning Graduation Working Group Chair), Meghan Holohan (Tuberculosis Coordination Advisor), Kelly Saldana (Deputy Director, Office of Health, Infectious Diseases, and Nutrition), Justin Elswit (General Business Specialist, Bureau for Economic Growth, Education and Environment), Joseph Obi (Economic Growth Analyst, Bureau for Economic Growth, Education and Environment), Karen Cavanaugh (Director, Office of Health Systems), Carl Mabbs-Zeno (Senior Economic Advisor, State FA/GF), Julian Brown (Program Assistant, Global Health) and Sarah Jackson (Information Officer, Office of Foreign Disaster Assistance). The authors are also grateful for their consultations with the following colleagues: Robert Clay (Deputy Assistant Administrator, Bureau for Global Health), Janis Timberlake (Senior Advisor, Bureau for Global Health), and Jeri Dible (Deputy Office Director, Health Sector, Georgia).

EXECUTIVE SUMMARY

USAID has a rich experience in graduating and phasing out health sector programs from assistance. Between 2008- 2015, USAID graduated or phased out 27 countries in the health sector. More than 65 health sector element (Maternal and Child Health, Nutrition, Family Planning, Tuberculosis, Nutrition HIV and AIDS and Malaria) level funding ended across countries in the last five decades. Graduation and Phase-Out are separate transition processes however they end in the same result, a closeout of external assistance. Graduation takes place once certain thresholds of development or intended results have been attained. Phase-out is the withdrawal of assistance over a finite time period, often as a consequence of resource constraints, instability, and economic or political considerations.

A literature review was conducted to document USAID lessons learned in graduations and phase out of programs. A total of 97 documents were found in the USAID Development Exchange Clearinghouse and in internal USAID files. In addition to the desk review, interviews were conducted with key informants.

Two companion papers summarizing the review's findings were developed. The first, *Five Steps Towards Implementing a Deliberate Health Sector Element Phase-out,* identifies key steps that USAID Missions should undertake in developing and implementing a phase-out strategy to make it a deliberate process. The second summary paper is this paper, *Graduation and Phase-out in the Health Sector: What Have We Learned?* This paper summarizes the findings in the following areas:

- Graduation and phase-out experiences in the health sector
- Four key factors for sustainability of any health program
- Five critical steps while phasing out of a health program
- Management lessons for staff in managing transitions
- Identification of USAID legacy mechanisms

Family Planning (FP) graduations merit a special mention in USAID history of health sector transitions. Many of the graduated health programs have been in the area of family planning, and largely in the Latin American and Caribbean (LAC) region. FP graduations offer a model process for other health programs to follow. In 2003, Global Health/Population and Reproductive Health (GH/PRH) and Regional Bureau health teams, with endorsement from the Health Sector Council, developed a technical note that identified thresholds for achieving graduation. Based on this technical note, GH/PRH implemented a rigorous assessment to identify countries that met the Health Sector Council's readiness criteria. The resulting graduations were planned, deliberate, and based on a country attaining certain thresholds in program goals.

In contrast to graduation, USAID also has experience in phasing out programs for a variety of reasons. Several health sector elements have been phased out due to resource constraints, instability, and economic and political considerations. Some of these transitions have been related to implementation of the Presidential Policy Directive on Global Development (PPD-6), which emphasizes greater focus and selectivity regarding the countries and areas in which USAID works, so as to maximize operational effectiveness and achieve better outcomes. The five steps paper details the critical steps that must be completed to deliberately close out any program.

The five critical steps while phasing out of a health program are the following:

1. Good coordination and clear communication with all stakeholders about close out dates;
2. Development of a phase-out strategy with the host country's government and partners early in the process;
3. Strengthening of existing or new collaborations for leaving a lasting USAID legacy- the long-term impact USAID has on the recipient country's health sector program;
4. Communication and documentation of the program's successes over the entire period of USAID assistance in a country; and
5. Evaluation of the program or health sector element at end of the assistance.

Whether the transition is a graduation or a phase-out, the research shows that the singular aim was to find ways to achieve sustainability of program goals once USAID assistance was coming to an end. The common underlying goal in both processes is achieving sustainability of program goals and self-sufficiency. In the health sector, Missions and partners typically focused on the following four key pillars for achieving health program sustainability:

1. **Country led financing**: Financing involves country-led and country-managed processes, whether the financing is public or private. The financing sustainability strategy may entail budget line items, cost-recovery mechanisms such as user fees, public-private alliances, and other options.
2. **Policy and regulatory reform:** Promoting supportive policy and regulation are key strategies for creating an enabling environment and moving toward sustainability. Experts who have been engaged in graduating countries from USAID assistance note that successful graduations arise not only from a country financing the program, but also from changes in policy accomplished through years of advocacy.
3. **Institutional strengthening**: Preparing country institutions to assume the responsibility for continuing USAID's work is critical for promoting sustainability. As donor support came to an end in various countries, the research team found that nongovernmental organizations (NGOs), civil society or the private sector often stepped forward to complement government efforts in providing health services or products.
4. **Leadership and stewardship**: Committed leadership and effective stewardship of health resources are prerequisites for advancing program sustainability. The capacity of a health program to realize strong outcomes requires committed leaders with an ability to manage resources sustainably.

A key lesson learned is that each of these four sustainability factors may take years, and possibly decades, to achieve. Thus, progressing toward sustainability requires careful planning and implementation from the inception of a program or project. These pillars constitute people-centered health systems and are built incrementally over decades. They require sustained commitments and harmonized plans amongst all stakeholders.

The literature suggests that as Missions transitioned out health sector elements, they strengthened existing relationships with different host country institutions as a step toward establishing a USAID legacy. These organizations included but were not limited to think tanks, business development centers, nongovernmental institutions, and research and academic institutions. Missions also formed bi-national commissions through a formal bilateral agreement and a high level of official involvement from both nations and bi-national foundations to promote sustainability. Post-graduation or phase-out, these institutions would serve as the USAID legacy in the country.

USAID has also made a concerted effort to establish or identify new legacy mechanisms, such as funding endowments, trust funds, local foundations, investment funds, or utilization of the USAID development credit authority (DCA). These strategies served not only as legacy mechanisms for USAID but also to promote financial sustainability during graduation or phase-out processes. Tapping local capital and partnering in new ways to unleash sustainable financing were keys to success. Many other innovative financing mechanisms are available today and these should be explored, and from inception of the program.

In conclusion, for every new project developed and implemented with USAID assistance, there should be a clear understanding with the host country government and partners about when and under what conditions assistance will end. Strengthening local institutions capacity and utilizing local systems are key to building sustainable programs. Development assistance for health today is dwarfed by growing domestic health spending, private flows, remittances etc. Donors will have to conduct business differently. The ability of donors to help build sustainable health systems will be realized through technical collaborations, diplomacy, advocacy for domestic financing and partnerships with the private sector.

I. BACKGROUND AND SCOPE

We must say to the less-developed nations, if they are willing to undertake necessary internal reform and self-help—and to the other industrialized nations, if they are willing to undertake a much greater effort on a much broader scale—that we then intend during this coming decade of development to achieve a decisive turn-around in the fate of the less-developed world, looking toward the ultimate day when all nations can be self-reliant and when foreign aid will no longer be needed.

President Kennedy's Special Message to the Congress on Foreign Aid, March 22, 1961

President Kennedy signed the Foreign Assistance Act into law and created USAID by executive order in 1961. USAID was created as a force for progress, responsible for administering aid to foreign countries to promote social and economic development. The Agency has helped stabilize countries, enhance economic growth and help support human needs such as food and nutrition, health and education in countries around the globe. Today, fifty years after President Kennedy saw the ultimate day when all nations can be self-reliant and when foreign aid is no longer needed, we stands close to this ultimate day. USAID stands at the threshold of a new way of doing business.

This paper examines USAID's experience in graduating and phasing - out health programs, the context in which the health program are operating today and it offers lessons learned for sustainable development strategies for the health sector.

This paper summarizes the findings in the following areas:

- Graduation and phase-out experiences in the health sector
- Four key factors for sustainability of any health program are identified
- Five critical steps while phasing out of a health program are identified
- Management lessons for staff in managing transitions
- Identification of legacy mechanisms

The paper also provides recommendations based on experiences to date.

The team reviewed 97 documents related to USAID graduations and phase-outs over the past 50 years of USAID assistance, mostly from the USAID Development Experience Clearinghouse and in internal USAID files. Of these, 14 papers covered the subject of graduation policy at large, 12 were devoted to graduating entire Missions, 38 were on USAID's experience with legacy mechanisms, 30 were devoted to graduations in the health sector, and three discussed non-health sector experience with graduations. USAID staff wrote the majority of health sector graduation strategies. The team also drew upon available documents written by external organizations, which analyzed multiple USAID FP graduations. A bibliography and other information on the documents are provided at the end of the report.

In reviewing this material, the team focused on the following questions: (1) Are there areas of a program that are key to ensuring sustainability of health program achievements? (2) Are there any trends and lessons for sustainable health sector assistance from the onset? and (3) What are legacy mechanisms and what is the experience of using them for graduation or phase-out of programs in the health sector?

Based on this review, two summary papers have been written. The first, *Five Steps Towards Implementing a Deliberate Health Sector Element Phase-out*, identifies key steps that USAID Missions should undertake in developing and implementing a close out strategy. The main purpose of this

document is to provide operational information to Missions that have begun decreasing their assistance for a health sector element, with a defined timeline for closing out the assistance.

This paper *Graduation and Phase-out in the Health Sector: What Have We Learned?* summarizes findings from a review of USAID's experiences in this area. It does not speculate on the readiness of a health program to graduate or phase-out. It also does not explore the reasons why a particular country was selected for a health sector graduation or phase-out. Rather, the paper focuses on the experience of any **documented** graduation or phase-out plans that USAID Missions undertook and presents trends and lessons learned across those programs. In the review, lessons learned from other sectors are also presented in the context of the health sector to enrich the learning.

There are many limitations to this paper. In the literature, phase-out plans describe what was planned during the transition stage; however, there is limited information available on what was actually accomplished or implemented. In addition, other than one study on Mexico, which was conducted five years after USAID graduated the FP program, there is no information available on the status of programs after USAID assistance ended. Last, most of the sustainability analysis provided in this document rests on information available from the documentation on the USAID family planning graduations and two other health sector graduations. No written documentation was available on any other health sector element graduations or phase-out processes.

1. Terms and Terminology

Graduation and phase-out are two separate processes that end in the same result. Both result in a close-out of USAID assistance for a health sector, a health sector element, or health project activities in a country. The definitions of each are provided below. Phase-out is nuanced further into "phase-down" efforts.

The main aim of any phase-out or graduation plan is to ensure that the program goals and achievement are continued in the country. Either plan is, in effect, a sustainability plan.

Graduation refers to the graduation of a health sector element, health sector, or country from external assistance once certain thresholds of development or intended results have been achieved.

Phase-out is the withdrawal of a sponsor's involvement in a program, often but not always as a result of some constraints. In the broader literature, phase-out often refers to a withdrawal of involvement without plans to turn over the activities to another institution to continue implementation. In USAID's experience, however, phase-outs in the health sector, even those implemented on abbreviated timelines, are distinguished by some planning for sustainability. Any negative impact on the country program can be reduced by careful planning of phase-out activities.

- **Phasing down** involves the gradual reduction of activities, utilizing local organizations to sustain program benefits while the donor agency deploys fewer resources. Donors transfer program activities to local communities or institutions so that services can continue and can be managed through local organizations. Phasing down is often a preliminary stage to phasing out. One can have phase-down and phase-out activities at the same time in a given program—e.g., transfer of activities in a particular geographic area to a local entity while eliminating activities altogether in other geographic areas.

Transition is the change from one type of assistance to another process over a certain time period. It is the state that occurs between the decision to graduate (or phase-out) to the completion of the close-out.

Sustainability is the capacity of a host country entity to achieve long-term success and stability and serve its population without interruption and without reducing the quality of services after external assistance ends.

In the literature, "graduation" and "phase-out" have been used interchangeably thus far. For colleagues deeply engaged on the topic, the terms "graduation" and "phase-out" have different connotations: graduation is something that is achieved, while phase-out is a process that is presented to programs. In both processes, however, the aim is to find ways to achieve sustainability of the program goals once USAID assistance is coming to an end. This is accomplished in many ways, as described in the following sections.

The transition period otherwise known as the time between the establishment of a graduation or phase-out date and the close-out of activities, is a critical period. This period is one during which gains made under past programs should be consolidated, ongoing activities that are not contributing to program goals are removed from the strategy, and new activities are introduced only if they are necessary for successful graduation or phase-out.

What is done during this period often determines what USAID leaves behind in the country—also known as the USAID legacy.

2. Graduation and Phase-out Experience in the Health Sector

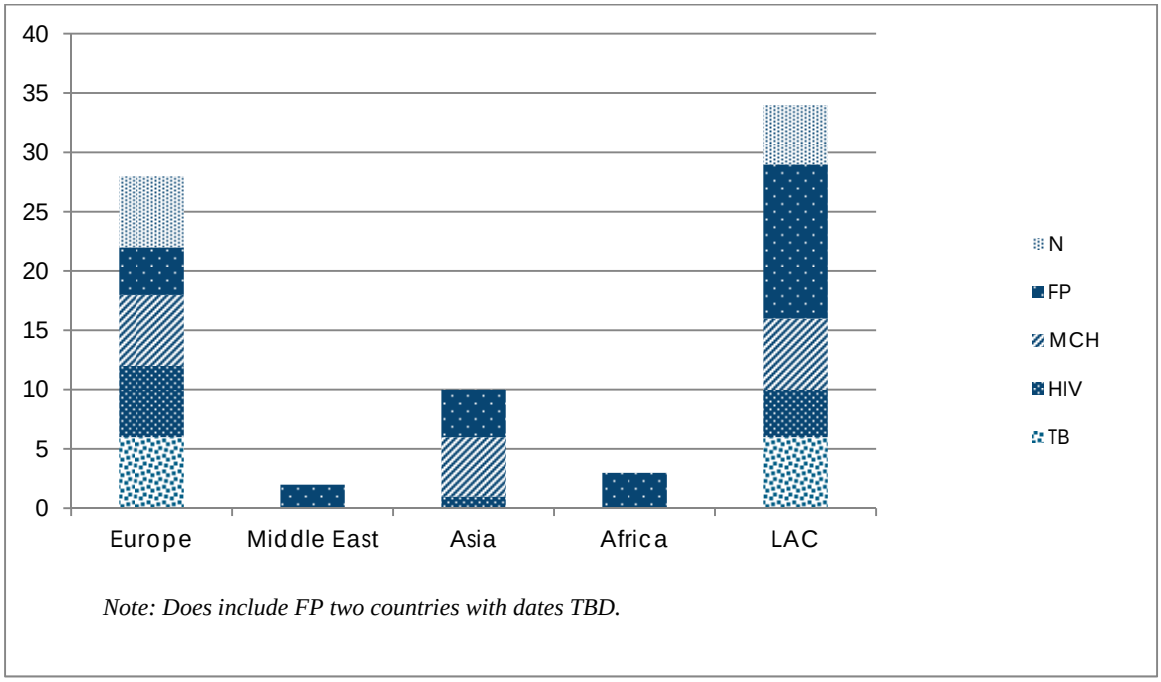
Throughout its history, USAID has graduated programs when development goals largely have been attained or when host countries have demonstrated readiness to take on activities without direct assistance. USAID also has phased out of programs due to resource constraints, instability, and economic or political reasons.

Turkey's health sector graduated from USAID assistance a decade ago along with ten of the European Union countries. Thailand graduated in 1993; however, it now receives small amounts of funding from the regional program. South Korea's health program graduated in 1980 as did the Mission. Argentina, Chile, Costa Rica, and Uruguay all graduated in the early 1990s, along with the entire Mission.

Between 2008-2015, USAID will close out health programs in 27 countries in order to increase resources in higher need countries. In the last fifty years, the Bureau for Global Health (GH) has graduated or phased out funding for 65 health sector elements globally. Of these, there have been 24 graduations in family planning, primarily in the Latin American and Caribbean (LAC) and Europe and Eurasia region.

Figure 4: Health Program/ Element closeouts by Region

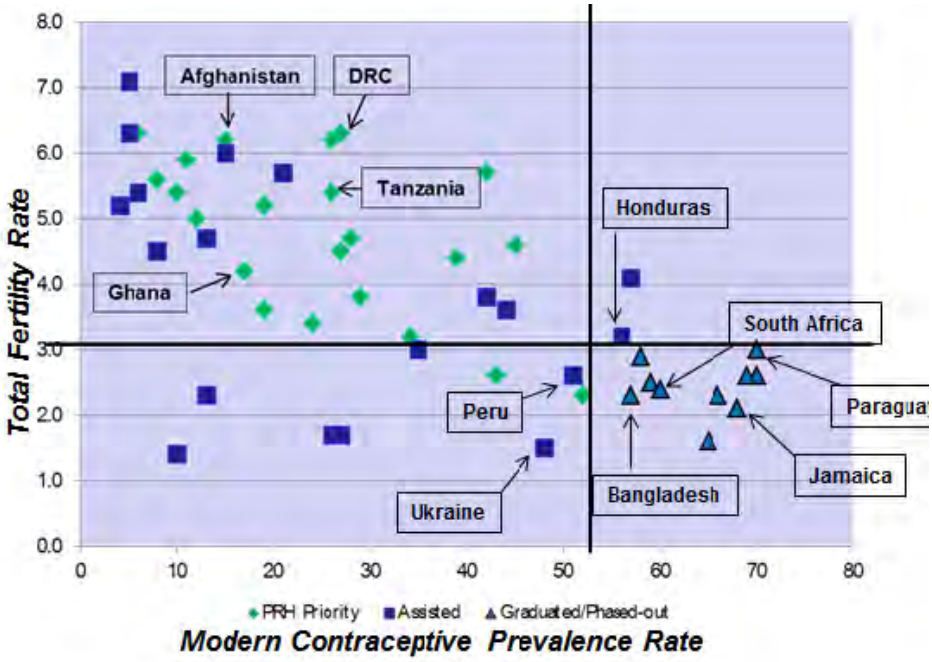
1976-2015



Note: Does include FP two countries with dates TBD.

Family Planning graduations merit special attention in USAID's history of health sector transitions. Overall, USAID has graduated 24 countries[1] from FP assistance, with two more on track to graduate by 2015. USAID's experiences in this area provide a model for close out processes. In 2003, USAID's GH Office of Population and Reproductive Health (GH/PRH) developed a technical note (see Appendix 1 for summary) that defined thresholds for graduation. A country's FP program was considered to be a candidate for graduation within a short term, two- to five-year period when (1) the total fertility rate (TFR) was less than 3.0 and (2) total modern contraceptive prevalence was greater than 55 percent for married women of reproductive age (see Figure 1). Likewise, a country's FP program was considered for graduation within a medium - long term, four- to 10-year timeframe if (1) the total fertility rate was 3.0–3.4 and (2) modern-method contraceptive prevalence was 48–55 percent of married women of reproductive age. The planning process also included a rigorous technical assessment to determine readiness for graduation.

Figure 1. Threshold for Graduation from USAID FP Assistance, 2012



In 2003, under the direction of the technical note, GH/PRH identified the Dominican Republic, El Salvador, Honduras, Jamaica, Nicaragua, Paraguay, and Peru for graduation in family planning. Ukraine also met the criteria, based on its TFR and modern contraceptive prevalence level; however, after implementing an FP assessment, USAID staff determined that the country was not yet ready for graduation. Between 2009 and 2012, many of the countries identified as graduation candidates completed their graduations (the Dominican Republic, El Salvador, Jamaica, Nicaragua, and Paraguay). Two other countries USAID identified to graduate in 2015: Albania and Ukraine (see Table 1).

Before the 2003 technical note, a number of countries reached a level of development at which external support were not required, including Brazil, Colombia, Costa Rica, Ecuador, and Mexico. Although USAID had not formalized the criteria and graduation process prior to 2003, many of the FP programs that ended before this time did successfully reach the indicators in the graduation criteria and are still

[1] This number includes countries reaching development indicators prior to the development of the 2003 technical note.

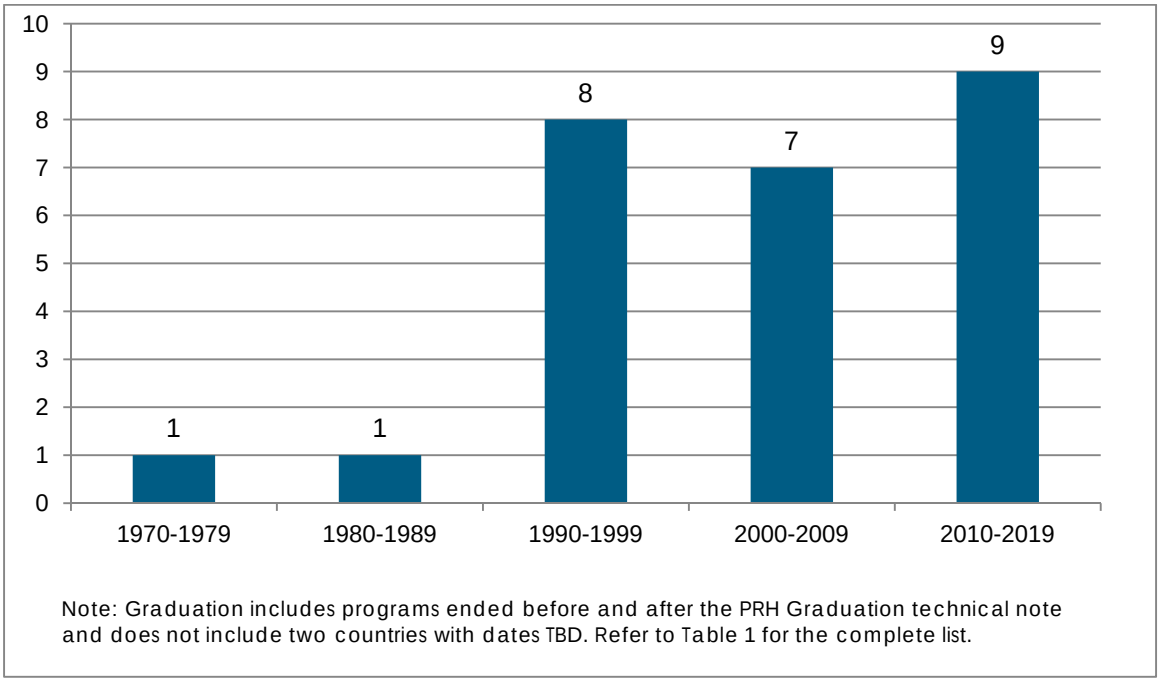
considered as having graduated. The 2003 technical note, however, marks a turning point. In this note, USAID identified countries that were ready for graduation by using a set of programmatic benchmarks. Out of the 24 graduated countries, 13 have completed an FP graduation strategy and graduated. Egypt and Ukraine have completed an FP strategy; however, they have yet to graduate. Two additional programs—Zimbabwe and Bangladesh—are on the path to graduation (see Table 1 and Figures 2 and 3)

Table 1: Family Planning Graduations by Year

	Graduations	
1	South Korea	1976
2	Panama	1988
3	Sri Lanka	1990s
4	Tunisia	1992
5	Botswana	1993
6	Thailand	1993
7	Costa Rica	1996
8	Swaziland	1996
9	Colombia	1997
10	Mexico*	1999
11	Brazil*	2000
12	Ecuador*	2001
13	Morocco*	2002
14	Turkey	2002
15	Indonesia*	2007
16	Romania	2007
17	Jamaica*	2009
18	Dominican Republic*	2010
19	South Africa	2011
20	El Salvador*	2011
21	Paraguay*	2011
22	Nicaragua*	2012
23	Honduras*	2013
24	Peru*	2013
	Current and future Graduations	
25	Albania	2015
26	Ukraine*	2015
27	Bangladesh	TBD
28	Zimbabwe	TBD

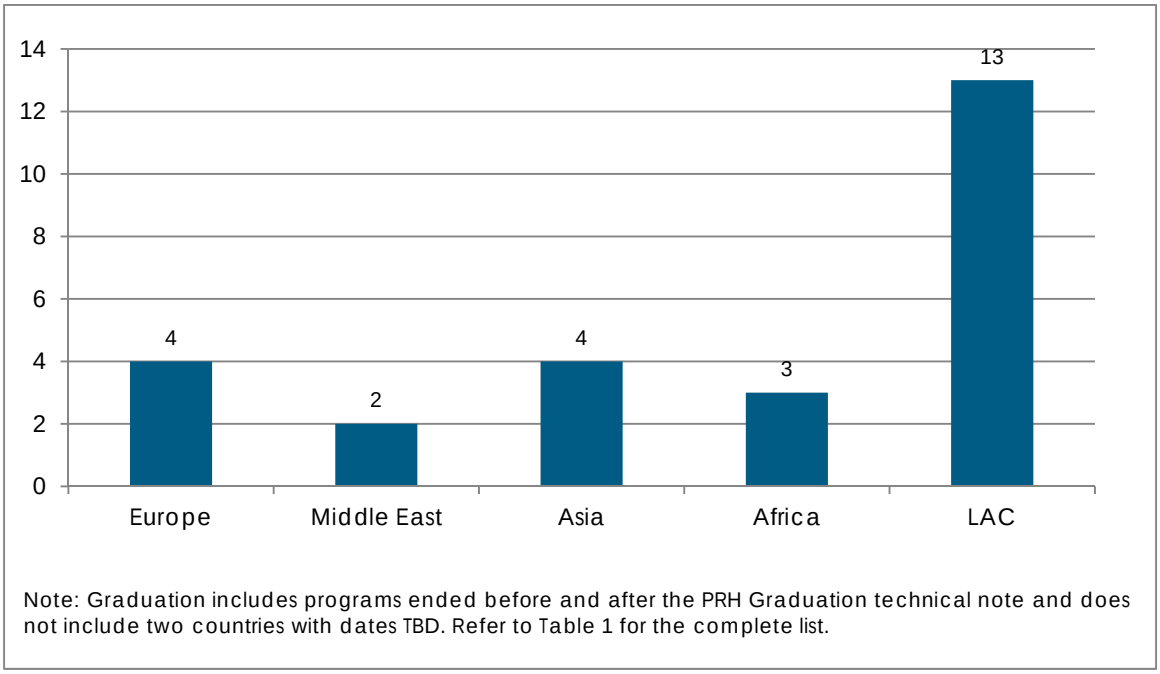
* Completed FP graduation strategy

Figure 2: Family Planning Program Graduations by Decade



Note: Graduation includes programs ended before and after the PRH Graduation technical note and does not include two countries with dates TBD. Refer to Table 1 for the complete list.

Figure 3: Family Planning Program Graduations by Region



Note: Graduation includes programs ended before and after the PRH Graduation technical note and does not include two countries with dates TBD. Refer to Table 1 for the complete list.

3. Other Transitions: Focus and Selectivity Strategies, Economic Transitions

Based on the Presidential Policy Directive on Global Development (PPD-6), USAID is implementing strategic decisions to focus and align its assistance. This process is intended to maximize operational effectiveness and produce better foreign policy and development outcomes. For some countries, this means assistance will decrease or end in areas such as maternal and child health, family planning, and tuberculosis (TB). HIV and AIDS programs through the President's Emergency Plan for AIDS Relief (PEPFAR) are subject to a similar focusing and strategic alignment process.

Focus and Selectivity: With focus and selectivity strategies, resources are being directed toward high-need countries for greater potential impact. In 2008, in response to congressional interest in establishing a more concentrated maternal and child health (MCH) strategy, GH identified 30 priority countries, plus an additional few that would continue to receive funding. In 2010,[2] these priority countries were narrowed further, to 25 priority countries. These are characterized by a high burden of under-five and maternal mortality, additionally, in these settings, USAID programs are most effectively integrate with priority programs in family planning and nutrition. With the advent of the Best Practices at Scale in the Home, Community and Facilities (BEST) planning process and the Global Health Initiative (GHI) goals, resources increasingly are targeted toward priority countries.

Economic Transitions: The nature of development assistance is rapidly changing. Development assistance for health is dwarfed by growing domestic health spending capabilities, international private flows, remittances and the like. Increasingly, health sector gains will be met not by donors but by countries themselves. The ability of donors to affect health will be realized not through traditional aid modalities but through technical collaborations, partnerships with the private sector and advocacy for increased domestic financing for health. USAID FORWARD reforms, initiated in 2010, recognize and pursue these changes in a concerted manner. Korea, India, Brazil are examples of former aid recipient countries that are now donors to other countries. Through a thoughtful process, USAID continues on the path of sustainable solutions and more aggressively than ever. The change in the global economic order makes it imperative to change the donor- aid processes.

II. FOUR KEY FACTORS FOR ACHIEVING SUSTAINABILITY OF PROGRAM GOALS ARE IDENTIFIED

The research team reviewed 13 graduation strategies to identify patterns and themes based on USAID's experiences. These documents included 11 family planning strategies and two overall health sector graduation strategies. Achieving sustainability of program goals is the underlying theme in these strategies as well as all of the graduation and phase-out documentation that could be found. Based on the review, four key pillars were identified for increasing the sustainability or self-sufficiency of health programs: (1) country-led financing, (2) policy and regulatory reform, (3) institutional strengthening, and (4) leadership and stewardship. Each of the USAID graduation strategies focused on strengthening these four pillars as donor assistance was coming to an end. Appendix 2 contains the details of the 13 strategies, with information delineated under these four pillars.

These pillars were a commonality across strategies, however, they may not represent the full array of activities that USAID supported to promote sustainability. A key feature is that sustainability is achieved more successfully when there is not an abrupt withdrawal from a program. For this reason, graduation processes are preferable to phase-out processes. It can take from a few years to 20 years to achieve sustainability of program goals. Thus, a key lesson learned for all USAID programs is that sustainability should be a key consideration at the onset of designing all projects.

1. Country-led Financing

Health sector commodity hand-over strategies were most clear and successful in contexts in which the national government provided specific line-item funding and/or there was a broad mix of nongovernmental and civil society organizations contributing to financing the commodity supply, distribution, and legal and policy frameworks over a sustained period of time. When assistance was coming to an end, USAID actively collaborated with other donors and advocated for establishing a line item in the government budget for FP commodities in many of the countries.

Missions employed a number of other strategies to promote financial sustainability. Asociación Pro-Bienestar de la Familia (PROFAMILIA) in Colombia was established as an independent business; as part of the graduation process, it received an endowment of US$6 million from USAID to serve as a financial sustainability mechanism. This is described in detail in Appendix 3. Ecuador utilized an endowment fund for the health program, and funding was linked to performance. In countries such as Egypt, Ecuador, and Morocco, civil society organizations (CSOs) provided a significant portion of commodities and services and support for social marketing activities—a key aspect of successful graduation. In the Dominican Republic, SENASA, the national health insurance fund, was established; it provides subsidized insurance for vulnerable individuals. Paraguay established a community-based health insurance scheme and a logistics management information system.

Table 2: Summary of 12 family planning and population graduation strategies and identification of key sustainability factors

Country	Financing	Policy & Regulations	Leadership and Stewardship (including M&E)	Human & Institutional Capacity
Dominican Republic-FP	x	x	x	x
Ecuador-FP	x	x	x	x
Nicaragua-FP	x	x	x	x
El Salvador-FP	x		x	x
Honduras-FP	x	x	x	x
Paraguay-FP	x	x	x	x
Jamaica-FP		x	x	x
Peru - FP	x	x	x	x
*Egypt- Pop	x	x	x	
Morocco-FP	x	x	x	x
Ukraine-FP	x	x	x	x
Mexico- FP	x	x	x	x

*Graduation strategy was developed, but graduation was not implemented.

In Peru, El Salvador, and Nicaragua, there were specific concerns about the FP graduation strategies related to uncertainties in financing (especially regarding commodities) and national-level political

commitment that could not be fully addressed within the context of the graduation. Fortunately, Nicaragua increased its funding for FP commodities and system strengthening during the period leading up to graduation.

2. Policy and Regulatory Reform

Several of the successfully implemented graduation plans—including those in the Dominican Republic, Jamaica, and Nicaragua—discussed engagement with various ministries (i.e., health, education, social security, youth, AIDS program, protection services, etc.) through the creation of national committees and working groups to ensure that comprehensive policies were in place to maintain quality and access to services. In the case of Ecuador, under the "no project assistance relationship" in 1991, USAID provided large sums for financial support in exchange for major national policy reforms, which helped to create an enabling regulatory environment. In El Salvador, USAID provided support to the Ministry of Health (MOH) to advocate for and set policies to expand funding for FP services, especially to under-served and vulnerable populations. In Nicaragua, Paraguay, and the Dominican Republic, USAID helped to initiate a contraceptive security (CS) committee, which later became an official MOH committee. In Peru, a new entity was formed within the government for providing procurement services.

There was a consistent theme that cost sharing and eventual hand-over of a program to the government, NGOs, and CSOs was a long process. At a minimum, it took three to five years for organizations to learn, adjust to, and take responsibility for the program.

USAID supported advocacy groups to help reform government policies related to the procurement of commodities in the international market, access to services, and the entry of the private sector to provide services.

Several graduation strategies also indicated specific support for institutionalizing Demographic and Health Surveys (DHS) or Reproductive Health Surveys (RHS) on a periodic basis, including ensuring local capacity and financing for continuation of these activities after graduation. Commodity S Security committees continued to be supported by an LAC Bureau Regional Health Program composed of the public sector, private sector, and NGOs; this was instrumental in improving contraceptive security. USAID took these measures in the Dominican Republic, Ecuador, El Salvador, Honduras, and Nicaragua.

For experts involved in graduating countries from USAID assistance, successful graduations arose not only from a country financing its program, but also from changes in key policies and processes that were accomplished through USAID support. This contributed to creating an enabling environment.

3. Institutional Strengthening (NGOs, government, CSOs, private sector)

Graduation strategies emphasized strengthening the human and institutional capacity to implement and manage activities, and included a variety of approaches to transfer knowledge and skills to the host country.

In Nicaragua, USAID assisted in the creation of NicaSalud, a successful federation of 28 NGOs working in the health sector, including in family planning. NicaSalud is now the recipient of grants from USAID and the Gates Foundation, as well as the principal recipient for Nicaragua's Global Fund grant. In El Salvador, ADS, an NGO providing reproductive health services achieved financial sustainability and stopped receiving funding from USAID. In 2003, it was providing 10 percent of FP services in the country through a sustainable mechanism. In the Dominican Republic, technical assistance (TA) was provided to three key NGOs: PROFAMILIA, MUDE, and ADOPLAFAM. PROFAMILIA, founded in

1966, is an International Planned Parenthood Foundation (IPPF) affiliate. With strong institutional backing from USAID, it has reached 92 percent sustainability. PROFAMILIA has been successful because it has diversified its program portfolio and its donor funding base. In 2005, PROFAMILIA reported that it provided 13,000 FP services through its clinics and distributed 342,000 oral contraceptives and 3.1 million condoms through its social marketing program.

In Honduras, to address the government's perceived reluctance to promote family planning services, USAID began supporting ASHONPLAFA (an NGO and IPPF affiliate) with financial and technical assistance early on in the program. It has been in the forefront of FP services ever since. In Ecuador, USAID provided funds to a private, nonprofit, Asociacion Pro-bienestar de la Familia Ecuatoriana (APROFE), and a social marketing program, Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF), to enable each organization to successfully provide FP services. CEMOPLAF, officially established in September 1974, began its operations as part of an agreement between USAID and the MOH and it is now a successful NGO operating in Ecuador. USAID focused financial and institutional support on APROFE and CEMOPLAF to ensure sustainability of the two major NGO providers of reproductive health and FP services in the country.

NGOs and the private sector played a key role in providing services and helping to build sustainable programs as donor support decreased.

In Indonesia, USAID has played a major role in strengthening nongovernmental and professional organizations that are channels for FP services, information, and advocacy, such as IBI (the Indonesian Midwives Association), IDI (the Indonesian Medical Association), PKMI (the Indonesian Association for Permanent Contraception), Nahdatul Ulama, Muhammadiyah, and the Coalition for a Healthy Indonesia (KuIS). These CSOs play a major role as catalysts for change and provide leadership on key issues that influence policy and quality service delivery at both the national and district levels.

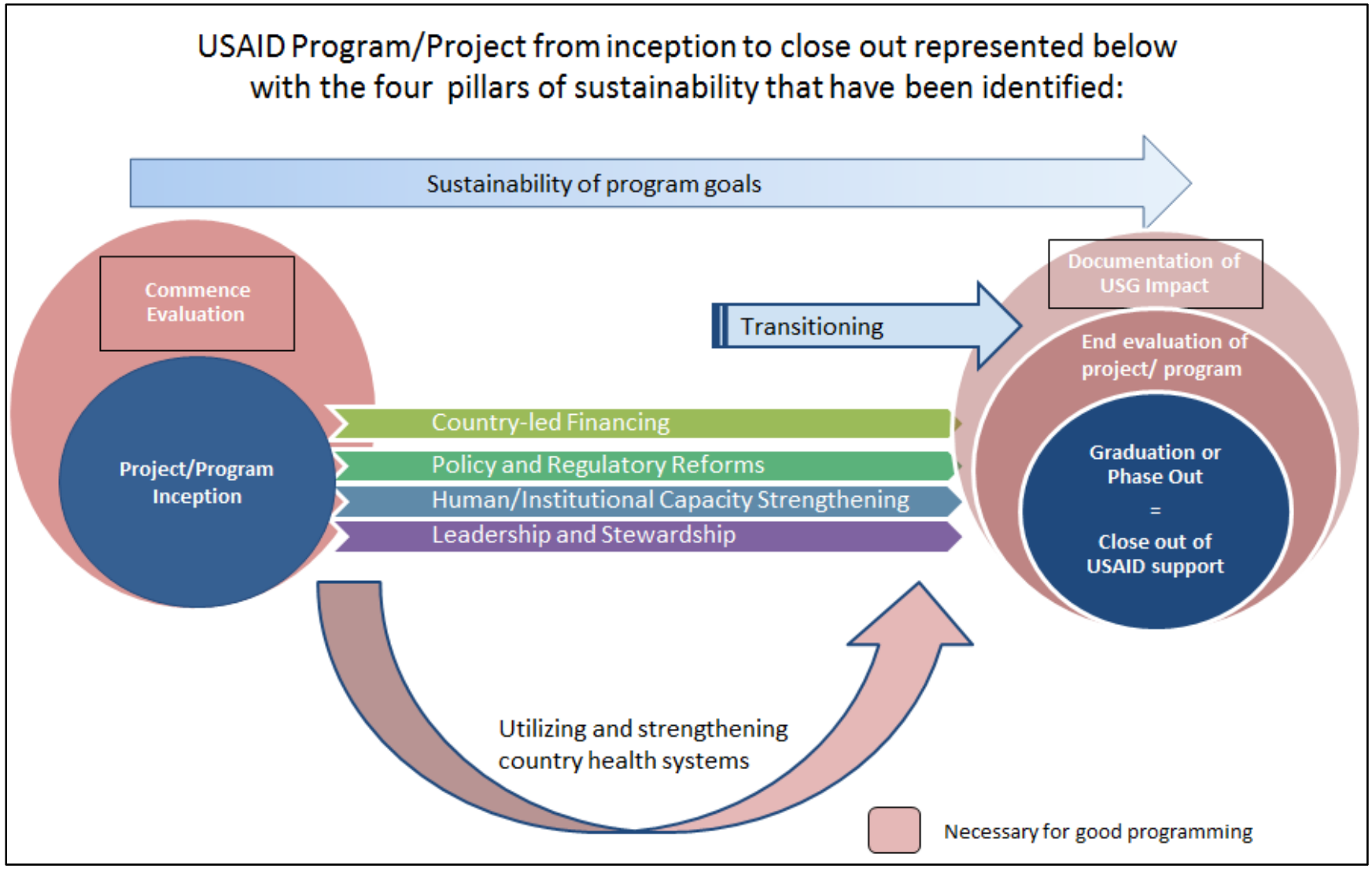
In addition to these efforts, strengthening private sector networks to reach rural or poor populations was a key focus area. In Peru, USAID set up MaxSalud in 1995 as a pilot program to see whether/how the private sector could provide high-quality basic health services to people with low incomes in a sustainable way.

4. Leadership and Stewardship

Government leadership and commitment to program sustainability was a prerequisite for all successful graduations. In Mexico, the graduation process benefited from strong support and consensus from the Mexican government and institutions. As a result of a renewed advocacy effort targeting state and national leaders following graduation and decentralization, the FP program in Mexico is a continued success. Despite the historical dependence of Paraguay on USAID, the country demonstrated a strong commitment and acceptance of responsibility for the FP program once it met the criteria for graduation. The MOH in Paraguay increased its engagement in the CS committee to establish M&E indicators for sustainability.

A particular subset of themes emerged in countries where graduations occurred in the context of broad decentralization of health and FP services, such as in Honduras, Indonesia, Paraguay, and Peru. In this context, graduation strategies tended to focus more on technical assistance to regional and district-level governance structures to increase their capacity to report on, manage, and budget for service provision. Strengthening information technology, capacity to conduct program M&E, and incorporating new curricula in schools and colleges were some of the broader health system reforms underway that supported program sustainability.

An ideal USAID Program/Project activity from inception to close-out is shown in Figure 5, with emphasis on the four sustainability pillars:


USAID Program/Project from inception to close out represented below with the four pillars of sustainability that have been identified:
Sustainability of program goals
Commence Evaluation
Project/Program Inception
Transitioning
Documentation of USG Impact
End evaluation of project/ program
Graduation or Phase Out
=
Close out of USAID support
Country-led Financing
Policy and Regulatory Reforms
Human/Institutional Capacity Strengthening
Leadership and Stewardship
Utilizing and strengthening country health systems
Necessary for good programming

III. FIVE STEPS TOWARDS IMPLEMENTING A DELIBERATE HEALTH SECTOR ELEMENT PHASE-OUT

Graduations represent an ideal in promoting sustainability in a planned manner over a number of years. Another common type of transition is the program or health sector phase-out. Given the rapidity of most phase-out processes, achieving sustainability will be challenging but, for programs facing phase-outs within three years, USAID can take steps to follow a deliberate and coordinated process. USAID's experience suggests five key steps that could help facilitate a more deliberate health sector element phase-out in a country. Each of these are applicable and key to graduation processes as well:

1. Good coordination and clear communication with all stakeholders;
2. Development of a phase-out strategy with the host country's government and partners early in the process;
3. Strengthening of existing or new collaborations for leaving a lasting USAID legacy in a country;
4. Communication and documentation of program successes over the entire period of USAID assistance in a country; and
5. Evaluation of the program or health sector element at the end of the assistance.

Below is a summary of each of these steps.[3] More detailed information, including phase-out planning tools, is available in the second paper that was written, *Five Steps Towards Implementing a Deliberate Health Sector Element Phase-out*. It can be found at: https://programnet.usaid.gov/library/five-steps-phasing-out-health-sector-elements

1. Good Coordination and Clear Communication on Close Out Plans

Coordination and communication with all stakeholders, both internal and external to USAID, is a key first step to a successful phase-out strategy and ensuring better program outcomes. It is important to articulate up front the timeline of the phase-out and the type of participation envisioned after the withdrawal of USAID funds. This includes communication with USAID staff, multilateral partners, implementing partners, the host government, beneficiaries of programs, and other stakeholders.

Communicating within the Mission will help staff agree on the priorities outlined in the phase-out strategy, facilitate internal buy-in for the change process, and pave the way for staff to transition to new employment opportunities.

USAID Washington and the Mission should share a consistent message and phase-out timeline with the government and partners. Clear communication will avoid a haphazard process. External communication will help USAID engage with other important stakeholders within the host country, explore alternative funding streams, develop a sustainability plan for the health sector element(s), and lay the groundwork for future USG-host country relationships.

[3] This material has been excerpted from the paper *Five Steps Towards Implementing a Deliberate Health Sector Element Phase-Out*, produced by USAID in March 2012.

2. Developing a Phase-out Strategy Document with the Host Country Government and Partners[4]

The phase-out strategy[5] is the first comprehensive planning document in the phase-out process. Its principal purpose is to delineate and justify the major objectives that will be pursued for the duration of the health program. Additionally, it serves as a road map to monitor country progress and the appropriateness of U.S. government (USG) assistance programs as the phase-out date approaches.

A phase-out strategy is developed in agreement with the government and partners. Phase-out strategies planned together with all stakeholders ensure improved program outcomes and encourage commitment to sustainability of the program. Phase-out strategies can clarify and define a donor's role to host countries and local partners, identify time limitations, reduce future dependency, and inform plans for the next phase of the programming.

The strategy should contain the following information:

- Introduction and overview
- Summary of health sector or health sector element performance
- Description of the phase-out strategy, including a vision for the program's sustainability, actions to be undertaken and the parties responsible, and indicators for measuring performance
- Budget and timelines, including a budget for activities relating to communication and documentation of successes, and an end evaluation of the program

Additionally, the strategy should describe the most substantial opportunities missed as a result of phasing out programs in the sector; e.g., what will not be done and what the implications are for not completing these strategic objectives.

To the extent possible the strategy should be incorporated into existing USG planning documents and cycles, such as the Global Health Initiative (GHI) strategy, Country Operational Plan (COP), Malaria Operational Plan (MOP), U.S. Department of State Mission Strategic Resource Plans (MSRPs), and USAID Country Development Strategies (CDCS). It should encompass the period from the date when a phase-out date is determined until the phase-out date itself. The plan should be prepared as soon as possible after a relatively certain decision is made to phase out a health sector element or health sector.

3. Strengthening of Existing or New Collaborations for Leaving a USAID Legacy in Country

As USAID plans to phase-out (or graduate) the health sector element or health sector in a country, the discussion on what to leave behind becomes paramount. The long-term impact USAID has on the recipient country's health sector program is also known as USAID's legacy. Moderate investments can leave an appropriate and visible legacy in a country if planned and executed carefully.

During the transition phase, efforts should be made to strengthen existing relationships or develop new collaborations with institutions such as think tanks, business development centers, nongovernmental

[4] Modified from: Gardner, Alison, Kara Greenblott, and Erika Joubert. September 2005. *What We Know About Exit Strategies: Practical Guidance for Developing Exit Strategies in the Field*. Consortium for Southern Africa Food Security Emergency (C-SAFE); USAID. Bureau for Democracy, Conflict and Humanitarian Assistance. Office of Food for Peace (FFP). Retrieved from http://pdf.usaid.gov/pdf_docs/PNADE671.pdf.

[5] Modified from: USAID, Bureau for Europe and Eurasia Operating Procedure: *Guidance for Preparation of an Exit Strategy.*

institutions, research institutions, and academic institutions. The literature suggests that strengthening relations with institutions is an important step toward establishing the USAID legacy in the country. Missions also may form bi-national commissions (with formal bilateral agreements and high-level official involvement from both nations) and bi-national foundations to promote sustainability. In USAID graduations in various sectors, Missions engaged legacy mechanisms such as endowments, trust funds, foundations, and DCAs. These collaborations served the dual function of a legacy mechanism for USAID and a new source of income for the continuation of the program(s). More information on these types of mechanisms is contained in the last section of this report.

4. Communication and Documentation of the Program Successes

As USAID plans for phase-out (or graduation) in the health sector or health sector element, the transition period serves as an opportunity to celebrate the long years of collaboration and successes achieved with the host government. It is important to document and widely disseminate the USAID support, successes, tools, and materials that the program has enjoyed over USAID's years of support to the health element or sector. There should be a plan for sharing this information with internal and external audiences through communication materials, media coverage, videos, and events. These activities should be described in the phase-out strategy, along with an associated budget.

5. Evaluation of the Program or Health Sector Element

As part of the phase-out (or graduation strategy), funding needs to be set aside to support a final evaluation of the health program. Evaluations are frequently neglected as part of program phase-outs. To be fully useful, there should also be an evaluation a few years after the phase-out has been completed. This will assist in determining whether the program or health sector element impact has been sustained, expanded, or improved after it has ended, and whether systems continue to function effectively. Funds for the post-phase-out evaluation could come from the existing health budget for evaluations or be budgeted in the part of the phase-out strategy that details monitoring of strategy benchmarks. For example, funding for technical assistance support for conducting a DHS is set aside in USAID FP-graduated countries.

IV. LESSONS LEARNED FOR TRANSITIONS IN THE HEALTH SECTOR

For those countries undergoing a graduation or phase-out of a health sector element in the immediate future, the following are a number of lessons that Missions can apply in their transition planning. The research team has distilled these lessons from review of literature on close-out of programs in all sectors.

1. There should be clear and transparent communication about the phase-out or graduation date within USAID (headquarters and Mission), and between USAID, the host government, and other stakeholders in a country. This is an essential first step toward a successful close-out of a health sector element in a country.
2. A recurring finding in past graduations or phase-out of programs is that typically there is insufficient time provided for close-out of activities. An appropriate length of time is required to negotiate and implement a graduation or phase-out agreement with the government and partners. The plan should be developed as soon as possible after a decision is made to close out a health sector element or health sector.
3. Sustained programmatic, technical, and financial commitment needs to be provided by USAID to follow through on an established graduation or phase-out plan.

4. It is useful to link the phase-out cycle or graduation to the USAID budget cycle and timelines.
5. If the entire USAID Mission is not closing, it is beneficial to communicate the close-out of the health sector or health sector element while also emphasizing continued assistance in other sectors in the country. This helps to maintain strong government relations.
6. It is useful to conduct a costing exercise for services, commodities, and/or infrastructure that need to be sustained once USAID assistance has ended.
7. A phase-out or graduation plan should be flexible enough to accommodate any unforeseen developments so that resources and approaches can be altered and adapted to meet changing needs. The plan should consider any potential interruptions. Elections, political circumstances and national disasters are examples of external conditions that can alter implementation of a plan.
8. Often overlooked in planning are institutionalizing skills for management and supervisory skills; these are important components of program sustainability.
9. In working on sustainability mechanisms for providing services, addressing the needs of base of pyramid populations is key; this often is overlooked.
10. While developing a phase-out or graduation plan, USAID staff should look at multi-sectoral collaborations within USAID and with all stakeholders. These may play an important role, as certain goals and activities of a close-out strategy could be absorbed into the work plan of another sector at a later date. For example, in past close-out's Missions have use democracy and governance support to help advance policy reforms for the health sector. The East Europe region has a wealth of experience in utilizing the democracy and governance sectors for such health policy changes.
11. Missions closing support for health sector elements should explore alternative avenues for financial and technical support e.g from diaspora groups, partnerships with local CSOs, the private sector, NGOs, and foundations in a given country. These alliances are in fact most beneficial from the start of projects and help develop sustainable programs at onset.
12. Donor coordination and collaboration is important in itself and even more important during the transition phase. USAID and other donors should plan the phase-out or graduation plan together, harmonizing their work to achieve the greatest impact.
13. A Mission may want to plan a post-graduation relationship with the host government, and funding could be kept aside for post-close-out research and collaborations. This has taken the form of evaluations (support for FP surveys), country assessments, travel grants, conference support, exchange programs, and university partnerships.
14. Diplomatic collaborations play a key role once development assistance is coming to an end. The diplomatic collaborations should be enhanced by USG as a whole in a concerted manner.
15. Funding should be set aside for a post-graduation assessment. This has been a shortcoming in most graduations to date and would offer a good learning opportunity for the USG and the global heath community at large.
16. Phase-out of health programs in general is a poor option. Graduation is the preferred option to achieve sustainability of program goals.

V. USAID Legacy Planning At Close Out of Project/ Programs

Thirty-eight of the 97 documents on USAID graduations and phase-out processes are dedicated to discussions of endowments, trust funds, foundations, investment funds, and utilization of the USAID development credit authority (DCA). These served not only as legacy mechanisms for USAID but were also utilized as financial strategies during program graduation or phase-out. Although other innovative financing schemes exist, they were not specifically referenced in the graduation literature.

The research team undertook a separate literature search to examine USAID's experience with legacy mechanisms. The authors found 73 USAID-initiated legacy mechanisms in use across multiple sectors in 37 countries between 1985 and 2007, in addition to four regional platforms. Of the total, 51 were designated as endowments and trust funds, 13 were foundations, two were grant-making funds, three were unknown, and one was a partnership. These legacy mechanisms covered all sectors, including economic growth, education, health, democracy and governance, and agricultural development. The complete listing and information on these 73 legacy mechanisms can be found in Appendix 4. The information is laid out by country, year of development, objective, lessons learned, and source of information.

1. Endowment

What are they?

An endowment, sometimes called a trust or sustainability fund, is money that has been set aside to generate income. Endowments can be "evergreen," meaning that they exist in perpetuity, and income generated from the principal investment is used to fund activities; or they can be "sinking" endowments, which allows the principal investment to be drawn down over a finite time period. Many donors, including USAID, have used endowments as a tool for sustainable development. Initially USAID could fund endowments primarily with local currency; however, in 1994, USAID Policy Directive 21, paved the way to establish and fund endowments with U.S. dollar appropriations. Note that at this time (2012), USAID is not able to fund endowments.

Mostly in the 1990's and 2000's, Missions have used USAID endowments for many purposes, including to initiate or sustain a development project, sustain an organization, leverage funds to a new donor, set up an endowment of an existing school or university, develop a new sector, and contribute to providing capacity-building grants (exit grants) to specific NGOs. Additionally, Missions may use an endowment to provide one-time grants to institutions with appropriate mandates and proven capacities as USAID attempts to conduct an orderly phase-out or graduation of a health sector in a country. The endowment can also effectively serve more than one nation through a regional platform. In countries where a tradition of private philanthropy is undeveloped, an endowment has been used to support NGOs in providing public health services.

There is a wealth of information available on the USAID experience with endowments and the advantages and disadvantages of setting them up. Most notably, the advantages are that endowments enable decision makers to sequester funds over the long term in support of specified objectives, place a relatively low administrative burden on USAID, and help make institutions financially stable. Further, the existence of an endowment, assuming it is well run, can also relieve funders of the burden of evaluating competing requests from alternative implementers or having to consider alternative program designs if additional funding for the objective is to be made available. The main disadvantages are that an endowment requires familiarity with host country laws and regulations, delays the full impact of the funds, and involves a risk of failure to meet USAID's objectives arising from lack of control over implementation and potential political interference.

In analyzing 25 endowments in 2002, Javaid, et al. concluded that endowments are a powerful funding mechanism, allowing an institution to build and plan for the future.

Endowments in the health sector, 1985–2007

In the health sector, USAID has funded seven endowments–two of them before Policy Directive 21. The other five were formed after the directive was enacted in 1994. These seven endowments are the following:

1. International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B)
2. Asociación Protección a la Salud (PROSALUD)
3. Asociación Pro-Bienestar de la Familia (PROFAMILIA)
4. Ghana Social Marketing Foundation (GSMF)
5. CARE Reproductive Health Trust Fund (CARE-RHTF)
6. International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR)
7. Family Life Association of Swaziland (FLAS).

CARE and IPPF/Western Hemisphere are global endowments; the remaining five are country specific. Five of the endowments (PROFAMILIA, PROSALUD, IPPF/WHR, FLAS, and CARE-RHTF) specialize in family planning, and three of these are based in the LAC region. PROFAMILIA is well known for its role in the graduation strategy and sustainability of the FP program in Colombia.

Of the seven endowments USAID has funded, six have experienced success and have helped to build sustainable institutions. Key ingredients to these successes appear to be long, sustained partnerships with USAID and other capacity-building organizations—partnerships that have stretched over decades. The movement to endowment rather than direct support occurred as the result of careful planning. Many endowments were not fully implemented until there had been several years of planning and creation of benchmarks and all of the endowments came with specific stipulations on how the money was to be tended and spent. All of the successfully endowed organizations were also able to generate donor support from organizations outside of USAID before their endowments were instituted. In the case of the lone failure, the Ghana Social Marketing Foundation, many of the ingredients for success were neglected. Five of the endowments received evergreen endowments, while the remaining two were sinking trust funds.

A brief description of the founding, development, and endowment of each of the seven health sector endowments is presented in Appendix 4. There are also other legacy mechanisms described in detail in the appendix.

2. Innovative financing mechanisms

USAID's DCA was referenced multiple times in the graduation literature. USAID ties the provision of DCA guarantees to its foreign assistance objectives and provides technical assistance at the enterprise, financial institution, and regulatory levels to complement the guarantee. USAID has utilized this tool since 1999, and the literature indicates that it can also be a useful transition mechanism, with the potential to leverage considerable resources at a small budgetary cost during the transition period. It is a good example of a public- private partnership. The recipient of a DCA loan need not be a central government; it could be a municipal government or even a private entity, provided the entity can be rated as to financial risk.

USAID has utilized DCAs in a wide variety of sectors since 1999. At the end of 2011, the USAID DCA portfolio spanned 267 guarantees in 64 countries. Between 1999 and 2011, six countries had utilized a

DCA in the health sector: Kenya, Nigeria, Nicaragua, Ethiopia, Georgia, and the Philippines. A DCA takes an average of six months to set up in the health sector, and there is evidence of it being used in a graduation strategy in middle-income countries. Georgia is the only country currently utilizing a DCA in its graduation strategy in the health sector. The Georgian DCA will remain in effect for five years after USAID health sector funding has ended. More detailed information on the six USAID DCA's in the health sectors (1999–2011) is provided in Appendix 5.

There are many other innovative financing mechanisms and there is much opportunity for health programs to explore and tap into these, to achieve sustainable development. The USAID DCA is one mechanism that was referenced in the literature and is thus mentioned here.

VII. CONCLUSIONS AND RECOMMENDATIONS

Achieving sustainability of program goals and self-sufficiency is the goal of both graduation and phase-out processes. Through the review, it is evident that sustainability or self-sufficiency rests on country-owned and country-managed processes. To achieve this, four key areas or pillars of sustainability are identified: country-led financing, policy and regulatory reform, institutional strengthening, and leadership and stewardship.

These four pillars of sustainability are part of health system reform in a country and may take years, and possibly decades, to achieve. While programs tend to focus on them during the transition years towards a graduation or a phase-out, a sustainability analysis should be built at the project or program design stage. Health systems are built up incrementally over decades and require sustained commitments from all stakeholders. It is not necessary for USAID or one partner to be engaged in all aspects of health systems strengthening; rather, development partners should coordinate and harmonize their plans with the national plans.

USAID policies and technical guidelines emphasize various factors that constitute good programming. Two important factors early in the program and project design phase are ensuring sustainability and phase-out planning. In addition, for every new project or program developed with USAID assistance, there should be a clear understanding with the host government and partners about when and under what circumstances assistance will end.

Tapping local capital and partnering in a new ways to unleash sustainable financing are key strategies and should be explored at the project inception stage. The literature provides substantial detail on USAID partnerships with local endowments, trust funds, local foundations, investment funds, impact investors or utilization of the USAID DCA. There are other innovative financing mechanisms available to global health programs today and these could be explored further.

In policy and regulation, USAID's experience with health sector graduations suggests that creating an enabling environment could yield long-term gains in program sustainability. An FP program can be considered as having achieved a successful graduation despite a lack of sustainable financing if advances have been made to create an enabling environment.

Handover of USAID-managed activities and services to local NGOs, CSOs, and government becomes key during the close out stage. For this exercise to be successful, Missions need to target candidates for assuming these responsibilities during the transition phase and invest in institutional strengthening, as appropriate. Based on joint analysis by USAID and the host country government, the close out plan should focus strategically on what is essential to maintain services and strengthen the respective systems. Investments in human and institutional capacity foster program sustainability, helping to cultivate the

skills for dealing with current and new situations. Last, strengthening management and stewardship of the host government is a prerequisite for long- term sustainability of any program.

Another important finding is the need for a rational planning process to phase-out selected programs as USAID efforts focus on priority countries. The history of USAID FP graduations offers a model process for other health sector elements to follow. In 2003, the USAID FP team developed a technical note detailing graduation thresholds for FP programs. Next, through a consultative process with Missions, headquarter staff, and the host government, countries were assessed and identified for graduation over an appropriate length of time to evaluate their readiness and ability to sustain the program once USAID assistance came to an end. USAID might usefully develop program thresholds for all health sector elements and implement periodic exercises to identify countries ready for graduation. This process should be transparent, communicated to all stakeholders, and consistent with the economic growth of the country.

While a phase-out of a health sector element can occur due to budgetary or political considerations, any negative impact on the country program should be reduced by careful and deliberate planning of phase-out activities. There is little documented experience on how to conduct a successful rapid phase-out; however, there are some key steps and lessons for developing and implementing this type of strategy. More detail may be found in the paper *Five Steps Towards Implementing a Deliberate Health Sector Element Phase-out.*

As USAID plans to phase-out a health sector element, the decision about what USAID will leave behind in a given country becomes paramount. The long-term impact USAID has on the recipient country's health sector program is known as USAID's legacy in the country. Moderate investments can leave appropriate and visible legacies in a country if they are planned and executed carefully.

As Missions implement transition activities, they often strengthen existing relationships with institutions that may have developed through decades of USAID support. These include, but are not limited to, think tanks, business development centers, nongovernmental institutions, research institutions, and academic institutions. Relationship building with these types of entities is an important step toward establishing USAID's legacy in a country. Other avenues for building a legacy include the formation of bi-national commissions (with a formal bilateral agreement and high levels of official involvement from both nations) and bi-national foundations. It is useful for all Missions to have a definitive statement on the legacy USAID plans to leave behind.

Regarding institutional recommendations, there are some clear messages: celebrate success, make it visible to the American people, and dream of bold end games, including ending preventable child and maternal deaths, and creating an AIDS-free generation.

> ***The true sign of success is not whether we are a source of aid that helps people scrape by- it is whether we are partners in building the capacity for transformational change.***
>
> ***President Barack Obama, 2009, Accra, Ghana***

VIII. AREAS for FURTHER RESEARCH

It would be useful to have additional research and documentation on the following four topics:

1. Review the country programs in which USAID has graduated health sector elements to learn the status of programs and perspectives of the host country stakeholders.
2. Review graduated programs to see if there is graduation to sustainable domestic management of programs and any distinction between operations sustained by government versus nongovernment entities.
3. Develop further research and policy guidance on innovative financing mechanisms within the health sector. Should the USG develop more of these? Should USAID again be allowed to establish endowments? Are endowments mainly successful in FP programs?
4. Document health sector element phase-out processes underway.

APPENDIX 1: APPROACH TO GRADUATION OF USAID FAMILY PLANNING ASSISTANCE

Summary of the USAID GH/PRH technical note.

Criteria for imminent graduation from USAID population assistance
A country's FP program will be considered a candidate for graduation within a two- to five-year time period when the following apply:

- TFR is less than 3.0
- Modern-method contraceptive prevalence is greater than 55 percent of married women of reproductive ages (MWRA)
- At least 80 percent of the population can access at least three FP methods within a reasonable distance (may be farther than 5 km. for long-term and permanent methods)
- No more than 20 percent of FP products, services, and programs offered in the public and private sectors are subsidized by USAID
- Major service providers (public sector, NGO, and private commercial sector) meet and maintain standards of informed choice and quality of care

Achievement of the first two indicators (measurable through surveys) will generally trigger an assessment of the other key aspects of a country's FP program. Using survey and service delivery data, supplemented with more extensive analysis if needed, USAID should determine the country's status relative to the other three indicators. If the program meets all or most (four out of five) of the criteria above at the country level, it should proceed on an expedited graduation process over a two- to five-year period.

Extenuating circumstances—such as low gross national income (GNI) per capita and/or populations of more than 80 million with a large proportion under 15 years of age, which would make it difficult to address unmet need or other important concerns—should be taken into consideration to assess whether a longer graduation period is needed. Please note that only the modern contraceptive prevalence rate (MCPR) criteria will be applied to countries in the Europe and Eurasia region, due to the differing circumstances and rationale for FP programs.

As noted above, the decision to graduate a USAID country FP program requires a phase-out plan that supports a process to reinforce the commitment to and existence of adequate financing, sustainable skills and leadership, and attention to under-served populations.

Criteria for near-term graduation from USAID population assistance
A country's FP program will be considered a candidate for graduation within a three- to six-year time period when the following apply:

- TFR is 3.0–3.4
- Modern-method contraceptive prevalence is 48–55 percent of MWRA
- At least 70 percent of the population can access at least three FP methods within a reasonable distance (may be farther than 5 km. for long-term and permanent methods)

- No more than 30 percent of FP products, services, and programs offered in the public and private sectors are subsidized by USAID
- Major service providers (public sector, NGOs, and private commercial sector) generally meet standards of quality of care and informed choice

Achievement of the first two indicators (measurable through surveys) will generally trigger an assessment of the other key aspects of a country's FP program. Using survey and service delivery data, supplemented with more extensive analysis if appropriate, USAID should determine the country's status relative to the other three indicators. If the program meets all or most (four out of five) of the criteria above at the country level, it should begin planning for a three- to six-year phase-out.

As noted above, the decision to graduate a country FP program requires a phase-out plan that supports a process to reinforce the commitment to and existence of adequate financing, sustainable skills and leadership, and attention to under-served populations.

The phase-out plan should pay attention to meeting unmet need among significant marginalized groups or geographic areas that are under-served, i.e., where more than 25 percent of couples or MWRA do not have access to an FP site within five km. of their homes, or encounter financial or cultural barriers that significantly impede access even if services are physically nearby. In these instances, USAID may plan to phase out most of its assistance but retain support for delivery of technical assistance and/or services to the under-served areas or population groups and other key components that need strengthening. The phase-out plan and graduation process would normally cover a three- to six-year period, which could be extended up to 10 years under extenuating circumstances.

For the Europe and Eurasia region, the only indicators that will apply will be the MCPR, due to the unique circumstances as explained in the technical note.

Criteria for medium- to long-term graduation from USAID population assistance
This category includes all other USAID country FP-funded programs that do not meet the criteria for imminent or near-term graduation.

Programs that have MCPRs below 15 percent generally should be focusing program efforts on creating and sustaining essential services and communication, including developing basic capacity, implementing a supportive policy agenda, and strengthening NGO services. Programs that have MCPRs above 15 percent but less than 30 percent should be addressing improvement of access and quality through securing the commodity supply; and developing staff's technical, administrative, and managerial skills while instituting FP and RH programming through multiple channels. Attention should also be given to improving data and their use and strengthening communication.

As countries start to approach 30–50 percent of MCPRs and thus near-term graduation, plans should be put into place to address CS within the public and private sectors. Programs should be working on the areas outlined in the attached population life-cycle framework while preparing for the issues that will need to be addressed for near-term graduation. The activities that need to be prioritized in each country are very much dependent upon the program characteristics and specific needs identified through assessments and evaluations.

Transition and Phase-out Plan Process
The GH/PRH Office will work with the USAID Health Sector Council to identify which countries meet the first two criteria (TFR and MCPR) for imminent and near-term graduation. Once a country has been identified in one of these categories, a joint team (comprising members from the USAID Mission and USAID/Washington, including representation from GH/PRH and health staff from the appropriate

regional bureau) will work with the Mission to determine whether data exist for the other criteria and plan how to gather these data if they do not. The team will work with the Mission in a collaborative process to develop a transition and phase-out plan specific to the country context and needs. At that time, extenuating issues within the country or program (e.g., low GDI per capita or large population) will be taken into account in determining the appropriate timeframe for phase-out. Each year GH/PRH Office will work with the Sector Council to revisit this exercise using updated DHS and RHS data to see where specific countries fall with respect to the first two criteria for imminent and near-term graduation. Each country will have its own specific transition plan and plans for inclusion in selected post-graduation activities, including monitoring of key indicators.

APPENDIX 2: USAID EXPERIENCE IN GRADUATIONS: KEY SUSTAINABILITY PILLARS

Jamaica, Family Planning, Graduation Year: 2009

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• For the new strategy period FY2005–2009, and with an anticipated overall population funding level of roughly US$12.4 million, the Mission revised its health strategy under the new Strategic Objective 11: "Improved Health Status among Youth and Vulnerable Targeted Groups." • A combination of population and other health funding was used by USAID/Jamaica-funded JA-Style. For FY2007, HIV/AIDS funds were added to the project to address the issue of HIV/AIDS and youth. • **Other Donors:** *European Union* – Through the UNFPA, provided three years of support to the National Family Planning Board (NFPB's) peer counseling and education program scale-up. *The Global Fund for AIDS, Tuberculosis and Malaria* – Awarded 2004 (ended 2008) to scale up HIV/AIDS treatment, prevention, and policy efforts in Jamaica. *IDB* – supported a health sector reform project that aimed to improve the efficiency, equity,	• In 2004, the MOH's Health Promotion and Protection Division developed and subsequently launched a National Strategic Plan for the Promotion of Healthy Lifestyles in Jamaica. • TFGI/POLICY II supported the MOH Strategic Framework for Reproductive Health (strategic planning at regional and parish levels), conducted a Policy Environment Survey (PES) and supported a multisectoral approach to adolescent policy development through the National Center for Youth Development (NCYD). *UNFPA* – In Jamaica, UNFPA supports the Planning Institute of Jamaica (PIOJ) with policy formulation, human capital planning, and support for the 2010 Jamaican census. UNFPA supports the National AIDS program with reproductive health as a key component of prevention, including universal access to care, support, and treatment. *UNAIDS* – established its office in 2005 in Kingston. UNAIDS supports advocacy	• In 2001, USAID provided a substantial amount of support to the NFPB to conduct and complete the RHS. Through the Global Health Cooperative Agreement mechanism with the Centers for Disease Control and Prevention (CDC), TA was provided for data collection and analysis. • JA-Style has developed a Project Management Information System (PMIS) to help track and record the various interventions and activities. • In 2001, USAID provided a substantial amount of support to the NFPB to conduct and complete the RHS. The RHS, conducted every five years, is the main source of data for Jamaica's reproductive health statistics. • AED/Change conducted a study of youth resiliency and assets. • Deloitte Touche Tohmatsu/Commercial Market Strategies conducted an adolescent condom survey and improved condom access	• For FY07, the project will reduce the number of activities and focus on sustainability of activities. In addition, activities will focus in targeted geographic areas and communities. There will also be a greater attention paid to strengthening the capacity of organizations and transferring knowledge and skills quickly to the relevant ministries and NGOs to implement adolescent reproductive health and HIV/AIDS activities. This includes strengthening the capacity of partner organizations to conduct surveys and implement M&E systems. • AED/LEARN Link Project provided MOH management information systems strengthening. • FHI/Contraceptive Technology Research carried out parent education and trained Ministry of Education (MOE) school guidance counselors utilizing ASHE, developed a client appointment system, and improved counseling for contraceptive users. • JHPIEGO Corporation/Training in Reproductive Health III – Under subcontract to TFGI, conducted pre-service training for nursing schools and the Nursing Council of Jamaica. • Margaret Sanger Center International (MSCI) – Under subcontract to TFGI,

and quality of healthcare services and the financial sustainability of the sector and supported a health capital project that strengthened health sector policy and programs; expanded health system planning, managerial, and maintenance capabilities; and improved the quality and availability of secondary and tertiary care services and their efficient articulation with the primary healthcare network.	programming for disabled populations and M&E policy and prevention through TA to the National HIV/AIDS program of the MOH.	through the commercial sector. • Family Health International (FHI)/Contraceptive Technology Research completed on a Behavioral Surveillance Survey (BSS).	delivered in-service training to providers. *JICA* – promoted the South-South cooperation in Jamaica to solve regional problems in disaster prevention, infectious diseases control, environmental conservation, and utilization of marine resources. *UNICEF* – UNICEF entered a five-year planning cycle working around three foci: improving the enabling environment, supporting policy implementation, and institutionalizing capacity in high-impact targeted areas (including adolescent groups, the poor, and commercial sex workers). This included work on legislation for optimal sexual reproductive health.

Graduation Strategy

Policy

- Align the Adolescent Reproductive Health Program (JA-Style) with the MOH's Healthy Lifestyles Strategy.
- Continue to work in a multisectoral approach through the MOE, the National Security Council, the National AIDS Program, the NFPB and the Department of Protection and Prevention within the MOH, the National Youth Council, and the Prime Minister's Office to build upon existing resources and synergies that support the youth resiliency model.
- Consider the possibility of reinvigorating and updating advocacy tools developed under the Youth.now program.

Financing

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M&E

- Provide NFPB with additional training and support to fill technical gaps in reproductive health/family planning (FP/RH) M&E to ensure that future M&E needs can be addressed effectively.
- CDC has worked to build the capacity of a local counterpart to analyze the RHS data and can provide further support while tapping into other local institutionalized M&E expertise.

Human/Institutional Capacity Development

- Continue to bolster partnerships with existing community-based organizations (CBOs), such as police clubs, youth organizations, faith-based organizations (FBOs), YMCA, Girl's and Boy's Clubs, and Girl Guides and Cadets. This collaboration will ensure institutionalization of the resiliency approach in local organizations as well as sustainability.

El Salvador, Family Planning, Graduation Year: 2011

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Human and Institutional Strengthening**
• USAID support has raised the awareness, commitment, and Government of El Salvador (GOES) funding for the purchase of the country's own contraceptives needs. • The GOES has allocated funds to procure contraceptives since 2003 and is committed to continue allocating funds in the near future. Note: GOES funds for contraceptive procurement must be secured each year. • USAID-donated contraceptives comprised more than 50% of the contraceptives used in the MOH. The MOH started to procure a significant portion of its contraceptive needs in 2003, using treasury funds. • USAID provided gap funds to the Women's Comprehensive Health Unit (GAIM in Spanish), in 2006, (when the National Treasury could not cover total funding needs), to procure nearly 80% of the country's total contraceptive needs.	• FHI has worked with a national committee, having public and private sector members, to design and develop standardized national norms in family planning. • PRIME assisted the development of FP norms in collaboration with FHI and provided training on implementing the norms to different types of providers (including midwives and promoters).	• CDC has assisted in the development of the DHS in conjunction with ADS, the local contractor and IPPF affiliate. DHS surveys have been carried out in El Salvador since 1972.	• ADS provides the following sustainable reproductive health services: increased availability of contraceptives in pharmacies through social marketing; increased coverage of their nine clinics, which offer FP/RH counseling and services; a comprehensive program to reach adolescents in the formal education system with FP/RH prevention messages, and pregnant adolescents with guidance and messages regarding safe motherhood, family planning, and newborn care. According to FESAL (2003), ADS provides 10% of FP services in El Salvador. • Abt Associates, through USAID support, has provided assistance to strengthen managerial and administrative systems, such as personnel, logistics, procurement, and maintenance, to improve provision of services as well as ensure the efficient use of increased resources assigned to the MOH.
Graduation Strategy			
Financing			
• Establishing a protected budget line item for the procurement of contraceptives. • Establishing a budget for the support and management of the systems, e.g., information, monitoring and supervision, and distribution, needed to institutionalize the logistics system and its processes. • Ongoing TA and support to the CS Committee in general, and to the MOH in particular, in using existing data and tools (PipeLine, Spectrum) in advocacy			

efforts, and ensuring adequate funding for procurement of contraceptives and support to the operation and management of the logistics system.

- Continuing support to procure contraceptives through the most viable, cost-effective mechanism available in country.
- Defining the roles, market niche, and responsibilities of the various public and private institutions that provide FP services so as to target their efforts and, in coordination with donors, avoid duplication of efforts.
- Establish an adequate budget for systems support and management.
- Establish a specific budgetary line item for FP commodities and supplies.

Policy

- Assisting the MOH to advocate for and set policies to support the expansion of FP services, especially to under-served, vulnerable populations.
- Coordination with other institutions providing FP services, e.g., Social Security and ADS, to achieve a more effective joint planning system.

M&E, HSS

- Involve the Regions and Districts (SIBASI) in the CS process, especially in forecasting, logistics, and training of services providers.
- TA to the procurement/logistics function, to increase transparency in the acquisition process for contraceptives and supplies.
- Support and TA to enable the GOES to identify funding for future health surveys once the USG support decreases.
- TA to establish an information system under the new regional structure, and integration of all current information systems into a single system.

Human/Institutional Capacity Development

- TA to incorporate family planning into the university medical school curriculum to allow for improved provision of services.
- Due in large measure to USAID support to FP services in the private sector, local contractor, and IPPF affiliate, ADS has achieved financial independence, allowing this excellent NGO to provide sustainable RH services (targeting especially rural women and adolescents). When ADS became legally established, it became a member of IPPF and started receiving financial support from the USG through USAID/El Salvador (circa 1966). The USG support ended in September 2005, once the ADS reached a level of sustainability to ensure its continuity.

Nicaragua, Family Planning, Graduation Year: 2012

Sustainability			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Strengthening Nongovernmental Organizations**
• USAID has provided approximately US$139 million (not including USAID/Washington or P.L. 480 Development Assistance Program investments in Nicaragua) since 1991; roughly one-third of these funds was designated for FP/RH programs. In the latest 2003–2008 SOAG (it was established that "although USAID will continue to support procurement of public sector contraceptives, the aim is to do so at diminishing levels through the strategy period." The Letter of Implementation (LoI) Number 4 (1/09/07) confirmed and recorded the joint understanding of the Government of Nicaragua (GON) and USAID of gradually reducing USAID contraceptive donation to the public sector starting in 2007. This LoI has been implemented effectively through the DAIA Committee, and the GON is working to gradually assume full responsibility for the MOH contraceptive needs.	• In 2001, USAID initiated a CS Committee (DAIA) to guarantee the security and continued availability of contraceptives, including after USAID FP graduation; this is now an official MOH committee, with participation of the United Nations Population Fund (UNFPA), USAID projects (Deliver, Health Care Improvement/HCI, Famisalud), PROFAMILIA, PASMO, and the Nicaraguan Social Security Institute (INSS).	• USAID supported the completion and dissemination of the RHS for 2006/7 (ENDESA), implemented by CDC with assistance from the PRONICASS project, in the dissemination of results to policymakers at the central and local levels, as well as NGOs, the press, and universities.	• USAID has had a significant presence in private sector FP/RH services by expanding and improving the quality of FP/RH services provided by the major NGO working in this area and the local IPPF affiliate, PROFAMILIA. USAID also helped PROFAMILIA introduce a network of community-based services and social marketing of injectable contraceptives and condoms to increase its market share of FP commodities. • Following Hurricane Mitch, USAID assisted in the creation of NicaSalud, a successful federation of 28 NGOs working in the health sector in Nicaragua, including family planning. NicaSalud is now the recipient of grants from USAID and the Gates Foundation, as well as the principal recipient for Nicaragua's Global Fund grant. At the systemic level, the Nicaragua Social Sector Reform project (PRONICASS),Implemented by the Leadership, Management, and Sustainability project of Management Sciences for Health, Inc., works with key public entities at the central and municipal levels, as well as NGOs, to help define institutional improvements in administrative and financial

			systems. PRONICASS has also provided TA to Nicaragua's IPPF affiliate, PROFAMILIA, to become financially sustainable in its maternal and child healthcare program, which includes family planning. Further, PRONICASS has assisted NicaSalud in the development of its administrative systems so that the local NGO could qualify for direct USAID assistance.

Graduation Strategy

Policy

- Support and advocate for policies to allow contraceptives procurement on the international market when national markets cannot provide quality contraceptives at a reasonable price.
- Support the MOH's use of the agreement to use UNFPA as an international procurement agent.
- Support advocacy for increased resources for contraceptive procurement; advocacy should be directed toward the MOH, the Ministry of Finance (MOF), the Secretary for Planning, and Congress, and could be conducted by the CS Committee, CSOs, UNFPA, and USAID itself.
- Continue strengthening DAIA—especially skills related to leadership, advocacy, forecasting, and logistics monitoring—while decreasing dependence on USAID for the administrative and technical lead. DAIA will include a representative from CANSALUD or other IPSS groups to help the IPSSs find affordable ways to purchase commodities for FP service provision.
- Work with the MOH to explore the way to best target the poor, uneducated, and inaccessible populations, who have some of the lowest rates of contraceptive use. The MOH's MAIS (Integrated Health Care Model) project has the potential to target the poor with services, including family planning. Focus work with the MOH on implementation of the management systems needed for the MAIS activity.
- Ensure that FP standards and guidelines have been developed, tested, adopted and are being disseminated through multiple channels in an effort to achieve their broadest possible use and application.
- Advocacy with GON to include line items for funding the RH survey as part of M&E activities written into newly negotiated health sector loans.

Financing

- Monitor MOH resource availability and procurements. If the MOH does not have sufficient resources to fully support contraceptive needs in 2010, agree to a new LoI or reserve funds for emergency contraceptive donations.
- Provide technical support for joint purchasing of medicines, including contraceptives, between MOH and emergency medical physicians (EMPs), and possibly other governmental or nongovernmental agencies. The USAID LAC Regional Initiative will continue to examine opportunities for regional cooperation in procurement.
- Advocacy with other multilateral donors (UNFPA, UNICEF, PAHO, World Bank, and the Inter-American Development Bank) that have contributed funding to

the implementation of the ENDESA/RHS previously to plan for future funding at a more significant level than in the past.

- Encourage PASMO to supply socially marketed FP methods to IPSSs and the Nicaraguan Social Security Institute (INSS) and to introduce these mid-priced products. This will help further segment the market and reduce the burden on the MOH of supplying all methods to all income quintiles.

HSS

- Improve coordination among MOH divisions with roles in contraceptive procurement and logistics [Family Planning Program, National Directorate of Medical Supplies (DNIM), Division of Financial Administration (DAF), Planning Division (DP), Acquisitions Unit (UA), and the Health Commodities Center (CIPS)] to ensure effective contraceptive procurement mechanisms.
- Support roll-out of SIGLIM to two to three new departments per year, coordinating support with UNFPA's Global Programme and a Dutch-funded project. Build capacity of the MOH to prepare materials, conduct training, and introduce systems necessary for the SIGLIM.
- Work with the IPSSs contracted by the social security health system to ensure that they provide FP services to the insured and their spouses, in accordance with the service package supposed to be provided within the INSS health package of coverage.
- Work to ensure that select public sector service delivery points in the poorest and most under-served departments and municipalities have FP norms, are familiar with them, and are following them.
- Ensure that IPSSs FP norms are distributed and used. This work will be done with both the IPSSs and MINSA providers through a number of innovative activities that may include master trainers, centers of excellence, certification programs, etc.
- Identify Centers of Excellence that can serve as training centers for a range of procedures, including postpartum and post-obstetric event procedures for sterilization and IUD insertion, as well as interval sterilizations and insertions.
- Select pre-service training in key medical schools and nursing schools will also be undertaken to ensure that new cadres of providers learn all FP methods, including IUD insertion and sterilization procedures, along with counseling and informed choice. The Asociación Nicaragüense de Ginecobstetricia and/or the Nicaraguan Nursing Association may be called upon to assist with the training, as they are experts in these procedures.

Human/Institutional Capacity Development

- Explore possibilities of working through NicaSalud to consolidate advocacy activities among NGOs relating to FP/RH issues.

Lessons Learned/Key Considerations for Graduation

- As the Nicaraguan program matured over the years, USAID assistance also evolved to address the changing nature and requirements of partners involved in the delivery of FP services. For example, USAID has begun the phase-out of contraceptive supplies to the country program; USAID also no longer provides support for operational costs, infrastructure improvements, salaries, or other budgetary support (with the exception of some very modest training costs).
- TA has been designed to strengthen FP service delivery through developing improved standards of quality, strengthened management systems and enhanced delivery mechanisms, and improved CS. This assistance is valuable to—and highly valued by—our Nicaraguan partners. However, its nature evokes the profile of a program poised for an orderly completion and a transition to a different kind of U.S.-Nicaragua relationship.

Peru, Family Planning, Graduation Year: 2013 (*planned graduation year was: 2010)*

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• MOH started to purchase contraceptives in 1999, following three years of intermittent procurement. In 2005, the MOH budgeted a total of US$4.7 million for contraceptives for the year 2006. • USAID provided the MOH with contraceptive donations through 2003. The MOH is currently purchasing contraceptives under two mechanisms: direct procurement from commercial distributors, and through a procurement agreement with UNFPA. Until December 2005, the contraceptives purchased by UNFPA were stored in the USAID-supported PRISMA warehouse and distributed using USAID funds. Since January 2006, the distribution has been done with MOH resources. • USAID has worked with implementing partners to try to increase the availability of affordable contraceptives to attract those able to pay into the commercial market. In part because of those efforts, this situation has improved somewhat from 2000, when 79% of contraceptive users were	• In 1995, the Congress modified the National Population Law to legalize surgical sterilization as an FP method, making this service available for the first time to many women who wished to limit family size. In the same year, the MOH also began offering FP services free of charge. USAID/Peru opposed all approaches to FP promotion that were not wholly voluntary and based on providing accurate and understandable information to patients. In February 1998, the MOH instituted safeguards to ensure that women would be able to make free and informed choices. • USAID's support through the PHRplus project and its sequel PRAES (both implemented by Abt Associates), has played a key role in launching decentralization in the health sector. PHRplus developed a detailed map of functions to be devolved in the health sector and identified competencies and training required at the receiving levels. Its designs have been validated in four regions, and are being used as a model in the other 20	• Earliest (1964) USAID FP assistance to Peru began with support for demographic studies carried out by the Center for Population and Development (a Peruvian NGO).	• PRISMA provides TA and training on logistics services to public and private sector agencies without USAID/Peru support, and APROPO continues providing social marketing services. With the broad experience gained by PRISMA on contraceptive logistics, USAID began supporting that organization again in 2010 to provide training at the LAC regional level on management and logistics of contraceptives and medicines, both of which contribute to CS. • USAID provides support for improving SISMED, the MOH logistics system. The system is being rolled out now to the more than 6,000 MOH facilities across the country to improve management and delivery of contraceptives and other drugs. • USAID supported development of an integrated administrative and procurement system called SIGA, which allows regional purchase of drugs and contraceptives in the seven focus regions, with PRISMA's

obtaining modern contraceptives from the public sector and only 19.5% from the private sector. • Between 2005 and 2010, the major USAID/Peru population-funded bilateral instruments have been Improved Health for High Risk Populations, ReproSalud, and Coverage with Quality. The major population-funded unilateral instruments have been MaxSalud, Health Sector Reform, Health Policy Reform and, currently, Health Policy, Quality Healthcare, and Healthy Communities and Municipalities.	regions. • In December 2009, the MOH created the Strategic Resources Procurement Directorate (DARES), a new entity that will assume responsibility for purchasing and distributing medications and supplies (including contraceptives). The old directorate (DIGEMID) was widely viewed as ineffective, but DARES is not yet functioning, as it has no staff. • 2002–2012 Health Policy Guidelines laid the foundation for a National Decentralized and Coordinated Health System to (1) coordinate the different health subsystems currently functioning in Peru, and (2) achieve consensus on national policies and laws on health. • In September 2002, the MOH formed a National Health Committee comprising governmental and civil society representatives to manage this process and implement it at the regional and local levels. Decentralized planning and budgeting processes have been delayed. • USAID/Peru supported the National Ombudsman (Defensoria del Pueblo) and a woman's rights group, Red Nacional de la Promoción de la Mujer, and built civil society awareness of and support for FP rights,		support. • Until 2005, USAID supported project Reprosalud (of Peruvian NGO Movimiento Manuela Ramos (MMR)) aimed to promote sexual and reproductive health and rights and respect for indigenous cultures by establishing dialogue and understanding between health providers and indigenous people. Through this dialogue, the project encouraged the integration of modern health knowledge with traditional knowledge and practices that are not harmful to health. The project was committed to gender equity and women's empowerment as well as participatory processes that put community members in charge. After Reprosalud, limited USAID funding provided TA to increase MMR's sustainability and institutional strength. • USAID set up MaxSalud in 1995 as a pilot program to see whether/how the private sector could provide high-quality basic health services to people with low incomes in a sustainable way. MaxSalud provides a full range of FP/RH services in five clinics (four in the region of Lambayeque and one in Cajamarca).

	including knowledge of how to report any abrogation of those rights. After 2007, TA will be provided via the Health Policy Initiatives project aimed at strengthening the ombudsman's oversight capacity and the enforcement of key quality indicators for health services, including reproductive health. • The advocacy groups for women's rights, under the leadership of the Red Nacional de la Promoción de la Mujer, now serve as watchdog agencies that press for appropriate funding for sound management and high quality in the health system, especially in its provision of services for women. USAID's support to the Red Nacional de Promoción de la Mujer ended in 2005, and the network is now self-sufficient.		**Other Donors:** • Apart from USAID, Peru received FP support only from UNFPA—mostly acting as a purchasing agent for the Government of Peru (GOP) for contraceptives. No other donors play a significant direct role in family planning in Peru.

Graduation Strategy

Policy

- Develop an advocacy plan of action for supporting national and regional activities to ensure that FP services are available to all.
- During the presidential election campaign, work with political parties to get their approval of an agreement on health policies, including family planning, and then ensure wide distribution of this agreement, including in the media. Complementarily, work with the recently elected regional authorities to ensure their commitment to and support for FP activities.
- Train civil society representatives to advocate for family planning and mentor them in working toward ensuring political commitment for family planning at the national and regional levels.
- Change policy and reimbursement to health services, if necessary, to ensure poor women's access to VSC and other FP methods.
- Advocate for policies that allow contraceptive procurement on the international market when the national market cannot provide quality contraceptives at a reasonable price.

- Develop an active and legally recognized coordinating mechanism for CS that monitors and advocates for public and private sector contraceptive needs, especially regarding political commitment, financing, procurement, supply chain management, and healthy market segmentation.

Financing

- Use advocacy tools to ensure that regional and local financial opportunities, such as results-based budgeting (PPR) and municipal incentives plans (PIM), are utilized by regional and local governments to implement FP/RH activities. Provide TA to regional health offices and municipalities on results-based budgeting and municipal incentives plans using family planning as the training module.
- Advocate with the new regional and national governments, INEI, and the MOH to ensure ongoing financing for and the sustainability of the DHS, possibly including a regular line item within the MOH and/or INEI budget.
- Monitor government financing for contraceptive procurement to determine if it is sufficient for contraceptive and supply chain needs, and monitor to ensure procurements occur in a timely manner.
- Support advocacy to ensure sufficient funds are available for procurement of 100% of contraceptive needs, including buffer stock at all levels of the health system.
- Develop strong arguments for increasing budgets at every level for improved health and FP services.
- Establish a high-level FP revitalization project, chaired by the MOH, with representation from regional governments, NGOs, the private sector, and other donors, including the UNFPA.

HSS

- Work with INPPARES to explore offering mobile delivery of services to reach beneficiaries in the lower-income quintiles.
- Build capacity at all levels of the MOH for implementing a consumption-based "pull' contraceptive logistics system, with special attention to the logistics management information system and a formal distribution system that reaches health centers and posts.
- Provide TA for contraceptive procurement, including building technical capacity of DARES for contraceptive procurement.
- Monitor appropriate implementation of policies and operational procedures for ensuring quality of contraceptives procured by the government (in coordination with MSH and USP for AMI and SAIDI programs).

Human/Institutional Capacity Development

- Conduct a private sector assessment to identify the TA needs of APROPO to expand its contraceptive product lines into under-served areas and possible TA to INPPARES to expand its Red Salud Network to increasingly cover poor and under-served populations.
- Help MOH and its RH Unit publicize the fact that family planning is an included benefit in SIS and universal health insurance through FP educational and promotional materials, such as clinic posters, brochures, and flip charts.
- Promote family planning as a key intervention and healthy practice within community-based USAID projects (e.g., Healthy Communities and Municipalities). This is especially important, as the Healthy Communities and Municipalities model is being replicated by GOP in implementing CRECER, the national initiative to address childhood malnutrition, and by the mining sector in its community-based programming for mining communities (part of its corporate responsibility strategy).

- Limited activities for strengthening the private sector to improve sustainability and access to family planning may continue under the "Making family planning a priority within decentralization" component of Peru's FP sector graduation plan extension.

Lessons Learned/Key Considerations for Graduation

- Critical aspects of several parts of the FP program—including political commitment at the national, regional, and local levels, extent of promotion of FP services, quality of public sector services, and strength of the public sector logistics system—have ongoing institutional weaknesses that limit use of FP products and services and threaten program sustainability.
- Since 2006, when the USAID/Peru FP graduation strategy was drafted, there has been a lack of leadership and focus on family planning at the MOH (the central level of the MOH) and in the regions.
- In 2006, a joint USAID/Peru-USAID/Washington Graduation Strategy Team determined that Peru met only two out of the six measures USAID uses to gauge readiness for graduation and only one of the two key indicators (TFR and MCPR). Because the MCPR met the near-term graduation target but then dropped below it—it actually decreased since 2000—the Graduation Team concluded that "this puts into question whether Peru is in fact ready for graduation." Regardless, the graduation team concluded that "the reality of radically decreasing FP funding available to the LAC region makes it necessary for the team still to recommend that Peru adopt a five-year phase-out strategy."

Ukraine, Family Planning, Graduation Year: 2015

Note: While Ukraine's FP graduation strategy was developed, it will not be implemented.

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Partnerships/Other Donor Support**
• The public health sector is funded from the national budget only at 30–40% of its need. This funding is spent on payment of utilities, electricity, water, food for patients, and salary of medical personnel. Funding is not sufficient for medications, technology, and new equipment. Health services in the private sector are not affordable for an average Ukrainian, and their costs have increased by between 30% and 60%. • 80% of Ukrainians pay doctors illegally in the shadow market of health services, representing about US$2.5–5 billion per year. • The economic downturn is also impeding collaboration between USAID and pharmaceutical producers in Ukraine due to the significant increase in prices for pharmaceutical products, including contraceptives; reduced corporate marketing budgets; and high turnover of individuals in charge of FP/women's health products. • Following the USAID-	• USAID supported the POLICY project, beginning in 1998, in providing TA to the MOH to guide the development of the National Reproductive Health Program (NRHP) for 2001–2005. The NRHP facilitated the policy dialogue among governmental and nongovernmental entities, thus promoting the MOH's strategic approach to women's RH issues and bolstering the participation of well-informed Ukrainian citizens in health policy and decision making. The NRHP executive directive was issued in 2001. • The POLICY Project's collaboration with the MOH was also instrumental in raising awareness of RH issues across many sectors of the government. This collaboration resulted in the development of two groups: The Policy Development Group (PDG) and the Ukraine Reproductive Health Network (URHN). • The Women's Reproductive Health Initiative (WRHI 1995–2000). • USAID supported policy	• In 1999, the Ukraine RHS (URHS) was conducted with assistance from CDC, and the results were published in 2001. • The Birth Defects Surveillance and Prevention Program supported modern pregnancy outcome data processing and analysis, and provided valuable data for RH and maternal healthcare.	• Through WRHI, USAID supported additional training of service providers, and an information, education, and communication (IEC) effort directed at postpartum and postabortion clients. • The Ukraine Reproductive Health Network (URHN), which arose through collaboration under the USAID's POLICY Project, served as a useful mechanism for stimulating public awareness of RH issues, engaging civil society in the advocacy process, and bringing the influence of a multi-organizational force to advocate for policy reforms. • The number of health facilities providing FP services expanded from 500, when TfH started, to 1,350. The latest numbers indicate that nearly 5,000 health providers (including ob-gyns, family doctors, midwives, feldshers, and nurses) have participated in five-day training courses on FP/RH and three-day courses on postpartum/postabortion family planning. • The TfH project worked with the MOH and the MOE to develop and adopt new guidelines and training materials on family planning. • Under TfH, an EBM Center was

initiated launch of Together for Health (TfH) Ukrainian Government commitment to FP/RH was bolstered through support for development of the SPRHN and oblast RHPs. The SPHRH since has allocated significant government resources from both central and local budgets. SPRHN has a budget of UAH761 million (about US$97 million), of which UAH98 million (about US$12.5 million) is allocated for improving FP services, including UAH91.5 million (US$11.5 million) for contraceptive procurement. Twenty oblasts (out of 27 total oblasts and administrative units) adopted regional RH programs and allocated funds for FP/RH, with budget lines amounting to more than US$10 million for contraceptive procurement.	work through WRHI with the MOH to develop an RH strategy. • USAID/Ukraine supported health reform efforts between 1994 and 1999. As a result of these efforts, the Family Doctor position was established in 1997 by the MOH. • In October 2005, USAID initiated the TfH to develop a strong policy infrastructure to promote improved FP/RH services. The project is working in 13 oblasts.		opened at the National Medical Academy for Postgraduate Education (NMAPE), which will serve to update the knowledge and practices of Ukrainian health providers through improved FP curricula. • TfH's cooperation with private pharmaceutical companies, formalized by a Memorandum of Partnership signed in 2006, improved contraceptive availability in Ukraine and expanded TfH geographical reach beyond 13 participating oblasts. • TfH coordinated with the HIV/AIDS Alliance to distribute USAID-donated condoms to vulnerable populations in Ukraine, as a complement to oblast funding for contraceptive procurement. • **Other Donors:** • USAID has been the primary donor supporting FP/RH activities in Ukraine.

Graduation Strategy

Policy

- Continued national budget allocations for contraceptives and central procurement of contraceptives, especially for poor and indigent women; continued oblast and rayon budget allocations for contraceptives for poor and indigent women.
- Network of NGOs and CBOs in USAID-supported oblasts established.
- MOH and MOF budget decisions based on need, as indicated by data and information collected from lower levels.
- Contraceptives included in future health benefit package or reimbursement system under healthcare reform.

Financing

- Identify and support selected NGOs or CBOs in the oblasts that USAID supports (currently 13) to continue advocacy efforts with oblasts and rayons for continued budget allocations for family planning. NGOs and CBOs may have greater reach at the local level than a USAID project, so it will be important to

engage them in fulfilling this needed advocacy role.

- Meet with other donors, such as WHO and UNFPA, to discuss co-financing the DHS FP section.
- Given that publically procured contraceptives are rationed throughout the health system, the system is based on funds available, not on need. USAID should support TA to the MOH to help it use data collected through the Logistics Management and Information System (LMIS) to better inform budget decisions with the MOF, and better forecast its own public procurements.
- Continue working through its partners—including NGOs and CBOs—to advocate at both the national and oblast levels for dedicated funds for family planning, including assisting them in a plan to sustain free contraceptives for women in need beyond USAID or other donor partner donations.

HSS

- Expand in-service training, thus far covering 13 oblasts, by rolling out in-service training to cover additional oblasts.
- With continuing medical education (CME) post-graduate trainings just underway in medical academies, USAID should eventually evaluate delivery and content for effectiveness and assess whether further assistance is needed regarding these two aspects. Also, CME should be expanded through additional training facilities to help meet the training needs of the healthcare workforce.
- Scale up CME training for pharmacists to additional oblasts. The vast majority of contraceptives are purchased in private sector pharmacies (commonly co-located in public sector health facilities of all sizes); this provides a valuable opportunity to expand the modern method mix by increasing the capacity of pharmacists to provide accurate and knowledgeable information about the contraceptives they are selling.
- In-service curriculum development was the most common articulated need of key stakeholders in Ukraine's FP sector during the assessment.
- Institute data collection methods for RH in partnership with GOU and stakeholders. Work closely with ministry and oblast counterparts to create a simple paper-based LMIS to utilize such data to better inform decision making.
- Develop and distribute job aids, flip charts, brochures, and other FP counseling materials to target providers and clients.
- Train pharmacists on counseling and patient education about hormonal and other methods of family planning.
- Continue contraceptive donations shipments to (1) "prime the pump" for client demand, (2) serve as an incentive for data recording/reporting, and (3) use as a tool for decision making at the national level—both in budget allocations and forecasting.
- Institute a basic, paper-based LMIS in project sites to determine the number of women in Ukraine in need of free products.

Human/Institutional Capacity Development

- Explore using small grants with NGOs to raise awareness of family planning in communities. As exposure to FP messaging is the lowest in rural areas, working with community groups and NGOs through a small grants program would be an avenue to explore to increase awareness and improve knowledge of family planning.
- Establish a working group tasked with planning and financing the upcoming DHS and plan for the post-graduation financing and conduct of FP data collection and use. Given that most clients receive their products in private pharmacies, a national LMIS may not be required, nor does it need to be elaborate or automated. It should, however, feed data up to the national level, for use in decision making.

Lessons Learned/Key Considerations for Graduation

- The POLICY Project's collaboration with the MOH was also instrumental in raising awareness of RH issues across many sectors of the government. This collaboration resulted in the development of two groups: the PDG and the URHN. The latter served a useful mechanism for stimulating public awareness of RH issues, engaging civil society in the advocacy process, and bringing the influence of a multi-organizational force to advocate for policy reforms.

Dominican Republic, Family Planning, Graduation Year: 2010

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/ Institutional Support**
• To overcome difficulties in successfully procuring contraceptives for the country, the Government of the Dominican Republic (GODR) (through the National Population and Family Council (Consejo Nacional de Población y Familia) (CONAPOFA) purchases nearly 85% of public sector contraceptive needs using national budget funds; remaining contraceptive needs are addressed by purchasing needed supplies from UNFPA—this is only a short-term solution however, and GODR will need to establish a sustainable plan for Contraceptive Security (CS).	• Social Security Law 87-01 established the National Health Insurance Fund (Seguro Nacional de Salud – SENASA) as the public health risk management organization. SENASA provides subsidized insurance to 400,000 vulnerable individuals (of the $1 million programmed). • A significant step toward CS was the establishment of the National CS Committee (DAIA). Following several regional USAID LAC meetings on CS, DAIA advocated for a direct source of funding dedicated to CS. The current plan is to earmark funds for CS through a ministerial decree, backed by a commitment from financial authorities, and develop agreements for SENASA to reimburse SESPAS for contraceptives provided. • In 1990, the country began discussing the need for health reforms that would improve the organization, operation, and financing of the healthcare system, particularly in the government-run services. • In 2001, Congress drafted two new laws, the General	• A USAID-funded study in 1999 targeting remote rural areas along the Haitian border where majority population are Haitian origin (a third of whom have no identity documents and thus, limited access to health services) showed that while 57% of women in union used modern contraceptives, use was highest among Dominican women (65%), with only 32% of the Haitian women using contraception. • USAID measured the CS of the DR through the CS Index.	Historical USAID support to the Dominican Republic (DR): • A bilateral project with the University Research Corporation to strengthen systems within the MOH. • Buy-ins to the PAC I and II Global Project (Development Associates) to conduct FP training for auxiliary healthcare workers. • Technical assistance was provided to three key NGOs—PROFAMILIA, MUDE, and ADOPLAFAM—during this time period. • Buy-ins to the USAID | DELIVER Project, (1989–2003) to strengthen the logistics systems of PROFAMILIA, ADOPLAFAM, SESPAS, CONAPOFA, and IDSS and thereby increase availability of contraceptives at service delivery points. • ADOPLAFAM, which began in 1986 under the FP Service Expansion Project, has undertaken reproductive health (RH) activities, including FP services, pre- and postnatal care, cancer screening, and counseling for adolescents. Its contraceptive social marketing program includes community-based distribution of modern methods, including contraceptive pills and condoms. Under a subcontract with the CONECTA project, ADOPLAFAM has implemented adolescent

	Health Law and the Social Security Law. • The Social Security law, 87-2001, provides for an increased participation of the social security system in the provision and promotion of FP services. • Prior to the health sector reform laws, the National Population and Family Council (Consejo Nacional de Población y Familia [CONAPOFA]) was established. This is a decentralized entity set up to forecast and arrange for the purchase, distribution, and monitoring of all contraceptives. • REDSALUD is the principal source of technical assistance in implementing the health sector reform and advocating for improved decentralization of the health system.		reproductive healthcare education activities in schools through peer education programs. • MUDE is an NGO focusing on empowering women through economic and health activities. With USAID funding, the program has increased access to quality RH services to more than 75,000 women in rural areas. Additionally, MUDE has established 110 outlets that provide condoms and oral contraceptives. • PROFAMILIA is an IPPF affiliate founded in 1966. With strong institutional backing from USAID, it has reached 92% sustainability. PROFAMILIA has been successful because it has diversified its program portfolio and donor funding base. In 2005, PROFAMILIA reported that it provided 13,000 FP services through its clinics and distributed 342,000 oral contraceptives and 3.1 million condoms through its social marketing program. **Other Donors:** • UNFPA: Coordinated closely with USAID and worked closely with the MOH in procuring contraceptives and other equipment, channeling contraceptive purchases at the national level, giving technical assistance to the national and regional programs, supporting the information systems, developing norms and protocols, giving TA, and advocating for FP activities. The collaboration between UNFPA and USAID was particularly evident when training activities were divided so that USAID would support training at a national level

			and some regional levels and UNFPA would cover other regions or more localized levels. Collaboration extended to other spheres, such as complementary actions in training in emergency obstetrical care.

Graduation Strategy

Policy

- Advocate for and support CONAPOFA in establishing an official policy that FP is a right of all people, especially vulnerable populations.
- Advocate with SENASA to include FP in the collective healthcare and individual healthcare packages.
- Assist the MOH with setting policies and procedures for the provision of contraceptives and services to insured and uninsured populations.
- Conduct seminars and advocacy activities to push the agenda of FP services to vulnerable populations.
- Integrate FP into existing HIV and RH programs targeting vulnerable populations.
- Advocacy with and by DAIA to ensure that FP/RH and CS are on the health agendas of each competing party's platform in the upcoming elections, and publicize the issues to the general public.
- Support DAIA in sponsoring forums in which competing political parties share their health agendas with the voting public and commit themselves to strengthening FP programs.
- Conduct discussions with political parties and policymakers about the need and potential funding support for the DHS.
- Strengthen the DAIA and CONAPOFA with a focus on their roles as advocates for contraceptive availability and FP services in the public and private (NGO) sectors.
- Promote a closer relationship between SESPAS and SENASA to address FP issues and expeditious payment for contraceptives delivered by SESPAS to SENASA.
- Facilitate special meetings between key members as they negotiate and reach consensus on key FP administrative, financial, and technical issues.
- Assist the Provincial Health Directorates (DPS) to interact with the central level to obtain adequate support so that all populations in the provinces can be covered by FP programs and adequate M&E of activities can be achieved.

Financing

- Advocate for and support CONAPOFA to include an adequate budget line in the national budget to provide FP services to vulnerable populations.
- Develop a transition plan to support those vulnerable populations currently being covered by ADOPLAFAM and PROFAMILIA, should their role come to an end.
- Introduce discussion of the 2012 DHS among stakeholders and look for the inclusion of its funding in their strategic or long-term plans.
- Establish mechanisms that will ensure a secure budget for the procurement of contraceptives and establish support mechanisms for the procurement system.

HSS
• Strengthen overall procurement and logistics systems. • Clarify and define the roles and responsibilities of the various member organizations in contraceptive procurement and management. • Establish standard logistics management procedures and manuals for use throughout the public healthcare system. • Design and develop a monitoring and supervision system, including the needed tools, for logistics management. • Develop a set of guidelines, based on the experiences and best practices of CONECTA and the NGO community for the integration of family planning into other RH programs, including those focused on HIV/AIDS, which provide services to vulnerable populations. • Provide support and follow-up to managers as offices and provincial officials implement the monitoring and supervision systems. • Systematically implement the tested integration guidelines in RH service programs that reach vulnerable populations. (CONECTA, in conjunction with the NGOs it supports, for example, can use this approach to health services in Region V, where REDSALUD is currently working with the health sector reform.) The TDB grant/CA will continue with this process.
Human/Institutional Capacity Development
• Support CONECTA and/or the NGOs to implement FP/health policy integration guidelines into their services aimed at vulnerable populations. • Design and implement a training module, which includes training of trainers (TOT) and on-the-job training methodologies, on logistic management policies and procedures, monitoring, and supervision for MOH and SENASA managers and support personnel. • Conduct a TOT workshop in the management of FP services for DIGEMIA and selected provincial-level health officials. • Provide follow-up and support to DIGEMIA and provincial officials to continue their own self-sustained training for others. • Identify and develop local expertise that can provide future TA to DAIA and its partners in advocacy for improved FP services. • Conduct an analysis of the 2007 DHS's scope, adequacy of content for informing policy and practices, cost, and other relevant concerns for the purpose of strengthening the 2012 DHS. • Develop a scenario for the 2012 DHS that will include possible activities, costs, and funding sources.
Lessons Learned/Key Considerations for Graduation
• As a result of further definition and review of the situation at a USAID/LAC meeting on CS (October 2006, Antigua, Guatemala), the DR team recognized that CS first had to be dealt with during the transition period, during which the social security system will take increasing responsibilities in service provision and the health sector reform law will be established. Funds are to be earmarked for CS through a ministerial decree, backed by a commitment from financial authorities, and for developing agreements for SENASA to reimburse SESPAS for contraceptives provided. • Pending elections would slow the pace of the phase-out and also the pace at which health sector reform is implemented. Experience has shown that as new authorities come into the government and as personnel changes are effected, there is the danger of losing advances made during the previous administration. There is a need to follow up on the progress made to date in the DR until the new government is established.

Paraguay, Family Planning, Graduation Year: 2011

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• Donated contraceptives currently comprise 95% of the contraceptives used in the public program. They come from USAID (75%) and UNFPA (20%). This percentage may vary from year to year. • In areas such as Encarnación, where the local health council has taken on the responsibility for purchasing contraceptives as part of its essential drug package, they still rely on donated commodities from the central level even if they are purchasing the supplies.	• Plan de Acciones Inmediatos de Salud (a Plan for Immediate Health Actions), 1989. • Constitution (1992) includes an article that allows for the right of all citizens to freely and responsibly decide the number and spacing of the births of their children, as well as the right to receive, (through relevant institutions) education, scientifically based guidance, and adequate FP services. • USAID supported the incorporation of a new vision of quality and models of efficiency into the MOH's reproductive health (RH) programs. • The Ministry of Health and Social Welfare has developed a National Sexual and Reproductive Health Plan for 2003–2008.	• USAID received support from other donors to implement the 2004 National Demographic and Sexual and Reproductive Health Survey.	• USAID/Paraguay supported the development of social marketing in Paraguay through Population Services International (PSI) and its NGO, PROMESA, beginning in 1998. After USAID support ended, PSI/Paraguay became quasi-independent of PSI/Washington and is completing the process of becoming an entirely autonomous, locally based business. With no support from donors, the organization cut costs and staff and became a completely self-sufficient, for-profit local business with the ability to purchase product with its own funding.

Graduation Strategy
Policy
• Develop policy and regulatory support within the public sector, including the MOH, and within CEPEP to ensure increased access to interval female sterilization. • Facilitate a signed memorandum of understanding (MOU) with the MOH, Ministry of Finance (MOF), the Paraguayan Congress, and UNFPA to ensure that the logistics system is strengthened and the central level improves its capacity to finance, forecast need, and procure and distribute contraceptives. • Develop an MOU with the MOH for patient referrals to CEPEP.

- Working in conjunction with the DAIA Committee, identify contraceptive security (CS) priorities.
- Strengthen the systems for facilitating the decentralization process at the national level, including policy-level work to ensure that the legal and regulatory frameworks necessary for successful decentralization are in place. This includes developing agreements to allow local retention of funds, e.g., an agreement that will institutionalize the authority now granted through an administrative agreement with the MOH.

Financing

- Ensure (in conjunction with UNFPA) that an increasing line item for FP commodities is included in Paraguay's national budget throughout the five-year period and that the funds allocated for the FP line item are used by the MOH as intended.
- Work with local health councils to mobilize communities for health funding and prioritization.
- As appropriate, establish community-based health insurance schemes that include RH services.
- Define a minimum threshold level for population assistance to ensure that appropriate funding is available to sustain the investments that have been made to date in the sector.

HSS

- Identify appropriate South-South TA to help CEPEP develop a business plan for its surgical services, allowing it to subsidize its sterilization, as well as train a team that can transmit interval mini-lap skills, including counseling and informed consent, to CEPEP.
- Contract with a South-South TA group to train a trainer in mini-lap, including counseling and informed consent in CEPEP's main clinic in Asunción and in its Encarnación clinic, to train and provide female sterilization services in those two clinics. CEPEP's associated clinic staff and community outreach personnel will also be trained to provide effective referrals to those two clinics for female sterilization, thus increasing its availability to high-risk groups and women who want interval tubal ligation.
- CEPEP will also receive South-South TA to develop a business plan to ensure the sustainability of CEPEP's female sterilization program via the offer of other surgical procedures that can subsidize its sterilization program and perhaps increase CEPEP's overall sustainability.
- Develop the capacity of local health councils and establish social pharmacies under the direction of the local health councils.
- Develop an advocacy and community mobilization scale-up schedule and phase-out plan with a local contractor for covering all selected regions and areas.
- Complete the capacity building of selected departments' local health councils for improving financial, administrative, and fund allocation processes, as well as establishing broad participation on the councils.
- Establish and systematize tools and approaches on critical issues related to decentralization, including identifying health needs and the means for obtaining local funding for family planning and ensuring CS, especially for the poor.

Human/Institutional Capacity Development

- Strengthen the ability of the MOH to understand its need for commodities and procuring commodities internationally at the best possible prices.
- Strengthen the logistics system at the central MOH level and throughout the different levels (regional, health center, health post) to ensure access to a constant supply of FP methods. Prioritize those departments and municipalities with the worst population indicators, such as TFR and CPR, and the highest levels of poverty.

• Involve the local health councils in Asunción and Encarnación and nearby catchment areas so they understand mini-lap within the context of quality of care and can help with dissemination of information to local communities.
Lessons Learned/Key Considerations for Graduation
• USAID's prior support to PSI has served an important function by increasing demand for privately supplied contraceptive methods and higher-end products for those who can afford to pay by priming the market for the entry of new pharmaceutical manufacturers' purely commercial (non-subsidized) products, while continuing to provide access to low-cost methods to lower-income populations through private and social pharmacies.

Honduras, Family Planning, Graduation Year: 2013

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• In FY2007/08, USAID was by far the largest FP donor in Honduras, and the two most significant service providers were the MOH and ASHONPLAFA (an NGO and IPPF affiliate). • The Government of Honduras (GOH) procurement of its own contraceptives and commercial sales have both increased; as a result, USAID phased out donations of contraceptives; donations to the MOH were discontinued in 2000 and the last donation to ASHONPLAFA was in FY2008. • USAID, UNFPA, and Germany (KFW) combined provide about 40% of the country's contraceptives.	• The Mission supported the MOH in decentralizing government-financed health services and strengthening the central and departmental MOH capacity to manage a decentralized health system. • In FY2006, the MOH formally made FP service provision a major component of its plans for decreasing maternal mortality and approved a detailed strategy, previously formulated with USAID TA, for planning, organizing, monitoring, and evaluating these services in MOH facilities nationwide. • USAID supports the GOH procurement of its own contraceptives and sales through its active participation in the MOH/NGO/donor CS	• Provision of ongoing technical assistance (TA) to ensure that the Instituto Nacional de Estadisticas (INE, the National Statistics Institute) has the capacity to conduct, analyze, and disseminate a quality Democratic and Health Survey (DHS).	• To address the government's perceived reluctance to promote population services, USAID began supporting ASHONPLAFA with financial and TA. It has been the forerunner in family planning ever since. • USAID support to the MOH to implement its FP service provision includes the principal activities of training in FP clinical skills and contraceptive logistics processes; supervision, monitoring, and evaluation activities; and broadcasting FP messages on 97 radio stations nationwide to promote service utilization. • USAID works with the World Bank and the Inter-American Development Bank (IDB) to improve, increase, and decentralize maternal and child health (MCH) services in four targeted (low income) departments of the country. • ***Other Donors***

	Planning Committee. • USAID held a member seat on Honduras's multisectoral DAIA committee, which oversees national CS. This committee includes members from the MOH, IHSS, ASHONPLAFA, and UNFPA.		• UNFPA: Provides a relatively small amount of funding for FP services, focused on adolescents, and some contraceptives.

Graduation Strategy

Policy

- Support advocacy to fight for a protected budget line for contraceptive procurement.
- Support and advocate for policies to allow contraceptives procurement on the international market when the national market cannot provide high quality contraceptives at a reasonable price. This may include advocating for an agreement to use UNFPA as an international procurement agent.
- Strengthen policies and operational procedures for ensuring quality of contraceptives procured by the government.
- Identify and prioritize rural, non-covered, and vulnerable populations.
- Institutionalize FP monitoring and evaluation (M&E) activities within the regular MOH M&E meetings and at national, departmental, and local levels.
- Work with the MOH to ensure that the IHSS (Honduran Social Security Institute) is included in FP training opportunities and FP norms, distribution, and dissemination.
- Improve coordination within the MOH for matters related to CS, to allow DAIA to focus on CS at the national level.
- Continue strengthening DAIA—especially skills related to leadership, advocacy, financing, forecasting, and the in-country supply chain management system.
- Support development of a strategic plan for the DAIA committee that focuses on CS on the national level.

Financing

- Monitor government financing for contraceptive procurement to determine if it is sufficient for contraceptive needs.
- Develop tools for monitoring, regulating, and financing health service provision in a decentralized system.
- Support a study that will demonstrate the costs savings to the IHSS by providing FP services and eliminating unwanted pregnancies among its members and covered dependents.
- Work with DAIA (which oversees national contraceptive security (CS)) and the MOH to ensure that IHSS purchases contraceptives with its own funding through the UNFPA or other cost-saving procurement mechanisms.

HSS

- Support monitoring and supervision of a vertical contraceptive logistics system, including materials and equipment for LAPMs. Consider also monitoring several

"tracer" commodities in the integrated system, for comparison. Build support for maintaining consumption-based logistics system for contraceptives and other health commodities.

- Build capacity at all levels of the MOH for implementing a vertical contraceptive logistics system, with special attention given to logistics information.

Human/Institutional Capacity Development

- Seek firm financing for future DHSs by exploring national possibilities with Banco Central, MOF, and international donors and banks working in Honduras. USAID's Global and Regional Health offices will explore possible regional/international funding for TA in capacity building and possible longer-term support for the DHS in Honduras and other countries phasing out of family planning.
- Provide technical support for joint purchasing of medicines, including contraceptives, between the MOH and IHSS, and possibly other governmental or nongovernmental agencies, such as ASHONPLAFA. The USAID LAC Regional Initiative will continue to examine opportunities for regional cooperation in procurement.
- Define strategies and funding sources to provide the infrastructure and maintenance needed for central, departmental, and local warehouses.
- Develop/implement in-service training for auxiliary nurses, including IUD insertion.
- Provide TA to the MOH at national and regional levels to effectively provide in-service training for staff, actively supervise staff, monitor and evaluate programs, and use the data for program corrections and decision making.
- Support commercial social marketing activities of high-quality FP products that are affordably priced and conveniently accessed.
- Increase the capacity of ASHONPLAFA to manage a high-performing social marketing program of FP products.
- Obtain MOH, university, and technical training school approval to include family planning in their curricula; review and modify training curricula for medical, nursing, and auxiliary nursing students.
- Incorporate FP/RH in the medical, nursing, and auxiliary nursing schools' curricula, including didactic and clinical training.
- Before the next survey, provide TA to INE to enhance its staff skills for analyzing DHS survey data, drawing appropriate conclusions, and writing an international-level report.

Lessons Learned/Key Considerations for Graduation

- During the FP phase-out, USAID should continue to support not only institutionalizing the pre-phase-out FP strategy in 1,443 facilities nationwide, but also decentralizing the facilities' network to ensure access, efficiency, and quality of FP services. The decentralization support should include M&E.
- While a critical mechanism, DAIA has become focused on the contraceptive supply issues of the MOH, with insufficient attention to multisectoral approaches to improving CS at the national level. Further, it has not been utilized effectively as an agent for effective organizing and advocacy to strengthen policies and support laws that would improve CS, such as a protected budget line item for contraceptives.

Ecuador, Family Planning, Graduation Year: 2001

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• Financing for the implementation of the Ley de Maternidad Gratuita was contemplated from both the Fondo de Solidaridad (National Solidarity Fund), created in 1998 as a national social welfare fund, and through a 3% luxury item tax. • In their efforts to achieve greater financial sustainability, APROFE and Centro Médico de Orientación y Planificación Familiar (CEMOPLAF) diversified their services beyond family planning to include other reproductive (RH) services, as well as pediatric care and dental services. • USAID supplied contraceptives to CEMOPLAF to ensure its sustainability after graduation.	• National Population Policy, issued in 1987, and Article 39 of the Ecuadorian Constitution of 1998 guarantee the right of all individuals and couples to space and plan the size of their families through access to information and the provision of safe, modern contraceptive services. • Technical assistance (TA) for a national population policy came from USAID–funded projects, such as the RAPID presentation developed by The Futures Group International. The computer model was used as an advocacy tool, as it demonstrated the impact of population growth with and without family planning. • In September 1994, the government issued the Ley de Maternidad Gratuita (Law for Free Maternity Services). It was expanded in August 1998 to include infant healthcare and now is known as the Ley de Maternidad Gratuita y Atención a la Infancia. • CEMOPLAF, officially established in September 1974, began its operations as part of an agreement between USAID and the	• Since 1987, CDC's Division of Reproductive Health (CDC/DRH), through a partnership with USAID/Washington's Office of Population and Reproductive Health, has collaborated with the Center for Studies in Population and Social Development (CEPAR) and provided TA in carrying out four Demographic and Maternal and Child Health Surveys (Encuesta Demográfica y de Salud Materna e Infantil [ENDEMAIN]). • USAID/Ecuador has consistently contributed the major share of the costs for the various Ecuadorian national Reproductive Health Surveys (RHSs).	• Provide technical support for joint purchasing of medicines, including contraceptives, for the MOH. • Gradually reduce donated products, contraceptives, over a planned phase-down which covered two to three years to allow recipient organizations the necessary time to learn, experiment, and adjust, gradually taking on responsibility. The Mission provided TA for an additional year to ensure successful management of supply chain logistic systems. • USAID has provided funds to a private, nonprofit, Asociación Pro-bienestar de la Familia Ecuatoriana (APROFE) and a social marketing program, CEMOPLAF, to enable each organization to successfully provide FP services. • The USAID centrally managed institutions that worked with CEPAR over the years were successful in transferring technology and developing local technical capacity, particularly in the areas of demographic research, analysis, communication, and policy reform advocacy. • USAID focused financial and institutional support to APROFE and CEMOPLAF to ensure

	MOH and is now a successful NGO operating in Ecuador. • In 1991, USAID/Ecuador entered into a new relationship with the Government of Ecuador (GOE), called no-project assistance (NPA) in the area of population and FP assistance. At that time, the Agency was experimenting with an innovative way to transfer large sums of financial support in exchange for major national policy reforms in specific sectors.		sustainability of the two major NGO providers of FP/RH services in the country. • IPPF – Funding support and TA for local affiliate APROFE.

Graduation Strategy

Policy

- A highly professional, reputable, and technically well-prepared private nonprofit institution working in the field of demographic and health research and studies, coupled with its strong commitment to family planning, can have a valuable and effective role in formulating national population policies.

Financing

- Transition for the procurement of contraceptive commodities from a donor-supported program to that of local institutional responsibility is a long and difficult learning process and requires dedicated TA and guidance.
- Despite the long and costly investment of USAID and its cooperating agencies in the design and production of IEC (information, education & communication) materials, little attention has been given to ensure the future funding of these activities beyond the termination of donor support. TA must be provided during the early stages to develop local capacity that will ensure the future funding for and production of IEC materials.

HSS

- As USAID and other donors continue to fund local organizations in carrying out national RHSs and DHS, additional TA needs to be provided during the early stages to ensure the institutional and financial sustainability of those organizations, prepare them for marketing their services, and allow them to conduct future similar surveys with or without international donor support.

Human/Institutional Capacity Development

- In addition to TA provided in program areas such as social marketing, contraceptive technology, and IEC, USAID needs to ensure that in preparing local NGOs for graduation, they receive assistance as needed in areas such as human resource management, leadership capacity, organizational values, and

financial management.

- TA in contraceptive commodity logistics management needs to be provided jointly with the provision of donated contraceptive supplies.

Lessons Learned/Key Considerations for Graduation

- The severe budgetary constraints facing the GOE have made it extremely difficult, if not impossible, to implement the Ley de Maternidad. At present, the country finds itself in the dilemma of having elaborated a politically powerful health plan, but not having the funding or institutional capacity for implementation.
- USAID/Ecuador's investment in its locally hired staff working in the population and FP sector can have a longer-term benefit in relation to other development programs in the country.

Morocco, Family Planning, Graduation Year: 2002

Graduation Strategy

Policy

- Gradual timeline of transition (10 years) for the purchasing of contraceptives between USAID and MOH.
- Reduction of taxes for contraceptive procurement to ensure lower costs.
- MOH created a system to estimate contraceptive needs based on Contraceptive Purchasing Tables.
- Currently, MOH has its own institutional capabilities for managing and purchasing contraceptives.

Financing

- Creation of social marketing programs, such as Moroccan Social Marketing Project (MSMP), has enabled private sector involvement in family planning.
- Focus on other organizations to provide long-term FP needs. Morocco has employed the Commercial Market Strategies (CMS) Project to strengthen the positioning of long-term methods in the private sector.
- USAID funded a social marketing program with CEMOPLAF through the Futures Group International—the Social Marketing for Change Project (SOMARC). The program became very successful in marketing contraceptive methods and medicines related to maternal and child health.

HSS

- Support from Family Planning Logistics Management Program (FPLMP) has enabled the MOH to strengthen its contraceptive logistics system. This includes training of health professionals and distribution of health manuals and other materials for monitoring stock.
- Standardization of procedures has enabled products to reach all levels of the MOH delivery network.
- With USAID's collaboration, the MOH has developed a state-of-the-art interactive computerized system that tracks service statistics across all programs and provinces.

Human/Institutional Capacity Development
• Priority given to sustainability issues/areas; a list of priority areas of family planning was created. • Institutional contractors provide TA in the areas of contraceptive logistics, the health information system, and IEC(information, education & communication). • Utilization of regional workshops to develop training manuals and courses to support quality assurance and an improved quality of healthcare. • The role of the private sector in providing contraceptives has the capability to fill a void when USAID exits.

Mexico, Family Planning, Graduation Year: 1999 *(planned graduation year: 1997)*

Graduation Strategy
Financing
• Between 1985 and 1995, USAID's average annual budget for family planning in Mexico was approximately US$10 million. • Support the government of Mexico to procure increasing levels of commodities to replace donations. • Improve income-generating capacities through cost recovery and increased domestic donor support for the Fundacion Mexicana para la Planeacion Familiar (MEXFAM) and FEMAP to ensure long-term financial sustainability. • Support the Government of Mexico (GOM) in assigning funds to the SSA annually and deliver monthly budgetary allocations for FP programming. • The SSA will lobby for increased funding for contraceptives from the MOF.
HSS
• In nine low-income and mostly rural states and peri-urban areas of Mexico City, increase access and improve quality of FP service delivery; design IEC (information, education & communication) activities aimed at hard-to-reach groups; conduct research on fertility practices, demographics, and operations in the FP sector. • Complete logistics training at all levels (national, state, and district) of the public sector (SSA).
Human/Institutional Capacity Development
• In nine low-income and mostly rural states and peri-urban areas of Mexico City, build capacity of health personnel in remote areas. • Support the expansion of MEXFAM and FEMAP networks/affiliates.
Lessons Learned/Key Considerations for Graduation
• During phase-out, Mexico joined the Organization for Economic Cooperation and Development (OECD), which meant that it was no longer eligible for nonrefundable donor support from certain countries. This complicated the process of securing other donor support for FP activities.

Population, Health, and Nutrition Sector Graduation Experience

Egypt, Health Sector, Graduation Year: 2009 (A family planning graduation note was developed but the Mission decided to not end assistance.)

Pre-graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• The private sector provides the majority of FP services and products (63%) while the government portfolio continues to decline, from 43% in 1997 to 28% in 2002–2003. • 89% of FP users pay for their contraceptives and only 11% receive free services. • In 2010, USAID supported an Egyptian Ministry of Health (MOHP) study looking specifically at the financial needs of programs previously supported by USAID, as well as other questions related to how they can be or have become institutionalized.	• In 2004, USAID and the Government of Egypt (GOE) began efforts that resulted in the development of the contraceptive security (CS) strategic plan. By 2007, under the plan, the GOE assumed complete responsibility for contraceptive procurement and management. • The MOHP and USAID worked as partners to define the essential package of maternal and child health (MCH) services in support of safe motherhood in the country. • More than any other segment of the health system, child health has benefited from the long-term USAID-GOE partnership in the health sector. • Based on the results of the Maternal Mortality Study (1993), the MOHP and USAID planned a program to systematically address the major causes of maternal death in the areas with the highest maternal mortality ratios (MMRs).	• Egypt's current health information system (HIS) has evolved from earlier efforts under USAID/Egypt-supported FP and MCH projects to collect reliable and timely service statistics. • After several years of technical support from USAID/Egypt, the Epidemiology Surveillance Unit (ESU) was formally established at the MOHP in 2000. • HIV/AIDS, maternal mortality, and FP commodity logistics surveillance systems were funded by, received technical assistance (TA), or were elaborated in partnership with USAID.	• USAID built excellent relationships and worked closely not only with the GOE, but with more than 20 implementing partners, including parastatal agencies, public and private universities, research organizations, NGOs, and private sector organizations. • USAID/Egypt provided NPC with significant support in capacity building through staff training, creation of planning and coordination capacity at the governorate level, and creation of research management and evidence-based programming capacity within the NPC Secretariat. • Egypt's capacity to control emerging and infectious diseases has been built through close coordination with the USG in the areas of control, research, and public health infrastructure. • Improving service quality has been one of USAID's major contributions to Egypt's health and FP programs. • USAID supported the establishment of the CSI Project. CSI's contribution was invaluable because these clinics had the unanticipated benefit of pushing

	• Since 1994, USAID has supported several elements of the MOHP health sector reform program: establishing the evidence base and rationale for reform; helping pilot the FHM, which operationalizes the basic benefit package; developing a system for quality improvement and accreditation; improving facility HIS; and, pilot-testing financing mechanisms.		the public sector to improve its performance and the quality of its services. • USAID used multiple approaches to strengthen human and institutional capacity: short- and long-term training of program participants, hands-on TA, on-the job training funded through ILs, and longer-term systems development.

Graduation Strategy

Policy

- Transitioning the national FP program to the host government without substantial external donor assistance will enable sustainability of programs.
- The host government assumes responsibility for purchasing contraceptives and providing trainings, supervision, travel, and equipment prior to USAID's exit, and will provide sufficient time for the GOE to test its ability to sustain its programs.
- The CWEFPA network of 85 clinics must be financially independent prior to the exit of USAID. Implementation of other projects at the government level focuses on achieving desired outcomes: Improving Our Health through Planning Our Families (TAHSEEN), Healthy Mother/Healthy Child (HM/HC), and Infectious Disease Surveillance Response (IDSR).

Financing

- The MOHP has maintained a strategic course in which steadily improving quality and marketing of FP/RH services in the public sector have continued to enlarge the MOHP's market share and financial burden.
- In 2004, USAID and the GOE began working on a plan to enable the GOE to assume financial and technical responsibility for procuring and managing contraceptive supplies.

HSS

- Structurally align NGOs to more effectively advocate for improved primary healthcare services for the poor.
- Emphasis on the commercial sector's role in introducing new products and services and contributing to public health education and CME of pharmacists and private physicians.
- Look to improve technical skills and provider capacity via the Sustainability and Transition Plan, which stresses the improvement of both pre- and in-service training systems and programs.
- Partnerships between American medical and nursing schools and Egyptian faculties of medicine and nursing will be established to institutionalize exposure to

international health experts and ensure an ongoing exchange of technical expertise. • SO 20 will address pre-service training through the HWD project, which will improve quality and expand the content of the curricula in all public medical and nursing schools to address family planning and maternal and child health. • From 1976 to 2008, the total CPR for all methods increased substantially, from 18.8% to 60.3%. • Unmet need for family planning fell by more than half, from 19.8% in 1992 to only 9.2% in 2008.
Human/Institutional Capacity Development
• Continued support for the commercial sector via CME to pharmacists and private physicians in the Ask-Consult network, and timely coordinated advertising of FP products and services. • Ability of NGOs and the private sector to expand FP/RH services and products to appropriate segments of the market, as GOE continues to lower barriers to participation.
Lessons Learned/Key Considerations for Graduation
• The Population and Development Program approach (1974), supported by numerous international donors—among them USAID, the World Bank, and UNFPA—resulted in an important FP lesson learned in the country. Dedicated FP services were the most direct way to lower fertility, and dispersing FP field worker efforts to other development issues, no matter how worthy, did not raise contraceptive prevalence.

Indonesia, Health Sector, Graduation Year: 2005 (PHN) 2007 (FP)

Pre-Graduation			
Financing	**Policy/Relevant Legislation**	**Leadership and Stewardship (including M&E)**	**Capacity Building/Institutional Strengthening**
• Historically, USAID has contributed financial and technical support to the National Family Planning Program to strengthen overall management and human capacity; social marketing; contraceptive supplies; behavior change communication; private and public sector initiatives; clinical training; policy development; and the implementation of the DHS for family planning, reproductive	• Virtually all USAID assistance is limited to two areas (policy advocacy and capacity building of partners): it provides technical assistance (TA) to promote advocacy in support of family planning. • Most recently, USAID provided the majority of its FP technical assistance through the STARH Program (Sustaining Technical Achievements in Reproductive Health). The STARH program was designed	• During the first years of decentralization, the reporting and recording systems of most sectors had broken down. Without a reporting system, BKKBN and the district management teams would not have been able to monitor the impact of decentralization on FP services and utilization. BKKBN requested TA from USAID to help establish a temporary early warning and rapid response system to	• USAID has played a major role in strengthening nongovernmental and professional organizations that are channels for FP services, information, and advocacy, such as IBI (the Indonesian Midwives Association), IDI (the Indonesian Medical Association), PKMI (the Indonesian Association for Permanent Contraception), Nahdatul Ulama, Muhammadiyah, and the Coalition for a Healthy Indonesia (KuIS). These NGOs play a major role as catalysts for change and provide leadership on key

health, and child survival.	to build upon Indonesia's successful history in family planning and to support the Badan Koordinasi Keluarga Berencana Nasional (Indonesian population and family information network) (BKKBN) with its New Era Strategy, which focuses on quality improvements and informed choice. • USAID Indonesia has directly supported health sector financing reform since 1988; the Government of Indonesia (GOI) has successfully developed and implemented policy reform in hospital finance, rational drug use, and managed healthcare. • The 1992 National Health Law sets the course for future health sector development in Indonesia. • The Health and Economic Policy Analysis Unit (HEPAU), under the MOH, started with USAID support.	identify systemic problems and help resolve them.	issues that influence policy and quality service delivery at both the national and district levels. • USAID has provided substantial technical and financial assistance to develop the technical and managerial capabilities of BKKBN staff and BKKBN's research and evaluation capacity. • USAID worked closely with BKKBN, the MOH, private sector stakeholders, and other donors to develop the framework for an assistance program that would immediately address the more recent challenges to the FP program, while also continuing an orderly progression toward a graduation that all parties would acknowledge to be timely and warranted. The four critical intervention areas identified within the framework are district-level advocacy, private sector enhancement, quality improvement, and management information strengthening. • *The Asian Development Bank (ADB):* Assisted the GOI in developing decentralized health services. • *The World Bank:* Supported four Centers of Excellence for Voluntary Sterilization and ongoing support for micronutrient programming.
Graduation Strategy			
Policy			
• Complete the capacity building of advocacy and journalist teams in selected districts and at the national level. • Finalize FP advocacy tools and approaches on critical issues related to quality, district funding for family planning, and CS, especially for the poor. • Develop an advocacy scale-up schedule and phase-out plan with KuIS for covering all districts, using intermediary organizations such as IBI, FBOs, KuIS coalitions,			

local advocacy teams, and others that have broad geographic presence and high credibility among the Indonesian population.

- Support for increased role of the private sector and market segmentation in health.
- Achieve the inclusion of managed care in the GOI's seventh Five-Year Plan.

Financing

- Developing a USAID transition strategy for STI/HIV/AIDS involves making a fundamental decision about how much to invest in Indonesia's response to the epidemic.
- Support sustainable financing of health services.
- Support for the General Allocation Grant (DAU) to fund the district FP programs.

HSS

- Expand Bidan Delima (a private sector midwife quality-of-care program) to all remaining districts in the six provinces.
- Expand Bidan Delima to at least 13 more provinces.
- Expand Bidan Delima to all 13 remaining provinces with support from other donors, as necessary.
- Conduct IUD (copper-T) in-service and refresher training for public and private midwives who need such training.
- Assist IBI to provide FP training in its 32 chapter-owned provincial clinics.
- Continue disseminating and promoting the application of the national FP standards and guidelines through orientation workshops at the district, province, and central levels.
- Complete the strengthening of strategic provincial training centers to provide training in quality FP/RH standards and tools.
- Design and test the national EWRRS; develop, design and test a district EWRRS or alternative MIS.
- Train BKKBN central and provincial staff in providing TA for district EWRRS/management information systems (MIS).
- Provide TA for the 2007/8 IDHS.
- Provide support for gender issues.
- Institutionalize a national clinical training system.
- Develop and institutionalize an STI surveillance system.

Human/Institutional Capacity Development

- Assist Muhammadiyah and Nahdatul Ulama to formalize their loose networks of health facilities.
- Assist Muhammadiyah and Nahdatul Ulama to expand FP services to all of their health units.
- If a viable decentralized MIS were found, MSH and STARH would provide TA to central and provincial BKKBN and/or the MOH in developing guidelines for setting up and troubleshooting decentralized FP monitoring systems. BKKBN would provide needed TA to the provinces and districts.

- Strengthen the Bapel, provider groups, and the regulatory body of the MOH.

Lessons Learned/Key Considerations for Graduation

- BKKBN has a history of being a strong, visible, centralized agency with a nationwide presence at the grassroots level. January 2004 represented an historical and critical turning point for BKKBN, as the institution officially decentralized. Authority over FP services was transferred to more than 425 local districts. Planning for decentralization was rushed and many issues related to contraceptive security, roles and responsibilities, funding, and reporting remain unclear. Decentralization of BKKBN offers many opportunities to make local governments responsible and accountable for providing quality services to their citizens. During these initial years of decentralization, much work still remains to ensure the availability of quality services, especially for the poor.
- Funding issues for BKKBN represent a major constraint and serious concern. BKKBN was decentralized rapidly in 2003, and insufficient attention was given at the central and local levels to ensure budgets for 2004–2005. In principle, the district government should use its DAU to fund the district FP program. However, the MOF and the Ministry of Home Affairs agreed to provide special funds for family planning in 2004 and 2005; it is unclear how districts will access these special funds.

APPENDIX 3: ENDOWMENTS IN THE HEALTH SECTOR, 1985–2007

i. Asociación Protección a la Salud (PROSALUD). PROSALUD began in 1985 as a public-private partnership, networking a group of Bolivian health facilities together to service lower-income individuals. USAID made an initial investment of US$1.94 million for the period 1985–90 and agreed that Management Sciences for Health would provide technical expertise to support the new network. USAID funding continued as PROSALUD grew: a US$6.5 million cooperative agreement supported the opening of a 25-bed secondary care hospital in 1993 and further funding helped finance the expansion of the network to a total of nine cities throughout Bolivia.[6] Finally, USAID provided a US$5 million evergreen endowment fund to help PROSALUD expand its services and promote its long-term sustainability.[7] Today, USAID and its implementing partners remain some of the principal supporters of PROSALUD, although the organization's primary revenue comes from out-of-pocket payments from their patients—in 2006, its overall cost recovery rate was more than 82 percent,[8] with the endowment and other donor funds helping to make up the difference. The endowment fund was projected to be worth more than US$7 million in 2007, but current information on its size is not readily available.

ii. Asociación Pro-Bienestar de la Familia (PROFAMILIA). PROFAMILIA was founded in 1965, joined the IPPF in 1967, and is currently the largest provider of FP services in Colombia. PROFAMILIA began receiving USAID funds in 1967 and remained a USAID partner until 1993, when—linked with certain graduation criteria—it was established as an independent business within Colombia.[9] As part of this graduation process, PROFAMILIA received an evergreen fund from USAID in 1993, endowed with US$6 million, to serve as a "long-term financial cushion."[10] This endowment has been used primarily to pay for renovations and to maintain PROFAMILIA's diversification of services following the end of USAID direct assistance. PROFAMILIA's revenue, however, is generated primarily through three venues: a widely recognized social marketing apparatus, public sector contracts to support social programs, and outpatient clinics at which RH services are provided above cost but below other clinics' charges.[11] Currently, PROFAMILIA is a sustainable business—it receives USAID funds only for its social programming[12] and not directly to cover regular operating expenses.

iii. International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B). ICDDR,B was originally established by the South East Asian Treaty Organization (SEATO) as the Pakistan SEATO Cholera Research Laboratory in 1960 with the support of U.S. collaborators and funds. The organization was run jointly by SEATO and Pakistan out of Dhaka, East Pakistan. When East Pakistan became the independent nation of Bangladesh in 1971, the lab's activities continued, albeit on a smaller scale. In 1979, the organization converted to an international research center—with the United States reconfiguring its bilateral aid agreement to produce an "autonomous agency in which interested countries may participate both financially and in the determination of policy and program… [it] can readily become a mechanism for international assistance … [and it] can receive grants and operate freely so long as it maintains the confidence of contributing nations and organizations."[13] In 1996, USAID's Office of

[6] Retrieved from http://info.worldbank.org/etools/docs/library/48622/oj_prosalud.pdf
[7] Retrieved from http://pdf.usaid.gov/pdf_docs/PNADB909.pdf
[8] Retrieved from http://www.abtassociates.com/presentations/apha2006_PROSALUD.pdf
[9] Retrieved from http://www.profamilia.org.co/pdfs/historia_profamilia.pdf
[10] Retrieved from http://pdf.usaid.gov/pdf_docs/PNADB909.pdf
[11] Retrieved from http://www.rhsupplies.org/fileadmin/user_upload/toolkit/B_Advocacy_for_RHS/The_FP_Graduation_Experience-Lessons_for_Future.pdf
[12] Retrieved from http://www.profamilia.org.co/index.php?option=com_content&view=article&id=246&Itemid=179
[13] Retrieved from http://profiles.nlm.nih.gov/ps/access/VVBBGP.pdf

Population, Health, and Nutrition provided US$1 million for an evergreen[14] endowment fund, as it—at that time—had already contributed up to US$50 million to the organization and was responsible for 25 percent of the ICDDR,B budget. The hope was to use the endowment to leverage up to 10 percent of the ICDDR,B's operational expenses. This appears to have been successful. As of 2010, the ICDDR,B did not include USAID on its list of primary donors.[15] USAID is acknowledged, however, as contributing to the independent ICDDR,B's programs.[16]

iv. CARE Reproductive Health Trust Fund. The Reproductive Health Trust Fund is a cooperative agreement supported by investments from USAID and CARE private donors. It currently totals US$14.5 million,[17] with US$9 million provided in 1999 by USAID as a 15-year sinking fund.[18] The Trust Fund was designed to support the institutionalization of RH programming within CARE and a core capacity to implement FP and other RH programs worldwide. The trust fund replaced CARE USA's central USAID grant support, which was withdrawn in 2003. While USAID no longer offers central support, it does fund multiple projects on which CARE International works as an implementing partner. In 2009, it received US$33 million in P.L. 480 freight, US$61 million in P.L.480-donated food, and US$108 million in USAID contracts.[19]

v. International Planned Parenthood Federation/Western Hemisphere Region – Endowment Fund for Sustainability (IPFF/WHR). The IPFF/WHR Endowment Fund was established in 1999 by USAID and the IPPF/WHR board of directors to enhance the sustainability of the Western Hemisphere Regional Office. The fund is a source of low-interest loans and grants for IPPF/WHR FP association affiliates[20] for income generation and sustainability efforts. USAID endowed the fund with US$4 million and IPPF provided US$1 million in an evergreen arrangement. The fund has grown substantially in the intervening years: according to the organization's 2005 financial statements, it had reached US$27,795,752, thanks to an US$18 million bequest added to the fund in 2002. In 2005, the board of directors approved an annual spending rate of 3.5 percent of the three-year rolling average for the Fund.[21] According to the Better Business Bureau, the organization used US$1.5 million from the endowment fund in its 2010 operations.[22] The IPFF/WHR 2009 tax returns indicated that it still did business with USAID, including investing funds on USAID's behalf;[23] however, it was not (as of 2009) receiving USAID or other USG support.[24]

vi. Family Life Association Swaziland (FLAS). FLAS was founded in 1979 to promote family planning at nominal or no cost in Swaziland. Its services since have been expanded to include ante- and post-natal services, along with STI treatment. USAID had been involved in supporting the organization's recurrent expenses but wanted to increase the sustainability of FLAS's operation. In anticipation of withdrawing all independent USAID funding from FLAS in 1995, USAID developed a US$1.7 million endowment for FLAS in 1993. The hope was that the endowment would eventually cover about 25 percent of FLAS's recurrent expenses, with enough interest/income remaining to reinvest and maintain the fund's capital value. The endowment became fully operational only in 1997, after a three-year program period of

[14] Evergreen funds are designed to last in perpetuity, with the original capital remaining intact over time. They are established "If an organization has ongoing financial needs that cannot or will not be covered by other sources and USAID believes that continuous support is viable and necessary."
[15] Retrieved from http://www.icddrb.org/who-we-are/about-us/our-donors
[16] Retrieved from http://www.icddrb.org/what-we-do/research/arsenic-in-tubewell-water
[17] Retrieved from http://pqdl.care.org/CuttingEdge/What's%20Innovative.pdf
[18] Retrieved from http://pdf.usaid.gov/pdf_docs/PNADB909.pdf
[19] Retrieved from http://www.pvo.net/usaid/pvo.asp?i=67&INCVOLAG=YES&INCSUM=YES&VolagText=
[20] Retrieved from http://pdf.usaid.gov/pdf_docs/PDABQ547.pdf
[21] Retrieved from http://apps.sos.wv.gov/business/charities/readpdf.aspx?DocID=50580
[22] Retrieved from http://www.bbb.org/charity-reviews/national/health/international-planned-parenthood-federation-western-hemisphere-region-in-new-york-ny-2486
[23] Retrieved from http://www.ippfwhr.org/sites/default/files/2009_IPPFWHR_Form_990_PIC.pdf
[24] Retrieved from http://pvo.usaid.gov/usaid/ipvo.asp?i=2808&INCVOLAG=YES&INCSUM=YES&VolagText=

evaluation, which recommended that FLAS further diversify its stocks to generate a sustainable level of returns.[25] While USAID remains a donor to FLAS, FLAS has been able to achieve relative financial independence, recently becoming a fully accredited affiliate member of the IPPF.[26]

vii. Ghana Social Marketing Foundation (GSMF). GSMF was established by USAID as a spin-off in 1993, charged with implementing FP and contraceptive social marketing programs across Ghana. In 1997, USAID/Ghana developed a sinking [27] endowment fund of US$5 million to help ensure GSMF's financial sustainability—a fund that would be turned over to GSMF after certain benchmarks were achieved. Following a very negative audit, however, it was determined that those benchmarks had not been achieved, and the endowment was not turned over to sole GSMF control. Indeed, following the audit, USAID ceased any further partnerships with GSMF after 2005, and lobbied for U.S. taxpayer dollars to be routed through other Ghanaian organizations. Unfortunately, USAID has been unable to retrieve the endowment from the Ghanaian bank where it is lodged without the approval of GSMF leadership—who have been loath to let the money go. A lawsuit—filed in February 2011—currently is pending in the District of Columbia District Court to negotiate this issue. The pitfalls experienced with the GSMF endowment represent several healthy cautions: partners cannot be manufactured, the trusting transition to an endowment arrangement cannot be rushed, and a thorough vetting of the organization—as well as the establishment of benchmarks as part of the process—can serve as important analytic tools in determining organizational fit.

[25] Retrieved from http://pdf.usaid.gov/pdf_docs/PNABY616.pdf, http://pdf.usaid.gov/pdf_docs/XDABM425A.pdf
[26] Retrieved from http://www.ippf.org/en/Where/sz.htm
[27] A sinking endowment provides a stream of income, comprising the endowment's interest and principal, over a specified period. This endowment is used if a project or initiative has a specific timetable in which it can or must be completed, or if the recipient organization is expected to seek additional funding sources to supplement/replace USAID funds.

Key:
USAID Health Sector Legacy Mechanisms

APPENDIX 4: USAID LEGACY MECHANISMS, 1985–2007

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
Albanian American Enterprise Fund (AAEF)	Enterprise Fund	1995	Albania	Economic Development	Established in 1995 with a USAID grant of US$30 million. In 2004, US$21.1 million had been spent.	The fund's investments "stimulated the Albanian economy by providing growth and export-oriented small and medium enterprises with access to equity, loans, and leases." The AAEF continues to consolidate and improve the quality of its portfolio and strengthen new investment opportunities.	Source: http://www.state.gov/p/eur/rls/rpt/55641.htm	
American University of Armenia (AUA)	Endowment	1999	Armenia	Education	The USG supported the University through the granting of a precedent-setting Congressional allocation through USAID as an endowment for AUA and multiple annual grants through USAID's office of American Schools and Hospitals Abroad (ASHA).		Source: http://www.aua.am/about/history.html	
International Center for Diarrheal Disease Research (ICDDR, B)	Evergreen Endowment	1996	Bangladesh	Health	"The (ICDDR/B) was authorized in May 1996 through dollar appropriated funds, initially to provide a measure of financial security to the institution. ICDDR/B was founded in 1978; since that time, USAID has invested approximately US$50 million in ICDDR/B activities. Although USAID historically has been ICDDR/B's largest donor, today the Agency provides about 25 percent of the organization's annual support. However, USAID continues to be the single largest donor in absolute terms. The US$1 million endowment is expected to leverage an additional US$3 million within one year of its disbursement, and an additional	2011 United Nations appoint ICDDR,B Executive Director to head independent panel probing cholera outbreak in Haiti. 2010 ICDDR,B sends teams to combat deadly cholera outbreaks in Pakistan and Haiti. ICDDR,B research team discovers and characterizes the "TLC phage," which changes the chromosomal sequence of the cholera bacterium, enabling incoming toxigenic CTX phage genome to be	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf and http://pdf.usaid.gov/pdf_docs/PNADB909.pdf; http://www.icddrb.org/who-we-are/achievements (Achievements)	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
					US$6 million (for a total endowment of US$10 million) after four years. An endowment of US$10 million could be expected to provide almost 10 percent of ICDDR/B's annual budget. The endowment funds are managed by the Child Health Foundation, a U.S."	incorporated and transforming a harmless strain of V. cholerae into a dangerous killer. ICDDR,B issued its first patent from the Director of the United States Patent and Trademark Office (United States Patent US7638271) for inventing a new diagnostic method for tuberculosis—antibodies produced by peripheral blood lymphocytes in culture supernatant, or ALS.		
Asociación Protección a la Salud (PROSALUD)	Evergreen Fund	1997	Bolivia	Health	US$5 million endowment from USAID in 1997, but began with initial funding from USAID in 1985.		Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
American University of Bulgaria (AUBG)	Sinking Fund	1997	Bulgaria	Education	Formed in 1991 with substantial USAID support and financial assistance; it was incorporated in Maine and chartered in Bulgaria. In 1997, USAID established a US$15 million 10-year sinking fund for the long-term financial sustainability of AUBG.	This fund was spent down faster than anticipated. Consequently, the endowment was recapitalized and a second endowment, this time an evergreen endowment, is in the final stages of planning and development.	Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
Bulgarian American Enterprise Fund (BAEF)	Enterprise Fund	1991	Bulgaria	Economic Development	Was authorized US$58.250 million by USAID, and by 2004 had expended US$57.850 million.	The BAEF has been instrumental in shaping legislation that has fostered new types of financial products, such as home mortgages, private pension plans, and capital markets. In 2003, the BAEF concluded its 11th full year of operations, showing a net increase in fund balance from operations of US$631,000 on total investment income of US$2.5 million. The total portfolio grew 7 percent over 2002, from US$46.5	Source: http://www.state.gov/p/eur/rls/rpt/55641.htm	BAEF presented a US$27.5 million check to USAID on Nov. 24, 2008 (http://www.usaid.gov/press/frontlines/fl_feb09/p5_enterprise.html)

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
						million to US$50 million, with reflows increasing from US$4.6 million in 2002 to US$5.3 million in 2003. During the year, BAEF disbursed US$5.2 million in the form of new loans and equity investments. Since 1992, BAEF has made more than US$73 million in loans and equity investments. BAEF's total investments (by sector) are as follows: construction and housing 33 percent; consumer goods, 27 percent; hotel and services, 21 percent; agriculture, agribusiness, and food processing, 17 percent; and financial services, 2 percent.		
Nachala Cooperative	Foundation	1997	Bulgaria	Economic Development	Nachala started in 1993 but was re-registered as a credit cooperative in 1997, with financial support from USAID due to the financial and banking crisis.		Source: http://www.european-microfinance.org/membres_en.php?pild=8079	
Ustoi		1998	Bulgaria	Economic Development	Ustoi Joint Stock Company is the legal successor of the Ustoi microfinance program of CRS/Bulgaria. The microfinance program was launched in 1998 with USAID support as part of the latter's "Economic Growth Initiative."	Problems faced included donor dependence, single product focus, and need to expand the client base.	Source: http://www.usaid.gov/locations/europe_eurasia/countries/bg/pdfs/assessments/microfinance_assessment.pdf and http://www.ustoi.org/read.php?name=22&lang=en	Ustoi website notes that "significant growth and outreach have been achieved with USAID financial support."
America for Bulgaria Foundation	Foundation	2007	Bulgaria	Economic Development	The foundation was to be endowed with US$200 million from the BAEF. As the BAEF "winds down its investments, its assets will be transferred to the America for Bulgaria Foundation… [to be] guided by a volunteer board of directors and organized as a 501(c)(3)."		Source: http://bulgaria.usaid.gov/cdir/bulgaria.usaid.gov/files/America-for-Bulgaria-en.pdf and http://www.americaforbulgaria.org/files/2009_Financial_Report.pdf	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
Bulgaria Fund	Grant-making Initiative Fund	2007	Bulgaria	Democracy and Governance	The Bulgaria Fund was a three-year, US$3-million grant-making initiative of USAID and the German Marshall Fund of the United States (GMF).		Source: http://www.gmfus.org/cs/grant-making/the_bulgaria_fund	
The Bulgarian Institute for Legal Initiatives (BILI)		2006	Bulgaria	Legal Reform	Formed as a legacy of USAID's Attorneys' Professional Development Initiative (APDI). BILI is a USAID legacy NGO.		Source: http://www.bili-bg.org/8/page.html and http://bulgaria.usaid.gov/19/news_item.html	
Program for the Development of the Judicial System (PDJS)		2007	Bulgaria	Judicial Reform	Established by the implementers of USAID's Judicial Strengthening Initiative. Its Court Improvement Plan (CIP) was approved by the Supreme Judicial Council and has been implemented in more than 40 courts.		Source: http://developmentaid.org/view_organization?org_id=148	
The Bulgarian Center for Development and Training (BCDT)		2005	Bulgaria	Democracy and Social Justice Training	Established in 2005 as a legacy of the USAID Participant Training Program in Bulgaria (93–07).		Source: http://bcdt.atspace.com/index.html	
Central Asian American Enterprise Fund (CAAEF)	Enterprise Fund	1994	Central Asia	Economic Development		"During its active operating years, CAAEF entered into 27 joint ventures with equity (or equity plus debt) financing totaling US$61.5 million, granted 352 loans to establish or expand small and medium-sized enterprises (SMEs) totaling US$37.3 million, extended 8 direct loans totaling US$8.0 million (that by size or type fell beyond the terms of The Fund's SME Loan Program), and funded more than 3,000 micro-credit loans totaling US$10.4 million."	Source: http://www.caaef.com/	
PROFAMILIA	Dollar-appropriated Endowment	1993	Colombia	Health	"In October 1993, USAID funded a US$6 million endowment to PROFAMILIA. PROFAMILIA concluded that an endowment,	"Following a meeting with a PEF board member and a review of the PEF board minutes, the evaluation	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf;	

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					combined with increased cost-recovery and diversification of services, would be the most effective financial mechanism to increase its revenues. The endowment's primary investment strategy is to guarantee PROFAMILIA a consistent annual source of income in anticipation of USAID's phase-out of population activities in Colombia. The endowment fund has a three-member Board of Directors and is managed by a U.S.-based investment bank. The fund was financed with an initial tranche of US$4 million; US$2 million was disbursed in the second year. In September 1996, after the endowment's initial appreciation, PROFAMILIA will begin receiving 95 percent of the interest/dividends earned from the US$6 million investment fund."	team concluded that the Board should be expanded from three to five persons and that it should be more proactive." (1995)	http://pdf.usaid.gov/pdf_docs/PDABL416.pdf	
Arias Foundation for Peace and Human Progress	Foundation	1993	Costa Rica	Women; Conflict Resolution; Demilitarization and Disarmament; Philanthropy	USAID provided an endowment to the Arias Foundation, which had been established by former Costa Rican President Oscar Arias Sanchez with the award from his 1987 Nobel Peace Prize. The foundation has an endowment of approximately US$2 million as well as a diverse funding base. In 1993, USAID provided a US$500,000 endowment, the earnings of which are to cover part of the foundation's operating expenses, to help ensure the financial sustainability of the organization.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Agricultural College of the Humid Tropical Region		1985	Costa Rica	Environment	Given US$60,000,000 by USAID.	There was a three-year delay in transferring funds to the Agricultural College, resulting in a US$14.1 million	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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						decrease in the projected principal in 1990.		
Foundation for the Development of the Central Volcanic Cordillera Region (FUNDECOR)	Foundation	1990	Costa Rica	Environment	"In April 1989, USAID and the Government of Costa Rica signed a bilateral agreement for a US$17.5 million project (FORESTA) to support the sustainable development of the Central Volcanic Conservation Area of Costa Rica. Under this project, the Foundation for the Development of the Central Volcanic Cordillera Region (FUNDECOR) was established to promote natural forest management and reforestation of the area. FUNDECOR functions as a regional development agency, an integrated forest consulting firm, and a credit agency. One of the reasons for setting up this endowment was to fund the operations of the foundation after FORESTA project support ended. USAID provided FUNDECOR with a US$10 million endowment from host country-owned local currency, the income from which covers operating expenses. FUNDECOR did not start using the endowment until March of 1996, but it had been capitalizing since 1990. There also is a built-in periodic program evaluation of FUNDECOR. The endowment funds are invested, through a private, local bank in Costa Rica, in the stock market and in government bonds."		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Costa Rican Export Promotion Fund (FUNDEX)		1990	Costa Rica	Trade/Export Promotion	In 1990, the Government of Costa Rica and USAID agreed to allocate US$27.15 million to FUNDEX from Economic Support Funds (ESF) local currency. The	An evaluation of FUNDEX was conducted in 1995 to determine whether or not funding for trade liberalization should	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					main beneficiary of FUNDEX was the Costa Rican Coalition for Development Initiatives (CINDE), a private sector institution established in 1982 with USAID support. Regarding USAID oversight, USAID was to assume an active role in monitoring of fund operations during the first four years.	continue and, if so, under what conditions. The evaluation concluded that the impact of the fund was positive and that there was a continuing need for financing (USAID 1995c:44-49). The evaluation also found that FUNDEX unfairly held up funds for CINDE in 1994. FUNDEX granted funds to CINDE based on a performance score related to CINDE's achievements. The evaluation noted that FUNDEX's monitoring methodology had a counterproductive effect on CINDE's capacity to implement its programs, since it was incorrectly imposing financial cuts to important and successful programs (USAID 1995c:45-47). The USAID Mission and the Government of Costa Rica have agreed to continue funding for trade liberalization under the overall umbrella of the Costa Rica/USA Foundation, rather than maintaining a separate fund with its own administrative costs.		
Costa Rica/USA Foundation	Grant-making Foundation	1996	Costa Rica	Broad/Sustainable Development	The foundation was created to continue development activities when the USAID Mission closed in 1996. To establish the endowment, the foundation received resources remaining in selected local currency trust funds managed by USAID/Costa Rica. The endowment currently is worth US$12 million but is expected to reach US$25 million.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Agric. College of the Humid	Local Currency	1985	Costa Rica	Agricultural Education	In 1985, USAID and the Government of Costa Rica	There was a three-year delay in transferring funds to	Source: http://pdf.usaid.go	

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Tropical Region (EARTH)	Endowment Fund				agreed to jointly fund the establishment of the Agricultural College of the Humid Tropical Region (EARTH), a four-year undergraduate institution. To achieve the long-term financial viability of the college, a US$60 million local currency endowment fund was established. The endowment was designed to help cover the college's operating expenses. A Board of Trustees manages the income from the endowment, which is invested in the Central Bank of Costa Rica. USAID also provided grants to EARTH during the period 1985–1995, mainly for the construction of the university.	the Agricultural College, resulting in a US$14.1 million decrease in projected principal in 1990.	v/pdf_docs/PNABY616.pdf	
Technical Services to the AID/FEDECOOP Special Trust	Trust	1990	Costa Rica	Agriculture	AID was not a party to the contract that created this project but was the source of the funds in the trust.	Phase 1 of the project included giving loans to individual farmers; Phase 2 included giving loans to local cooperatives. The coffee credit project was "narrowly successful in providing the projected support to the economy in the crisis years of the mid-80s... cooperatives were strengthened... But there were serious credit delivery design defects attributable to AID, and sloppy lending procedures...these conditions led to the feeling among the farmers that repayment was not essential."	Source: http://pdf.usaid.gov/pdf_docs/PDABJ115.pdf	
Foundation for Civil Society Development	Foundation	2003	Croatia	Civil Society Capacity Building	USAID selected the foundation to receive long-term TA over nearly two years to strengthen it and promote its sustainability.		Source: http://www.usaid.gov/stories/croatia/pc_hrv_civil.html	
Czech-Slovak American Enterprise Fund	Enterprise Fund	1991	Czech Republic and Slovakia	Economic Development	The Czech-Slovak American Enterprise Fund (CSAEF) was established in 1991 and		Source: http://www.state.gov/p/eur/rls/rpt/556	

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					capitalized with a US$65.0 million USAID grant. In 2003, the CSAEF committed US$8.8 million to three new investments. The two most significant were the Value Growth Fund Slovakia (US$5.7 million) and Gotive (US$2.7 million). The fund is a founding investor in the Value Growth Fund, along with the European Bank for Reconstruction and Development (EBRD), Raiffeisen, and a locally owned bank, Tatrabank, for a total of US$14 million (about US$16.8 million).		41.htm	
Agricultural Development Foundation (ADF)	Foundation	1987	Dominican Republic	Agriculture	USAID provided a grant to the Agricultural Development Foundation (ADF) in 1987 to promote research in nontraditional crops, establish a rapid-response capability for agribusiness and farmers, establish a technical information center, and set up an endowment to support the foundation. The endowment was established in 1988 with approximately US$4 million in local currency.	The foreign exchange rate fell, leaving the endowment with about US$2.7 million at the time of the evaluation (1993)—slightly more than half of its starting value.	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Superior Inst. Of Agriculture (ISA)	Grant/Endowment Fund	1989	Dominican Republic	Agricultural, Education, and Research	USAID had been providing support to ISA since its creation in 1962. In 1989, USAID and the GODR agreed to provide ISA with a large grant to enhance its educational and research capacities in nontraditional agricultural exports. The grant provided for the "strengthening" of an endowment fund to generate sufficient income to meet ISA core costs and provide faculty and staff with adequate salary levels. The endowment was established with US$2.4 million in local currency generated from ESF.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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Junta Agro-empresarial Dom. (JAD)	Endowment	1992	Dominican Republic	agricultural development	The endowment was established in 1992 using host country-owned local currency from PL-480 commodity sales and ESF agreements; the current dollar value of the endowment is US$1,260,000. The purpose of the endowment is to encourage the financial sustainability efforts of JAD, a promising NGO partner; in reality, the endowment will provide more of a financial "cushion" than independence. There is a requirement for leveraging the endowment funds; if the match is not met within a specified timeframe, the endowment grant will revert to a loan.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Fund. Economia y Desarrollo (FEyD)	Endowment	1994	Dominican Republic	Economic Development	The endowment for FEyD was established in 1994 using host country-owned local currency from PL-480 commodity sales and ESF agreements. The current dollar value of the endowment is US$652,000 [written in 1996]. Endowment earnings will provide about 30% of FEyD's basic annual income. There is a requirement for leveraging the endowment funds; thus far, FEyD has raised 7.5 million pesos of the 9 million pesos required for the match. The endowment funds are invested and managed locally.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Pontificia Univ. Catolica Madre y Maestra (PUCCM)	Endowment	1994	Dominican Republic	Democracy	An endowment was established for PUCCM under USAID/Dominican Republic's Democratic Initiatives project. It has a current [1996] dollar value of US$435,000. The endowment was established using host country-owned local currency from PL-480 commodity sales and ESF agreements. There is a requirement for leveraging the		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					endowment funds; the endowment principal will revert to a loan if the required match is not met. The endowment funds are invested and managed locally (Sources: (1) Phone interview with J. Michael Deal, USAID/Dominican Republic, 6/4/96. (2) Information provided by Luis C. Gonzalez, USAID/Dominican Republic).			
The Institute for Agricultural Studies (IDEA)	Endowment	1985	Ecuador	Agriculture	Created in 1985 under a grant agreement between USAID and the Government of Ecuador. The US$400,000 endowment was established by USAID from PL-480 local currency.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Fundagro (Fundacion para el Desarrollo Agropecuario) (FUNDAGRO)	Foundation	1988	Ecuador	Agriculture	In 1986, the Government of Ecuador established FUNDAGRO. In 1988, USAID provided FUNDAGRO with the local currency equivalent of US$3 million from PL-480 funds for an endowment.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Ghana Social Marketing Foundation (GSMF)	Sinking (20 years)	1993	Ghana	Health			Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
Ghana Heritage Conservation Trust	Evergreen Trust	1998	Ghana	Environment			Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
Ghana Community Enterprise Development & Investment Trust	Endowment/Trust	1992	Ghana	Enterprise Development	One of the first trusts created with funds generated from monetization of the U.S. PL-480 Title II Program. Endowments created through Title II monetization were prohibited by U.S. law until November 28, 1990, when the Agricultural Trade Development and Assistance Act of 1954 was amended. USAID provided US$3 million.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
CARE — Reproductive	Trust Fund	1999	Global	Health - Reproductive	The fund is a cooperative agreement supported by	Major Care RHTF Programming: Social	Source: http://pqdl.care.or	

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Health Trust Fund (RHTF)				Health	investments from USAID and CARE private donors, totaling US$14.5 million. The RHTF was designed to support the institutionalization of RH programming within CARE and a core capacity to implement family planning and other RH programs worldwide.	Change for Family Planning Results Initiative (http://www.care.org/campaigns/mothersmatter/downloads/SCFP_Series_1.pdf); Innovations Projects;	g/CuttingEdge/What%27s%20Innovative.pdf	
International Planned Parenthood Federation/Western Hemispheric Region (IPPF/WHR) – Endowment Fund for Sustainability	Evergreen Trust	1997	Global	Health - Family Planning	USAID made it possible for IPPF/WHR to initiate sustainability activities through funding the Transition Project from 1992 through 1997. The Endowment Fund for Sustainability was established in 1997 to benefit the IPPF/WHR). The EFS not only provides the necessary capital, but also enables the sharing of knowledge and expertise regarding sustainability gained during the Transition Project to all IPPF/WHR regional affiliates, and potentially other health NGOs in the region. IPPF/WHR, founded in 1954, is a network of FP NGOs throughout the LAC region, affiliated through common goals and funding. The US$4 million evergreen endowment [from USAID] serves as a permanent source of financing to support the organization's sustainability within the region.	The Endowment Fund for Sustainability offers IPPF/WHR Member Associations low-interest loans to invest in assets, such as medical equipment and new clinics, to sustain their programming and service. (http://www.ippfwhr.org/en/buildingstrongerinstitutions)	Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf; http://pdf.usaid.gov/pdf_docs/PDABQ547.pdf	
AMLGF Trust Fund > PRIDE/FINANCE	Trust Fund	1992	Guinea	Agriculture	A US$20 million project (US$12.5 million USAID Grant and US$7.5 million in local currency equivalent) between USAID and the Government of Guinea.	Evaluators found that the performance of AMLFG was inadequate and that it did not constitute a viable investment. Recommended action included the dissolution of the AMLFG. Funds were redirected to PRIDE/FINANCE, a local institution supported by USAID but moving toward formalization as an	Source: http://pdf.usaid.gov/pdf_docs/PNACH185.pdf	

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						independent financial institution, to continue supporting AMIP.		
Centro Asesor para el Desarollo de los Recursos Humanos/Advisory Council for Human Resources (CADERH)	Endowment	1995	Honduras	Education	In August 1995, USAID established a US$600,000 funded endowment for CADERH, which was formed in 1982.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Honduran Agricultural Research Foundation (FHIA)	Endowment/Foundation	1993	Honduras	Agriculture	In 1984, USAID helped establish FHIA, awarding a 10-year grant to assist with the foundation's operating and program expenses. In 1993, USAID and the GOH granted funds to FHIA for the establishment of an endowment. Local currency for the endowment was generated from ESF. There is a requirement for FHIA to match a percentage of the total USAID/GOH contribution to the endowment. The formula was designed to encourage FHIA to expand the endowment and build a long-term support constituency for its research.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Honduran Environmental Trust Fund (Fund. Vida)	Trust Fund	1993	Honduras	Environment	Started by USAID/Honduras to capitalize an Environmental Protection Fund (FOPMA). Funds for the endowment include US$10 million in local currency generated from PL-480.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Pan-American Agric. School (Zamorano)	Endowment	1987	Honduras	Agricultural Education	From 1942 to 1957, Zamorano covered its finances from a trust fund established by the United Fruit Company and after that from additional funds generated by student fees, private and public donations, and sales of products grown at the school. In 1987, negotiations were conducted between Zamorano, GOH, and USAID regarding the		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					possibility of securing a USAID grant to expand the endowment. Negotiations were concluded that year, and a project agreement provided Zamorano with the local currency equivalent of US$15 million to establish an endowment. There is a 25% matching requirement to encourage the school to mobilize funds from other sources.			
Hungarian-American Enterprise Scholarship Fund	Investment Fund	1989	Hungary	Economic Development	USAID appropriated a total of US$1.3 billion to establish 10 new investment funds, known collectively as the Enterprise Funds, throughout Central and Eastern Europe and the former Soviet Union.		Source: http://www.haesf.org/	
Hungarian-American Enterprise Fund (HAEF)	Investment Fund	1990	Hungary	Economic Development	As of September 30, 2003, HAEF had fully drawn down US$72.5 million from the grant and invested about US$130 million in Hungarian enterprises.		Source: http://www.state.gov/p/eur/rls/rpt/55641.htm	
Indonesia Biodiversity Foundation (KEHATI)	Foundation	1995	Indonesia	Environment	Once KEHATI was established [in 1994], it took about 15 months to meet the USAID "grant-worthiness" requirements so that the endowment could be funded. A total of US$19 million was provided to the new foundation; of that, US$16.5 million became the endowment principal. Of the remaining funds, US$1.25 million went to KEHATI's initial operating costs, and the remaining US$1.25 million was used for an interim grants program. The cooperative agreement requires that a certain percentage of the annual earnings from the endowment be added to the endowment principal as a hedge against inflation (so the	Setting up the new foundation and endowing it was very time consuming, requiring about three years of full-time effort (over a six-year period).	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					dollar value of the endowment will remain constant over time). There was no firm requirement for additional fund-raising (only on a "best-efforts" basis) and the endowment is meant to exist indefinitely.			
The Jamaica National Parks Trust Fund	Trust Fund	1990	Jamaica	Environment	USAID negotiated with the Nature Conservancy and the Government of Jamaica to convert approximately US$400,000 in U.S. dollar debt to a local currency endowment held by a national environmental NGO, the Jamaica Conservation and Development Trust (JCDT) (Church et al. 1994c:5-6).	The trust had more than doubled its initial investment upon evaluation in 1994.	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
American Center for Oriental Research	Evergreen Trust	1997, 1999, & 2001	Jordan	Historic Preservation			Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
National Environment Endowment Foundation (NEEF)	Foundation	1996	Madagascar	Environment	NEEF was established under USAID/Madagascar's Knowledge and Effective Policies for Environmental Management (KEPEM) Project. The equivalent of US$6 million in local currency was provided for an endowment. NEEF was recognized as a formal institution on January 25, 1996. It was estimated that the foundation would be able to grant approximately US$250,000 in 1997.		Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
Mexican Fund for the Conservation of Nature (FMCN)	Endowment	1996	Mexico	Environment	As a prerequisite for setting up the endowment, institutional strengthening of FMCN was made a priority. USAID provided US$500,000 in 1994 for start-up and training activities. The World Wildlife Fund and the Nature Conservancy assisted with the development of FMCN and the design of the endowment.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					USAID funding in dollars was US$19.5 million. The endowment agreement calls for USAID oversight for 10 years, during which time USAID will retain the right to approve FMCN investment management contracts for the USAID account.			
Nepal National Social Welfare Association (NNDSWA)	Endowment	1993	Nepal	Education	A US$600,000 endowment was established in 1993 with Save the Children-U.S. (SCUS) on behalf of a local NGO NNDSWA. USAID has two voting positions on the NNDSWA Board of Directors for the duration of the cooperative agreement that established the endowment, and for seven years thereafter. The endowment funds are managed by SCUS, and are invested in the United States.	[Between 1996 and 1999] more than 1,300 students have received scholarships.	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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Trust for Voluntary Organizations	Trust	1988	Pakistan	All	US$30 million obligated and disbursed by USAID.	Lessons learned: ensure perpetuity of funds/financial solvency, defining roles of the board versus the staff can be difficult, and donor control can be both positive and negative.	Source: http://pdf.usaid.gov/pdf_docs/PDABL053.pdf	*Document has several pages on the fund's accomplishments, lessons learned, and sustainability measures.
Ecological Trust Fund for Fundación Natura – part of the MARENA project	Trust Fund	1995	Panama	Environment	The US$25 million endowment was funded by USAID (US$8 million), the Nature Conservancy (US$2 million), and the Government of Panama (US$15 million, consisting of reflows from a previous USAID project). The endowment is set up as a trust agreement, with the Nature Conservancy as trustee. The Fundación Natura, a Panamanian NGO, is the endowment beneficiary. Half of the endowment earnings are designated for the Government of Panama's Institute for	Upon creation, no local NGOs with sufficient experience to manage the endowment could be identified. The Mission used a U.S. NGO as a financial intermediary and to provide programmatic oversight as a result.	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					Renewable Natural Resources to carry out environmental activities related to the MARENA project; the remainder is for grants to Panamanian NGOs. The activities of the Fundación Natura will continue after the MARENA project ends and USAID/Panama closes (Sources: (1) USAID 1995d. (2) Interview with Michael C. Trott, M/AS/OMS, 5/24/96. (3) Conference call with Guy Branch, George E. Like, and Jesus Saiz, USAID/Panama, 5/28/96).			
National Trust Fund for Protected Areas (FONANPE)	Trust Fund	1992	Peru	Environment	FONANPE was created as a trust fund in 1992. At the same time, GOP created PROFONANPE, a nonprofit, to manage the fund and direct the use of its investment proceeds.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	*Not USAID funded.
Foundation for the Philippine Environment (FPE)	Foundation	1992	Philippines	Environment	The Foundation for the Philippine Environment (FPE), an NGO, was established in 1992 to manage a proposed USAID-funded endowment. The purpose of the foundation is to provide grants for environmental activities to Philippine NGOs. USAID provided US$18 million for two debt-for-nature swaps, which yielded US$22 million for the endowment principal and additional funds for the foundation's initial operating costs and an interim grants program. Philippine Business for Social Progress (PBSP), a well-respected Philippine NGO, managed the foundation's initial program activities until permanent staff were selected.	Problems faced include developing a consensus for the foundation among a wide range of NGOs and equipping locals with the knowledge of how to run a foundation.	Sources: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf and http://pdf.usaid.gov/pdf_docs/PNABS326.pdf	

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Polish American Enterprise Fund (PAEF)	Enterprise Fund	1990	Poland	Economic Development		"The PAEF invested US$181 million in 50 medium size companies, 15 of which are now listed on the Warsaw stock exchange. It started a small business loan program that has made 7,000 loans totaling US$272 million to small businesses, launched a micro-enterprise fund that has made 30,000 loans totaling US$50 million, established a mortgage bank that financed 3,000 residences with US$40 million, and raised US$262 million in non-U.S. Government capital for investment in Poland. It converted its staff into a permanent venture capital manager in charge of three private investment funds plus the PAEF. They invested more than US$700 million in Poland, including reflows of capital. It is estimated this number will probably reach over US$1 billion in three more years."	Source: http://www.usaid.gov/press/releases/2000/fs000711_5.html	
Luso-American Development Foundation	Foundation	1985	Portugal	Economic, Social & Cultural Development	The foundation served as the focus of USAID/Portugal's "graduation" strategy, receiving an endowment of approximately US$118 million in local currency derived from ESF. Originally, there was extensive U.S. involvement in the management of the foundation; the U.S. ambassador served as an active board member, and the USAID representative served as the foundation's first executive director. However, the direction and management of the foundation eventually became predominantly		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	

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					Portuguese, and the U.S. ambassador no longer serves on the Board. The foundation has international recognition, but there is mixed reaction regarding the extent to which its U.S.-Portuguese "partnership" objective has been achieved. There have been no formal evaluations of the endowment (Sources: (1) Interview with David Leibson, G/ENR\UP, 6/13/96. (2) USAID 1989b).			
Black Sea Trust for Regional Cooperation	Trust	2006	Regional	Democracy and Governance	The trust was created in 2006 as a US$30 million grant-making initiative that supports democracy, good governance, and regional cooperation in the wider Black Sea region. It is a public-private partnership of the GMF and the Charles Stewart Mott Foundation, the Ministry of Defense of Latvia, the Government of Romania, and USAID.		http://pdf.usaid.gov/pdf_docs/PNADS397.pdf	
Enterprise for the Americas Initiative (EAI)	Multiple Endowments	1990	Regional/LAC	Debt Reduction	Under the EAI, the United States has reduced the foreign assistance and food aid debts of Argentina, Bolivia, Chile, Colombia, El Salvador, Jamaica, and Uruguay by US$875 million. In exchange for debt reduction, each country agreed to establish a local currency fund to support environmental and child survival programs. These funds are set up as endowments. EAI funds differ from USAID-funded endowments in that a USG representative sits as a voting member on the Board of Directors. If there is a USAID Mission in the country, a USAID representative serves on the board; if there is no USAID Mission, the board representative is a senior U.S.	A recent evaluation pointed out a number of problems with implementation of the FONAMA fund due to its links to a government agency. One lesson learned from Bolivia's experience is the importance of insulating a fund from "national political currents" and turnover in ministries (Asselin et al. 1996:37).	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	*Financed Not by USAID but by the USG.

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
					Embassy official. Another distinguishing feature of the EAI funds is the existence of a Washington-based EAI board. Of the seven countries that have received debt reduction, Bolivia, Chile, El Salvador, Uruguay, and Jamaica have operational boards that have begun disbursing funds. While most EAI funds are housed in private foundations established specifically for the EAI program, Bolivia's fund of US$21.8 million is housed in a government agency, FONAMA.			
Romanian-American Enterprise Fund (RAEF)	Enterprise Fund	1994	Romania	Economic Development	USAID initially capitalized the RAEF with a US$50 million grant and later added US$11 million to bring total obligations to US$61 million.	During the period 1995–2003, the fund has participated in more than US$150 million in equity investments. Through its previous trade and capital development efforts, it has acted as an advisor to business, generating an additional US$297 million in third-party investments. The fund's lending activity supplies capital to entrepreneurs and generates revenue for the fund's operations. To date, the fund has loaned more than US$30 million to more than 1,850 enterprises engaged in targeted sectors. In addition to the fund's loans, RAEF has attracted more than US$36 million in capital to investee companies. The RAEF also acts in an advisory capacity to the Romanian private sector.	Source: http://www.state.gov/p/eur/rls/rpt/55641.htm	
Russian-American Enterprise Fund	Enterprise Fund	1993	Russia	Economic Development		"…based on GAO's analysis of financial and investment patterns in Russia and	Source: http://www.gao.gov/products/NSIAD-	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
						Romania, the enterprise funds in both countries have a continuing development role for the foreseeable future; (6) despite private and international donor investments in these countries, the overall need for foreign investment capital and western business expertise in Russia and Romania continues unabated;"	99-221	
Endowment Fund for Local Initiatives for Tolerance and Sustainability	Endowment Fund		Southeastern Europe	Civil society capacity building			Source: http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
The Korea Development Institute (KDI) and Korean Inst. For Science and Technology (KIST)	Endowment	n.a.	South Korea	Science and Technology	The endowments for the Korea Development Institute (KDI) and the Korean Institute for Science and Technology (KIST) were set up consciously as part of the USAID "graduation" process. The intent was to leave behind two independent institutions that would further contribute to Korea's development. Although the organizations were not explicitly designed to promote U.S.-Korea linkages, these eventually developed. Both endowments were funded with local currency; the KDI endowment was in the range of US$70 million.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf and http://www.oecd.org/dataoecd/26/15/35078065.pdf	
African Center for Constructive Resolution of Disputes	Evergreen Endowment	1998	South Africa	Civil society capacity building	USAID provided US$5 million.		http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
Amy Biehl Foundation	Grant	1997	South Africa	Civil society capacity building	In 1999, USAID announced a US$1.4 million grant to the Amy Biehl Foundation Trust.		Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf and	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
							http://www.usaid.gov/press/releases/pr990930_2.html	
Libuyile Community Development Trust (LCDT)	Trust	1994	South Africa	`	In 1994, LCDT applied for and was granted a USAID grant of US$1 million (then R3 150 000). The period of the agreement was initially two years but this was extended until September 1999.	Lessons learned from LCDT's perspective included understanding good lending policies, learning not to depend too heavily on one individual, and understanding the value of coordinating and facilitating rather than doing. From the evaluators' perspective, the main lesson learned was that the program was too broad, and thus unachievable.	Source: http://pdf.usaid.gov/pdf_docs/PNACF043.pdf	
The Balkan Trust for Democracy	Trust	2003	Southeastern Europe: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Kosovo, Macedonia, Moldova, Montenegro, Romania, and Serbia	Democracy and Governance	USAID provided US$25 million.		Source: http://www.usaid.gov/locations/europe_eurasia/press/balkan_trust.html	
Swazi Business Growth Trust (SBGT)	Trust	1995	Swaziland	Economic growth	USAID provided US$5 million to initiate the endowment; SBGT was created to respond to the vastly inequitable economic landscape in Swaziland, where just a few individuals and enterprises control the bulk of economic resources in the country. USAID's goal was to design a project, and an institution, to grow as much income and jobs in Swazi business as quickly as possible, so as to set an example for the region.	Lessons learned: "Focus on synergy, not scope, in service and institutional development; Let demand drive sustainable non-financial services; Pay well, but keep people and institutions accountable; An institution can't do too much networking"; also considerations for TA, such as seeking local support, spending appropriately in other areas of the organization to retain adequate funds for TA	Source: http://pdf.usaid.gov/pdf_docs/PNABW914.pdf and http://pdf.usaid.gov/pdf_docs/PNABY616.pdf and http://pdf.usaid.gov/pdf_docs/PDABM275.pdf	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
						needs.		
Family Life Association of Swaziland (FLAS)(Family Planning Endowment Project for FLAS)	Endowment	1992	Swaziland	Health - Family Planning	FLAS was established through an endowment to an existing institution (established in 1979) with a successful record of programming and implementation. USAID has a role in oversight and monitoring of FLAS, since the endowment was provided through a project arrangement, including working with FLAS to select activities to be supported with endowment income, monitoring implementation, and evaluating results.	A 1995 evaluation revealed that unless revenue generation becomes an integral part of its operations, FLAS will not be capable of further growth or even sustain its current level of operations.	Source: http://pdf.usaid.gov/pdf_docs/PNABY616.pdf	
Kenan Institute Asia (KI Asia)	Endowment	1996	Thailand	Environment		Today, KI Asia uses the expertise and experience gained during its first 14 years to support sustainable development in Southeast Asia. KI Asia projects in 2010 attracted funding from USAID; the Royal Thai Government; the United Nations Development Programme; the UN Democracy Fund; and corporate donors such as MSD (Thailand), Microsoft, Citi and Boeing.	Source: http://www.kiasia.org/web/history.php?language=	
US-Thailand Development Partnership		1993 or 1994	Thailand	All	The partnership originally was developed as a five-year, US$20 million project. After a competitive process, a cooperative agreement was awarded to the University of North Carolina, working through the Kenan Institute – Kenan-Flagler Business School and two Thai partners. After considerable discussion, USAID, Kenan, and the RTG concluded that ending the project on September 30, 1995 (after less than two years of implementation) would		Source: http://pdf.usaid.gov/pdf_docs/PDABN562.pdf	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
					preclude the possibility of establishing a track record of individual partnership successes, thereby greatly reducing the chances of successfully institutionalizing the model. Subsequently, USAID/Washington approved a one-year extension of the project. The current PACD of September 30, 1996, provides for two years and nine months of actual implementation and funding of US$8.4 million for the Kenan cooperative agreement.			
Baltic–American Partnership Fund (BAPF)	Sinking Fund	1998	The Baltic States	Civil society capacity building	Established in 1998 by USAID and the Open Society Institute (the Soros Foundation), as a public-private partnership. Each founder has provided US$7.5 million to the BAPF to be spent over the next 10 years.	Challenges included weak or mixed legal frameworks; low civic participation and lack of trust in public institutions; few or no mechanisms for civic engagement and interaction among individuals, NGOs, the private sector, and the state; underdeveloped management, advocacy, coalition-building, and technical skills among NGOs; and limited sources of funding and experience with organized philanthropy.	Source: http://www.bapf.org/main_bg.html and http://pdf.usaid.gov/pdf_docs/PNADB909.pdf	
Baltic-American Enterprise Fund	Enterprise Fund	1994	The Baltic States	Economic Development	By the end of the fourth quarter of 2003, the fund had worked from an initial grant of US$50 million in 1994 to build more than US$160 million in investments in the Baltic States.	Best practices for the fund include building an American-style mortgage banking firm that averages US$5 million in monthly mortgage disbursements alone.	Source: http://www.state.gov/p/eur/rls/rpt/55641.htm	
Dairibord Employee Stock Ownership Trust (DESOT)	Trust	1994	Zimbabwe	Economic growth			Source: http://pdf.usaid.gov/pdf_docs/PNACB779.pdf	
Zimbabwe-	Foundation	2006	Zimbabwe	All			Source:	

Name of Organization	Type of Legacy Mechanism	Year	Country/ Region	Sector	What Was Done?	Lessons Learned and/or Accomplishments	Source	Notes
American Development Foundation							http://www.aiddata.org/project/show/29727793	
						General lessons learned across USAID experience, from http://pdf.usaid.gov/pdf_docs/PNABY616.pdf: "The existence of laws and regulations relating to endowments and foundations, including those that protect against the ability of the government to seize assets, is important (Rigby et al. 1993:49). The absence of this infrastructure in Africa has contributed to the limited USAID funding of endowments in that region" (p. 6).		

APPENDIX 5: DCA IN THE HEALTH SECTOR, 1999–2011

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
AFR	**Ethiopia**	Bank of Abyssinia	**9/30/2011**	9/30/2021	**Health**	USAID/Ethiopia plans to establish a US$13.4 million, 10-year, multibank loan portfolio guarantee for private health providers offering HIV/AIDS and TB services. This guarantee will work with two banks—Bank of Abyssinia and NIB Bank—guaranteeing allocated amounts of US$4.47 million each, while leaving US$4.47 million unallocated. Based on the banks' utilization rates of the guarantee in the first two years, USAID will determine the remaining unallocated amount's allocation. The DCA guarantee will provide the partner banks with a measure of security beyond the borrowers' limited collateral. This will enable a larger selection of healthcare providers to access finance for growth and quality improvements, enabling them to offer more and improved HIV/AIDS and TB services.	US$ 4,474,063.00	US$-	US$776,250.00	US$-
		NIB Bank International S.C.	**9/30/2011**	9/30/2021	**Health**	USAID/Ethiopia plans to establish a US$13.4 million, 10-year, multibank loan portfolio guarantee for private health providers offering HIV/AIDS and TB services. This guarantee will work with two banks, Bank of Abyssinia and NIB Bank, guaranteeing allocated amounts of US$4.47 million each, while leaving US$4.47 million unallocated.	US$4,474,063.00	US$-	US$776,250.00	US$-

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
						Based on the banks' utilization rates of the guarantee in the first two years, USAID will determine the remaining unallocated amount's allocation. The DCA guarantee will provide the partner banks with a measure of security beyond the borrowers' limited collateral. This will enable a larger selection of healthcare providers to access finance for growth and quality improvements, enabling them to offer more and improved HIV/AIDS and TB services.				
	Kenya	Bank of Africa Kenya Limited	**9/28/2008**	9/8/2016	**Health**	USAID/Kenya plans to obligate a US$5 million portable guarantee for Faulu Limited to attract financing. Faulu will use the proceeds of this loan to expand its health insurance premium financing product to lower-income households. Because low-income households do not have a regular income stream, they are in need of a product that allows them to pay a health insurance premium over time. The guarantee will enable Faulu to access financing at better terms, which it can then use to make its insurance financing product more affordable. USAID/Kenya will also provide TA to Faulu to improve the health insurance premium financing product. With the guarantee and TA, USAID/Kenya, through Faulu, hopes to insure thousands of low-income households. Faulu Kenya secured a loan with	US$ 5,000,000.00	US$5,000,000.00	US$250,000.00	US$-

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
						Bank of Africa, which is now the guaranteed party for this loan guarantee.				
		Faulu Kenya Deposit Taking Microfinance Limited	**9/29/2008**	9/29/2014	**Health**	USAID/Kenya plans to obligate a US$5 million portable guarantee for Faulu Limited to attract financing. Faulu will use the proceeds of this loan to expand its health insurance premium financing product to lower-income households. Because low-income households do not have a regular income stream, they are in need of a product that allows them to pay a health insurance premium over time. The guarantee will enable Faulu to access financing at better terms which it can then use to make its insurance financing product more affordable. USAID/Kenya will also provide TA to Faulu to improve the health insurance premium financing product. With the guarantee and TA, USAID/Kenya through Faulu hopes to insure thousands of low-income households.	US$-	US$-	US$-	US$-
	Nigeria	Accion Microfinance Bank Limited	**9/30/2010**	9/30/2015	**Health**	USAID/Nigeria proposes to extend a loan portfolio guarantee to ACCION Microfinance Bank Ltd for a period of five years to facilitate the launch of healthcare lending products in Nigeria. The objective of USAID/Nigeria's guarantee is to increase financing to private healthcare microenterprises offering FP, RH, and MCH services, thereby improving their capacity to make quality	US$400,000.00	US$99,464.00	US$19,880.00	US$-

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
						improvements and expand their services. Although Nigeria's private health sector is significant, it is severely underfinanced. The guarantee will benefit from TA to both financial institutions in the form of workshops on lending to the sector, market information, and facilitation of partnerships to reach potential borrowers. Additionally, USAID will work on building the management capacity of healthcare borrowers offering FP/RH/MCH services.				
		Diamond Bank Plc.	**9/30/2010**	9/30/2017	**Health**	USAID/Nigeria proposes to extend a loan portfolio guarantee to Diamond Bank Plc for a period of five years to facilitate the launch of healthcare lending products in Nigeria. The objective of USAID/Nigeria's guarantee is to increase financing to private healthcare microenterprises offering FP, RH, and MCH services, thereby improving their capacity to make quality improvements and expand their services. Although Nigeria's private health sector is significant, it is severely underfinanced. The guarantee will benefit from USAID TA to both financial institutions in the form of workshops on lending to the sector, market information, and facilitation of partnerships to reach potential borrowers. Additionally, USAID will work on building the management capacity of healthcare	US$8,300,000.00	US$308,578.00	US$331,170.00	US$-

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
						borrowers offering FP/RH/MCH services.				
ASIA	**Philippines**	Opportunity Microfinance Bank (OMB)	**9/29/2003**	9/29/2008	**Health**	USAID will provide a guarantee to the Opportunity Microfinance Bank (OMB) on 50% of its loan portfolio for loans made to midwife clinics. The characteristics of the portfolio will be such that funds for borrower loans will come from two sources: bank funds plus a credit fund to be established by the partnership. The partnership ensures quality control and, where necessary, provides coaching for borrowers facing financial challenges. Guaranteed loans will be made only to midwife clinics that are franchisees in good standing. The structure of the facility is as follows: The partnership will be partly capitalized until the end of 2004 through a US$300,000 grant from USAID under the current JSI/RTI Cooperative Agreement. Of that amount, US$150,000 will be applied to fund its capability-building TA costs. The balance or US$150,000 will be placed in a credit fund account with OMB in increments, as required. For every loan application approved by the bank, 80% will be covered by bank funds and 20% will be taken from the credit fund account of the partnership. Of the loan amount from the OMB, one half will be guaranteed by USAID under the DCA program. The credit fund of the partnership will not be	US$750,000.00	US$58,471.00	US$7,050.00	US$815.00

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
						guaranteed by USAID.				
E&E	**Georgia**	TBC Bank	**7/21/2010**	7/21/2020	**Health**	To support the refurbishment and/or construction of nine small hospitals and clinics throughout Georgia.	US$8,000,000.00	US$ 4,400,000.00	US$515,200.00	US$-
			9/30/2010	9/30/2020	**Health**	USAID/Georgia proposes a DCA portfolio loan guarantee to support the refurbishment and/or construction of hospitals and clinics throughout Georgia. With the DCA, USAID will encourage private financing for a key Georgian economic transformation program—hospital privatization. Private sector financing is currently difficult to access for the healthcare sector due to the repercussions of the worldwide financial crisis and the fallout from the 2008 war with Russia. Prospective borrowers' assets are not sufficient, and they are currently collateral-deficient in the eyes of banks. The 50% guarantee will primarily alleviate this perceived collateral deficiency and enable TBC Bank to extend a loan portfolio of US$20 million to prospective borrowers.	US$20,000,000.00	US$120,000.00	US$1,306,000.00	US$-
LAC	**Nicaragua**	BanPro (Banco de La Produccion)	**9/30/2004**	9/30/2014	**Health**	The objective of this loan portfolio guarantees is to stimulate access to working capital finance and infrastructure investment for private healthcare providers, such as medical clinics and EMPs, through risk sharing with conservative local banks.	US$4,000,000.00	US$3,987,399.00	US$319,200.00	US$103,301.00
	Nicaragua	FINARCA	**9/30/2004**	10/20/2010	**Health**	USAID/Nicaragua proposes the use of loan portfolio	US$1,000,000.00	US$60,478.00	US$ 79,800.00	US$-

Region Code	Country	Partner Name	Start Date	End Date	Primary Target Sector Code	Guarantee Summary	Total Authorized Disbursements	Total Actual Disbursements (Sept. 2011)	Cost to USAID Operating Unit (Subsidy)	Total Claims Paid by USAID to date
						guarantees to stimulate access to working capital and infrastructure investment for targeted borrowers through risk sharing with conservative local banks. The targeted borrowers are private healthcare providers, such as medical clinics and EMPs.				
Grand Total							**US$ 56,398,126.00**	**US$ 14,034,390.00**	**US$ 4,380,800.00**	**US$ 104,116.00**

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