**TABLE OF CONTENTS**

| Acknowledgments | 5 |
| Executive Summary | 6 |
| **Result 1: Strengthened organizational capacity to deliver high-quality FP/RH and other services to target groups** | 9 |
| Sub-Result 1.1: Global organizational systems that strengthen FP and other health program performance improved, streamlined, and disseminated | 10 |
| Youth | 10 |
| Leading with Evidence | 12 |
| Digital Health | 14 |
| Sub-Result 1.2: Innovations, tools, and approaches for delivering FP services to target groups tested, implemented, and disseminated | 18 |
| Gender | 18 |
| Method Choice | 19 |
| Equity | 25 |
| **Result 2: Increased sustainability of country-level FP and other health programs** | 27 |
| Sub-Result 2.1 Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged | 28 |
| Financial Sustainability | 28 |
| Strengthening FP Social Franchising and FP Workforce | 31 |
| Sub-Result 2.2: Capacity of local partners to provide quality FP and other health services built | 35 |
| Quality Assurance/Quality Improvement | 35 |
| Sub-Result 2.3 Innovative partnerships to strengthen service delivery networks pursued | 39 |
| Total Market Approach | 39 |
| **SIFPO2 Core-Funded Projects** | 45 |
| Liberia | 46 |
| Madagascar | 46 |
| Malawi | 48 |
| Mali | 49 |
| Mozambique | 51 |
| Ghana (COVID-19) | 52 |
| Benin | 54 |
| Cambodia | 55 |
| Dominican Republic | 57 |
| Democratic Republic of the Congo | 58 |
| Eswatini | 58 |
| Ghana | 61 |
| Guatemala | 63 |
| Liberia | 63 |
| Malawi | 64 |
| Niger | 67 |
| Somalia | 68 |
| Zambia | 69 |
| Latin American and Caribbean (LAC) Region | 71 |
| Zimbabwe | 72 |
| Annex I – Performance Monitoring Plan | 75 |
# ACRONYMS AND ABBREVIATIONS

## GLOSSARY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>A360</td>
<td>Adolescents 360</td>
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<td>ABMS</td>
<td>Association Béninoise pour le Marketing Social</td>
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<tr>
<td>AGYW</td>
<td>Adolescent Girls and Young Women</td>
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<tr>
<td>ANC ProFam</td>
<td>Association Nationale des Cliniques ProFam</td>
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<tr>
<td>ASF</td>
<td>Association de Santé Familiale</td>
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<td>ASQ-D</td>
<td>Assessing Service Quality and Contraceptive Discontinuation</td>
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<td>C4C</td>
<td>Counseling for Choice</td>
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<tr>
<td>CBRM</td>
<td>Client-Based Record Management</td>
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<tr>
<td>CEFM</td>
<td>Child, Early, and Forced Marriage</td>
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<tr>
<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
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<td>CRS</td>
<td>Catholic Relief Services</td>
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<td>CYPs</td>
<td>Couple Years of Protection</td>
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<td>D2A</td>
<td>Data to Action</td>
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<tr>
<td>DALY</td>
<td>Disability-Adjusted Life Year</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DIB</td>
<td>Development Impact Bond</td>
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<td>DRC</td>
<td>Democratic Republic of the Congo</td>
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<tr>
<td>DREAMS</td>
<td>Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe</td>
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<tr>
<td>ECP</td>
<td>Emergency Contraceptive Pills</td>
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<tr>
<td>EECO</td>
<td>Expanding Effective Contraceptive Options</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GHSP</td>
<td>Global Health Science &amp; Practice</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>HNQIS</td>
<td>Health Network Quality Improvement System</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<tr>
<td>HTS</td>
<td>HIV Testing Services</td>
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<tr>
<td>ICRW</td>
<td>International Center for Research on Women</td>
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<tr>
<td>IP</td>
<td>Implementing Partner</td>
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<td>IPC</td>
<td>Interpersonal Communication</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
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<tr>
<td>IUS</td>
<td>Intrauterine System</td>
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<tr>
<td>KP</td>
<td>Key Population</td>
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<td>KAP</td>
<td>Knowledge, Attitudes, and Practice</td>
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<td>LAC</td>
<td>Latin American and Caribbean</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>LARC</td>
<td>Long-Acting, Reversible Contraceptive</td>
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<td>LMICs</td>
<td>Low- and Middle-Income Countries</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MII</td>
<td>Method Information Index</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoHCC</td>
<td>Ministry of Health and Child Care</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organizations</td>
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<tr>
<td>OCP</td>
<td>Oral Contraceptive Pill</td>
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<tr>
<td>PASMO</td>
<td>Pan American Social Marketing Organization</td>
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<tr>
<td>PEPFAR</td>
<td>President's Emergency Plan for AIDS Relief</td>
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<td>PM</td>
<td>Permanent Methods</td>
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<tr>
<td>PPIUD</td>
<td>Postpartum Intrauterine Device</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<td>PRH</td>
<td>Office of Population and Reproductive Health</td>
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<tr>
<td>PSK</td>
<td>Population Services Khmer</td>
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<tr>
<td>PSZ</td>
<td>Pharmaceuticals Society of Zambia</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>R4D</td>
<td>Results for Development</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>SBCC</td>
<td>Social and Behavior Change Communication</td>
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<tr>
<td>SFH</td>
<td>Society for Family Health</td>
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<tr>
<td>SHOPS</td>
<td>USAID’s Sustaining Health Outcomes through the Private Sector Project</td>
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<tr>
<td>SIFPO</td>
<td>Support for International Family Planning and Health Organizations</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>SPIRES</td>
<td>Stanford Program for International Reproductive Education and Services</td>
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<tr>
<td>SR</td>
<td>Sub-Result</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TFHO</td>
<td>Total Family Health Organization</td>
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<tr>
<td>TMA</td>
<td>Total Market Approach</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Foundation</td>
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<tr>
<td>VIA</td>
<td>Visual Inspection with Acetic Acid</td>
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<tr>
<td>WASH</td>
<td>Water, Sanitation, and Hygiene</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YFHS</td>
<td>Youth-Friendly Health Services</td>
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ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

In 2014, Support for International Family Planning and Health Organizations 2 (SIFPO2) was awarded to Population Services International (PSI) and global implementing partners (IPs) Stanford Program for International Reproductive Education and Services (SPIRES), the International Center for Research on Women (ICRW), Results for Development (R4D), and PharmAccess. Under SIFPO2, PSI and its global and in-country partners worked to strengthen voluntary family planning (FP) programs and other health services worldwide, focusing on strengthening private sector channels, including social franchise networks. The project was conceived as a 5-year award and was eventually extended an additional 1.5 years, closing in March 2021. The SIFPO2 project was organized around two primary results and five supporting sub-results (SR):

Result 1: Strengthened organizational capacity to deliver high-quality FP and reproductive health (RH) and other services to target groups

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

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

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

SIFPO2 core-funded work and results outlined in the first half of this report were invested to maximize alignment with the United States Agency for International Development (USAID) Office of Population and Reproductive Health's strategic priorities of 2014–2020, the USAID Office of PRH Results Framework, the technical proposal for SIFPO2, and the existing or latent capabilities of PSI. The focus of these core investments included expanding method choice within the context of informed choice; strengthening the FP workforce, with a focus on social franchising; supporting a total market approach (TMA); sustaining quality assurance (QA) across all health areas; expanding access for youth; promoting gender equality; leading with evidence and using data for decision-making; strengthening sustainable health financing of FP services; integrating service delivery in support of voluntary FP/RH; and enhancing equity in the provision of FP/RH products and services.

AT A GLANCE

SIFPO2 investments in advancing youth access to Quality Assured FP among private providers directly strengthened the delivery of over 23.5 million CYPs through social franchising by PSI networks during the lifetime of this award.

The first half of this report will be presented using the framing of the award’s result areas and the themes outlined above. The nature of these result areas and themes is that overlap and connections occur frequently; an investment can be about organization-strengthening, innovations, and capacity-strengthening all the same time, or expanding method choice can be informed by the adoption of a TMA. Thus, where there is such overlap, the results of SIFPO2 are presented under the USAID SIFPO2 result area under which they made the greatest contribution.
SIFPO2 delivered on the USAID promise to strengthen PSI and partners’ organizational capacity to deliver high-quality FP and other health services to target groups and increase sustainability of country-level FP and other health programs. Highlights include:

- **SIFPO2 enabled extensive progress in measurable improvements** in Quality Assured FP/RH, as well as innovations in QA that enhanced efficiency, as well as strengthened localization and capacity to deliver sustainable, Quality Assured FP/RH. SIFPO2-funded tools and training contributed to high-quality QA/quality improvement (QI) clinical audits of over 800 facilities across 16 countries during the project’s period of performance and over 70,000 supportive supervision visits to providers, 89% of whom were in the private sector.

- **SIFPO2 acted as a catalyst for substantial progress in terms of youth populations reached with FP/RH services**, as well as the capacity of PSI and partners to design and deliver effective approaches to youth FP. SIFPO2 support in youth-friendly health services (YFHS) was directly cascaded to 1,686 health service providers and 277 referral agents in 35 countries and contributed to over 14 million young people being provided with voluntary FP by PSI networks between 2014–2019.

- **SIFPO2 core and field funds supported and improved a broad range of service delivery approaches.** For example, the SIFPO2 investments in advancing youth access to FP and to QA/QI among private providers directly strengthened the delivery of over 23.5 million couple years of protection (CYPs) through social franchising by PSI networks during the lifetime of this award. New technologies and policies were supported by SIFPO2 to create new channels for access to voluntary FP (such as facility-based providers supporting clients to initiate self-injection of DMPA-SC in Malawi, and task-sharing long-acting, reversible contraceptive [LARC] provision among providers Niger). SIFPO2 also focused on improving the quality and reach of existing, high-impact practices (such as social franchising, social marketing, and mobile outreach), including through developing guidelines and operating procedures across PSI platforms.

- **SIFPO2 innovated in the development and successful adoption of digital health technologies** that support enhanced, sustainable improvements in the supply, demand, and enabling environment for FP/RH. For example, to date, the provider-facing Health Network Quality Improvement System (HNQIS) has been used in 31 countries, in both private and public sector facilities (11 of these countries have used the tool to strengthen public sector health systems). PSI has embraced consumer-facing digital health technologies, with one illustration being over 275,000 clients redeeming e-referrals for voluntary FP services using digital technology developed with SIFPO2 support (the Connect technology, linking interpersonal communication (IPC) agents with consumers and provider networks).

- **SIFPO2 innovated in the quest to advance the financial sustainability of the provision of equitable, quality FP/RH provided by the private sector.** Leveraging expertise from partner R4D, SIFPO2 achieved a demonstrated transfer of capacity in health financing to country-level staff to better
access domestic resource mechanisms. Meanwhile, with catalytic funding from SIFPO2, PSI's social enterprise model, Tunza, is now supported by a wide range of donors across multiple countries, including European donor agencies and private philanthropic donors. An example of this from one country is the small but growing Tunza Uganda network, where clinic revenue has continually increased, and clinics are paying into the network structure an agreed proportion of revenue share for months where revenue exceeds pre-Tunza baseline. This is enabling a steady revenue stream for the Tunza social enterprise model that offsets costs currently covered by donors to help improve the provision of quality healthcare in the private sector.

- SIFPO2 strengthened the capacities of local partners and leaders in FP/RH beyond the lifetime of this award. For example, SIFPO2 supported the establishment and capacity development of new local social marketing organization Total Family Health Organization (TFHO) in Ghana, which was awarded a transition award from USAID/Ghana in 2020.

- Capitalizing on a surge in core FP funds in 2019, SIFPO2 scaled up a series of successful FP/RH interventions in Liberia, Madagascar, Malawi, Mali, and Mozambique and in 2020 was able to support interventions in Ghana that helped the country respond to the coronavirus disease (COVID-19) pandemic, work that was featured in the USAID Center for Innovation & Impact 2020 Impact Brief*.

In addition to core funds, project activities were implemented on the ground through field funding in Benin, Cambodia, the Democratic Republic of the Congo (DRC), the Dominican Republic, Eswatini, Ghana, Guatemala, Liberia, Malawi, Somalia, Zambia, and Zimbabwe, and with core or central funding in El Salvador, Honduras, Mali, Mozambique, Niger, Nigeria, Senegal, Tanzania, Uganda, and Zimbabwe. However, SIFPO2’s results inform and influence PSI’s approaches to implementing FP projects in countries around the globe. This field-funded work is presented in the second half of this report.

RESULT 1

STRENGTHENED ORGANIZATIONAL CAPACITY TO DELIVER HIGH-QUALITY FP/RH AND OTHER SERVICES TO TARGET GROUPS
In 2016, PSI committed to reaching 10 million more young people with voluntary FP by 2020 through its organization-wide efforts. By Year 5 of SIFPO2, PSI surpassed this goal with over 14 million youth reached. This success was facilitated by multi-year investments from SIFPO2 in developing and institutionalizing PSI’s ability to deliver high-quality, voluntary FP programming for young people in PRH priority countries. The project also supported PSI to collate learnings and share them across the organization and with the wider global community of practice. Key accomplishments included:

SYSTEMIC CHANGES TO EXPAND VOLUNTARY FP ACCESS FOR YOUTH (AGES 15–24)

Previously, under SIFPO1, PSI developed the tools and resources needed to ignite an evolution towards mainstreamed YFHS as a standard FP practice among PSI network member organizations. Under SIFPO2, PSI institutionalized YFHS across the organization through regional capacity-building initiatives, disaggregation of FP data by age, and the adoption of a youth-related QA standard.

To build organizational capacity in YFHS, SIFPO2 developed a training curriculum for FP providers and led regional trainings of trainers in East and Southern Africa, Francophone Africa and Haiti, and Asia. A total of 68 program staff from PSI network member organizations participated in regional YFHS trainings. Leveraging other funds, these staff cascaded YFHS training to 1,686 health service providers and 277 referral agents in 35 countries. SIFPO2 also supported deep-dive technical assistance for youth work in several PRH priority countries.

SIFPO2 successfully implemented two organization-wide changes to enable the monitoring of YFHS: (1) disaggregation of FP data by age, and (2) integration of a youth inclusiveness standard into PSI’s QA system. With technical assistance through SIFPO2, PSI network members improved their collection and analysis of client age data, enabling them to monitor service uptake among youth and to guide programmatic decision-making. PSI adopted the new youth-related quality standard developed by SIFPO2 and assessed performance on this standard in all quality audits of FP programs across its global network.

AT A GLANCE

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SIFPO2 also developed, piloted, and disseminated a youth-focused mystery client tool to strengthen the QA efforts of network members. The number of PSI network member organizations that monitor compliance with youth-friendly service standards rose from zero when SIFPO2 began to 26 by the project’s end, surpassing PSI’s endline projection of 20 network members.

**GENERATION AND SHARING OF EVIDENCE ON YOUTH PROGRAMMING APPROACHES**

SIFPO2 built the evidence base for youth approaches and shared its learning globally. For example:

- With SIFPO2 support, PSI co-led a technical consultation on Adolescent and Youth Sexual and Reproductive Health in 2015 and presented learnings from its youth work at conferences over the course of the project. SIFPO2 also co-hosted a symposium: *For youth, a healthy option with LARCs: expanding the method mix for voluntary contraceptive use among adolescents and young people*.

- SIFPO2 published a brief describing 10 components of PSI’s youth approach: *From innovation to scale: advancing the sexual and reproductive health and rights of young people*.

- SIFPO2 led research to document the effects of YFHS capacity-building for FP providers in Mali. The MEASURE Evaluation project used the results of that study alongside data SIFPO2 provided from two more countries to write the report: *Assessing efforts to mainstream youth-friendly health services in Madagascar, Malawi, and Mali*. Results of the retrospective analysis showed that the number of FP clients aged 15–24 increased after PSI’s YFHS interventions.

- The journal BMC Health Services Research published the paper co-authored by MEASURE and SIFPO2: *Evaluation of mainstreaming youth-friendly health in private clinics in Malawi*.

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Another significant legacy of SIFPO2 was acting as a catalyst for other donors to invest in youth-focused FP programs that built upon strengths USAID developed through SIFPO2. The Adolescents 360 (A360) project funded by the Bill & Melinda Gates Foundation and the Children’s Investment Fund Foundation and the Ignite project funded by the Dutch Ministry of Foreign Affairs both began in January 2016 and generated informed demand for the voluntary contraceptive services that SIFPO2 helped ensure were youth-friendly. Over the course of SIFPO2, A360, and Ignite, PSI shifted to serve younger FP clients across its global network. At PSI-supported service delivery points, the proportion of FP services provided to youth (< 25 years) rose from 32% in 2015 to 39% in 2020. Most of this change was attributable to an increase in the proportion of FP services provided to adolescents (15–19 years), which increased from 8% to 14% from 2015 to 2020.

LEADING WITH EVIDENCE

SIFPO2 was committed to generating new evidence and utilizing evidence-based best practices in expanding access to and uptake of high-quality FP products and services. The forms this took included new quantitative and qualitative research, capacity-building of staff for data collection and interpretation, analysis of evidence gathered through routine monitoring, and dissemination of evidence to key local and global stakeholders.

GENERATING AND SHARING INSIGHTS FROM QUANTITATIVE AND QUALITATIVE RESEARCH

SIFPO2 undertook several targeted research studies to address evidence gaps around method access, quality of care, and client preferences. The findings supported improved programming approaches and outcomes for the SIFPO2 project as well as contributions to the global evidence base.

SIFPO2 advanced a wide range of new research. Examples of studies (published or pending publication) that have been of critical value include:

- Patient-provider trust: Findings from the Assessing Service Quality and Contraceptive Discontinuation (ASQ-D) study in Uganda. This study is discussed further in this report’s Quality Assurance/Quality Improvement section.
- Evaluating counseling for choice in Malawi: A client-centered approach to contraceptive counseling. This study on Counseling for Choice (C4C) is discussed further in the Method Choice section.
- Supporting contraceptive choice in self-care: Exploring beliefs and attitudes towards emergency contraceptive pills and on-demand use in Accra, Ghana and Lusaka, Zambia. This study combines results from two qualitative studies on beliefs, attitudes, and patterns of use of emergency contraceptive pills (ECPs) among women in Ghana and Zambia and is discussed further in the Method Choice section of this report.

In addition, in 2018, SIFPO2 and other members of USAID’s Hormonal IUD Access Group co-authored a publication in Global Health: Science and Practice that laid out a global learning agenda for the Hormonal IUD. SIFPO2 conducted research in Nigeria and Zimbabwe to answer key questions from this shared learning agenda. In 2019, SIFPO2 and another USAID-funded global project, Expanding Effective Contraceptive Options (EECO), completed a four-country pilot study: Introducing the hormonal intrauterine system in Madagascar, Nigeria, Zambia and Zimbabwe. The prospective longitudinal study filled a gap in the literature by providing evidence on the profiles of clients who choose the Hormonal IUD in low-income and middle-income countries, their reasons for choosing the method, and their continuation and satisfaction with the method after 3 months of use. The profiles of voluntary users varied based on programmatic context, suggesting that the method can appeal to women regardless of their age, marital status, and parity. Results demonstrated the Hormonal IUD appeared to expand the range of contraceptive options in a meaningful way by offering attributes, such as its side-effect profile and bleeding profile, that users did not see in other voluntary FP methods. In all four countries, women reported high rates of satisfaction with the Hormonal IUD (67–100%) and high rates of continuation at the 3-month mark (91–
93%). Initial study findings have been used to improve voluntary FP service delivery for clients as well as enhance the global FP community’s understanding of client and provider experiences with Hormonal IUD service delivery within the context of informed choice. SIFPO2 and EECO submitted a manuscript for peer review in 2020 and will continue to pursue avenues for sharing this work as additional data sets are added. The Method Choice section of this report provides additional information on SIFPO2’s Hormonal IUD market development work.

**STRENGTHENING DATA UTILIZATION AND VISIBILITY**

SIFPO2 provided critical support for strengthening data utilization and increasing its visibility in countries across the globe. Under this core initiative, beginning in 2015, PSI conducted three regional trainings (East Africa, West Africa, and Southeast Asia) and multiple country-level deep dives to assist country teams in developing Data to Action (D2A) frameworks featuring key program indicators and precise and relevant program metrics. As a result of this support, 15 countries developed D2A frameworks with tailored dashboards for ongoing monitoring of program priorities. The creation of D2A frameworks and their use in developing district health information system 2 (DHIS2)-based indicator dashboards has been adopted as PSI’s standard institutional approach to the design of DHIS2 country-level configurations and use of that data for monitoring program performance. This approach is being shared with and adopted by public sector counterparts as well. In Mozambique, for instance, with SIFPO2 funding, PSI/Mozambique provided capacity-building to the Ministry of Health (MoH) to use the D2A framework approach for reviewing FP program data.

SIFPO2 supported the refinement and dissemination of PSI’s **Use/Need** analytical approach. PSI’s use/need analysis examines the FP2020 metric “demand satisfied” by applying national survey (i.e., Demographic Health Survey) percentages to United Nations population estimates to identify absolute numbers of individuals by specific demographic groups, such as marital status, age, geography (rural vs. urban), and wealth quintiles. An example of this analysis is included in Figure 1 below. These analyses allow PSI to identify which segments of the population in each country are not accessing an FP method despite their stated desire to avoid pregnancy. Data gleaned through this approach is integrated into programmatic decision-making through D2A frameworks operationalized at country level. How these analyses have been foundational to PSI’s TMA activities is discussed further in the Total Market Approach section of this report.

**EQUITY – USE AND NEED BY WEALTH QUINTILE – GHANA**

*Married Women of Reproductive Age (WRA) - 15-49*

![Diagram showing equity in use and need by wealth quintile in Ghana](https://www.psi.org/publication/kdp-diagnose-use-need/)

Data sources: 2015 World Population Prospects and 2014 Ghana DHS

Figure 1. Example of Use/Need Analysis in Ghana

5 https://www.psi.org/publication/kdp-diagnose-use-need/
CAPACITY-BUILDING FOR RESEARCH AND ANALYSIS

SIFPO2 emphasized building sustainable capacity for evidence generation and data utilization at global, regional, and country levels. These efforts included workshops and in-person and remote technical assistance. For example, SIFPO2 supported participation in a regional meeting of West and Central Africa PSI network members in Abidjan, Côte d’Ivoire that provided training on research methods and research ethics related to studies involving adolescents and youth. SIFPO2 also supported participation of researchers at the PSI global evidence meeting to introduce D2A frameworks and conduct a training on SurveyCTO, a mobile data collection platform utilized in over 20 PSI country programs to improve the quality of research data and ensure timely and actionable analysis.

PSI disseminated lessons learned in high-quality FP programming to a global audience of practitioners through network members and project staff, including but not limited to presentations on SIFPO2-supported research and activities at the International Conference on Family Planning conferences in Bali, Indonesia, in 2016 and in Kigali, Rwanda, in 2018.

DIGITAL HEALTH

SIFPO2 results in digital health were built upon the foundations established during SIFPO1, such as the adoption of the DHIS2 and introduction of common language and tools for data collection among PSI and its country-level counterparts. As this system grew and new data collection tools were introduced in countries around the world, the volume of service and client data captured dramatically increased, offering opportunities for improving projects and strengthening health systems, along with challenges in harnessing its potential.

As previously highlighted, under SIFPO2, PSI invested in promoting greater use of service data for decision-making. The D2A initiative included three regional technical workshops held in Nairobi, Kenya; Dakar, Senegal; and Bangkok, Thailand, that brought together more than 20 country teams to create tailored decision-making frameworks to guide data collection and use for program monitoring and improvements.
In addition to the global and regional initiatives to drive data utilization and visibility, a deeper dive was also taken to support this work in specific countries. For example, PSI network partners Society for Family Health (SFH) Nigeria and Malawi were supported to establish client-based record management (CBRM) systems employing DHIS-based data collection.

This CBRM work, and the introduction of a Unique Identifier Code used to track clients across a referral network of services over time, served as the foundation for later efforts to establish electronic medical record systems in countries such as Malawi and Zimbabwe under SIFPO2. The principles developed under the CBRM initiative were subsequently adopted by MoHs in these two countries as best practices for reducing the burden of data collection and helping to strengthen the continuum of care.

CBRM frees up staff time, means fewer delays when clients visit or call; having the full client history available during a consultation means less time spent discussing previous care and more time focused on the current visit, and strengthens a ‘client-centered’, long-term relationship between the provider and the consumer. CBRM also supports quality assurance processes, enabling case note reviews, providing an audit trail for use during supervision visits, and helping with the investigation and follow-up of adverse events.

A key tenet of the digital health work was also PSI’s promotion of data sharing between franchise clinic networks and government, allowing MoHs clearer insights into the type and quantity of services provided by private sector providers and critical information needed to evaluate and manage the total market for health in countries. This has happened via two means. First, PSI Network Members are now using the information provided through DHIS2 to report as required to governments and local USAID Missions when field support funding is being applied. Second, PSI has taken steps to enable direct sharing of public and private DHIS2 systems by governments. In Burundi, PSI’s Tunza social franchise is directly inputting service delivery data from its network providers into the government’s health management information system at the district level. In Malawi, service delivery data from all Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) partners is now shared with the MoH through the DHIS2 platform. This data is reviewed regularly by PSI and District officials as part of routine monitoring of key service delivery indicators.

Throughout this period, digital technology continued to evolve rapidly, with many countries experiencing a dramatic expansion of cellular networks, spectacular increases in mobile phone ownership, and a proliferation of new software applications needed to evaluate and manage the total market for health in countries. This has happened via two means. First, PSI Network Members are now using the information provided through DHIS2 to report as required to governments and local USAID Missions when field support funding is being applied. Second, PSI has taken steps to enable direct sharing of public and private DHIS2 systems by governments. In Burundi, PSI’s Tunza social franchise is directly inputting service delivery data from its network providers into the government’s health management information system at the district level. In Malawi, service delivery data from all Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) partners is now shared with the MoH through the DHIS2 platform. This data is reviewed regularly by PSI and District officials as part of routine monitoring of key service delivery indicators.

Throughout this period, digital technology continued to evolve rapidly, with many countries experiencing a dramatic expansion of cellular networks, spectacular increases in mobile phone ownership, and a proliferation of new software applications

**AT A GLANCE**

Client Based Record Management (CBRM) activities directly supported the provision of 136,045 family planning services in Uganda in the final year of SIFPO2, enabling the use of a client record with a Unique Identifier Code, allowing faster retrieval of a clients record and enhanced support and follow up to clients.
and social media platforms. These developments created exciting new potential for innovative client and provider-facing digital interventions in several countries where SIFPO2 was working.

SIFPO2-funding has enabled PSI to develop a suite of digital interventions, often led in partnership with local commercial digital technology companies, integrated to provide clients with health information, help them find providers, link them to services, understand their satisfaction with services received, and track these clients across the continuum of care.

With support from SIFPO2, PSI also developed client-facing interventions, such as in Tanzania, where PSI launched the use of an unstructured supplementary service data service for basic phone users to access voluntary FP information and provide feedback on their experience using a voluntary contraceptive method.

The technology has developed at a rapid pace, and the catalytic investment in the initial Connecting with Sara tools by USAID has now evolved into a suite of new tools and partnerships that facilitate effective health information provision, linkage to care, and ongoing engagement with clients sustained by new funding sources for sustainability and further scaling.

Another significant investment made in digital health under SIFPO2 was the development of the Health Network Quality Improvement System (HNQIS). HNQIS is an electronic, tablet-based application developed to improve the quality of health services across networks of providers, such as social franchises or private outlets and community-based health workers. The tool helps address health system challenges of determining efficient resource allocation...
for supportive supervision and limited use of QI data to improve service quality. It does this by enabling networks more effectively to: Plan supervision visits using a prioritization matrix which considers quality scores and patient volume; Assess providers’ quality of care against clinical standards and benchmarking; Improve providers’ quality of care through consistent, tailored feedback; and Monitor performance of providers over time to understand the return on their efforts.

Originally piloted as a tool to improve malaria case management among private sector pharmacies, continuous improvements have enabled the system to be used to evaluate 13 different health service areas, including FP, HIV, maternal and child health (MCH), and tuberculosis. While designed with the objective of quality improvement, benefits have been seen in provider behavior change communication, CBRM, and stock management. HNQIS is currently live in 31 countries, supporting service improvement efforts in both private and public sector facilities. Governmental entities in Angola, Benin, Cameroon, Ethiopia, Haiti, Malawi, Mali, Mozambique, Puntland, Somalia, Somaliland, South Africa, and Zimbabwe are in varying stages of adopting the tool. Since launching in Kenya in 2015 through April 2020, more than 90,000 assessments have been conducted, with 11% of these in public sector facilities.

Consistent with USAID’s vision for the creation of open-source, adaptable, and reusable digital tools, PSI has developed HNQIS as a global good using open-source Android software, working with partners already in the market and minimizing the use of boutique, project-specific solutions. The USAID flagship Human Resources for Health project (HRH2030) highlighted HNQIS as one of the best supportive supervision tools available. At the time of this writing, PSI is working with the DHIS2 development team of the University of Oslo to incorporate HNQIS’s features as core functions of the application, downloadable with the ability to be adapted by any public or private entity.

With support from SIFPO2, and by organizing its efforts around the WHO Digital Health Classification and Principles for Digital Development, PSI has developed its own Digital Strategy Framework for 2020–2024 where the organization articulates its vision for supporting digital health initiatives and contributing to global learning in this area over the years to come.
SUB-RESULT 1.2  
INNOVATIONS, TOOLS, AND APPROACHES FOR DELIVERING FP SERVICES TO TARGET GROUPS TESTED, IMPLEMENTED, AND DISSEMINATED

GENDER

SIFPO2 supported PSI and its partner ICRW to apply a three-pronged approach to promote women’s reproductive agency in alignment with PRH’s gender priorities:

1. Research and programs focused on constructive male engagement in FP;
2. Development and dissemination of internal guidance for responding to gender-based violence (GBV); and
3. Development and rollout of PSI’s organization-wide Gender Equality Policy.

CONSTRUCTIVE MALE ENGAGEMENT IN FP

To better understand couple communication and support for FP among men married to adolescent girls, ICRW conducted a global literature review and a qualitative research study with married couples in urban and rural Zambia. With SIFPO2 support, ICRW also included questions on couple communication dynamics in qualitative research funded under the USAID/PRH-funded IMPACCT study in Haryana, India. ICRW shared the findings of these studies locally and globally to inform future programming.

PSI also led a communication activity in the DRC to constructively engage men in FP. SIFPO2 integrated FP content into a popular national TV gameshow called “Libala ya Bosembo” (“Peaceful Wedding”). The gameshow brought together four real newlywed Congolese couples to answer questions about their spouses. SIFPO2 added questions such as: “Where does your spouse get information about contraception?” At the end of the game, an FP expert spoke about the wide range of FP methods available and suggested viewers visit a health center or call a FP hotline for more information. This core-funded activity complemented broader field-supported FP communication activities by PSI’s local network member.

In Côte d’Ivoire, SIFPO2 and the USAID Transform/PHARE project jointly funded work to explore innovative approaches to male engagement in FP. PSI and IDEO.org used a human-centered design process to capture insights from young, unmarried Ivorian men (ages 20–24), then used these insights to design, prototype, and refine an intervention to promote couple communication and voluntary FP use by men and women. The intervention combined a serial comic book on Facebook with in-person discussion clubs. PSI documented and disseminated learnings from this process through project briefs and presentations.

RESPONDING TO GBV

All over the world, FP and HIV service providers encounter clients who have experienced sexual assault or partner violence. To prepare these providers, PSI refined its clinical and programming standards and guidelines for responding to GBV. With SIFPO2 support, PSI gathered input from its network members, including those in Guatemala, Madagascar, and DRC, who had begun to use the organization’s GBV guidelines, which were developed under SIFPO1. To address a need expressed by network members, SIFPO2 developed as an internal tool a provider handbook called Responding to gender-based violence in social franchise health care

12 https://www.psi.org/publication/transform-phare-learning-briefs/
settings. SIFPO2 translated the provider handbook into French and disseminated both the French and English versions to network members with funding to address GBV. In addition, the DRC MoH’s National Adolescent Health Program adopted the use of the French version of the handbook. Furthermore, SIFPO2 developed an internal tool called Gender-based violence research and programs at PSI: Checklist for program design and start-up. SIFPO2 also provided technical assistance for GBV programs in India and Haiti and presented learnings from the GBV work in India at an Interagency Gender Working Group meeting in 2015. These core investments supported SIFPO2 field support in Malawi that included activities to advance an integrated approach to addressing GBV\(^\text{13}\) and HIV among Adolescent girls and young women.

**ORGANIZATIONAL GENDER EQUALITY POLICY**

SIFPO2 supported the development and rollout of PSI’s organization-wide Gender Equality Policy. This policy, endorsed and promoted by PSI’s executive team, provides a vision for PSI achieving gender equality in its own operations as well as within the programs it implements. SIFPO2 contributed to the development of a policy implementation roadmap as well as webinars and briefings to orient PSI staff on the new policy. Reflecting the caliber of this work, the Global Health 50/50 initiative listed PSI in 2019, 2020, and 2021 as one of the world’s highest-performing global health organizations based on a review of gender-related organizational policies and practices.

**METHOD CHOICE**

Expanding method choice for voluntary FP was a central technical tenet of SIFPO2 programming. SIFPO2’s work encompassed support for high-quality FP information and counseling, market entry, and scale-up of new methods, and increased access to and uptake of underutilized methods, such as voluntary LARCs. All method choice activities were built on foundational principles of informed choice and voluntarism.

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**HIGH-QUALITY FP COUNSELING**

Recognizing that informed choice is predicated on client awareness and understanding of FP method options and a supportive environment in which to exercise choice, SIFPO2 developed a client-centered FP counseling approach called Counseling for Choice (C4C). Over the course of three project years, SIFPO2, with support from other donors, developed the C4C approach, which built on existing evidence and approaches and sought to address identified gaps in FP counseling when viewed from a client perspective. This tool was developed with input from a broad range of stakeholders, including many USAID IPs, such as via a 2017 LARC & Permanent Method (PM) Community of Practice meeting organized by SIFPO2 that focused on emerging approaches to FP counseling. C4C includes a suite of tools for providers and clients using the C4C approach and aims to better inform clients and address known reasons for method dissatisfaction, particularly method-related side-effects and bleeding changes. Method information is presented in a way that helps clients compare various method attributes and potential impact on their life. Further, it assists the provider in being proactive about counseling clients for follow-up and management of side-effects.

With SIFPO2 support, the C4C approach was piloted in Malawi with a prospective-quasi experimental study to assess the impact of the approach’s use on method choice, client satisfaction, and method continuation while in need. The research, concluded in Year 6 demonstrated a positive correlation between use of the C4C approach and client satisfaction with their counseling experience and continuation of chosen method. The study, *Evaluating counseling for choice in Malawi: A client-centered approach to contraceptive counseling*, showed that women counseled by a provider using the C4C approach, i.e., the intervention group, were more likely to report a positive experience from their FP visit and were more likely to be satisfied with and still using their method 6 months after their FP visit than the control group. At every time point measured after 1 month, the probability of discontinuation while in need was lower in the intervention group than in the control group.
Results were all statistically significant at p<0.05. The study will be published in a peer-reviewed journal in 2021, and the C4C suite of tools will be available for download on PSI's public website in English, French, Spanish, and Portuguese.

EXPANDING ACCESS TO NEW METHODS

The SIFPO2 project undertook substantial work facilitating introduction and scale-up of new voluntary FP technologies to be provided in the context of informed choice in PRH priority countries, including DMPA-SC and the Hormonal IUD.

Among the highlights of SIFPO2’s DMPA-SC work were method introduction activities in the DRC in Year 1, where DMPA-SC was introduced via community-based distribution by authorized health workers in Kinshasa. This was a vital step in familiarizing PSI globally on the acceptability of DMPA-SC as a contraceptive method and the considerations to ensure DMPA-SC is always provided in the context of informed choice.

In subsequent years, SIFPO2 supported DMPA-SC introduction in Malawi and Zambia, where a broad range of interlinked activities were utilized, including policy advocacy for self-injection; training of pharmacists and community health workers to teach women to self-inject; and support for monitoring, evaluation, and commodity security. In Malawi, SIFPO2 supported the introduction of self-injection of DMPA-SC in the private sector through more than 200 providers in support of the MoH’s 2018 rollout plan, while in the Copperbelt, Muchinga, and Luapula provinces of Zambia, SIFPO2 supported training and coaching of more than 1000 public sector providers in self-injection of DMPA-SC.

In addition to this core support at a country and global level, SIFPO2 played a leading role in the multi-stakeholder effort to harmonize programmatic scale-up and effective in-country marketing of DMPA-SC. SIFPO2 co-convened or participated in several major global and regional technical meetings in support of DMPA-SC rollout. These included a joint DMPA-SC operational learning tour14 to Uganda in 2017 organized between PSI, International Planned Parenthood Federation, and Marie Stopes International and serving as a steering group member of three global DMPA-SC-related meetings: the 2017 Increasing Access To Next Generation Injectables15 meeting in Dakar, Senegal; the 2018 Access Collaborative-led Evidence to Practice16 meeting in Nairobi, Kenya; and the 2019 Second DMPA-SC Evidence to Practice Meeting17 global meeting in Dakar, Senegal led by the Access Collaborative. SIFPO2 served as an active knowledge resource for these forums, which provided opportunity for PSI country staff to gain practical information on introduction and scale-up of DMPA-SC through different service delivery models, including self-injection.

SIFPO2 served as the key catalyst in growing the number of PSI countries increasing access to DMPA-SC in the context of informed choice; from beginning with initiatives in DRC and Benin in 2015 to PSI supporting DMPA-SC scale up in 16 countries, including four independent PSI network affiliates in 2020. PSI has distributed more than 3 million DMPA-SC units since SIFPO2 began, with more than 600,000 units distributed yearly on average since 2015. Ninety-one percent of the approximately 3 million total units have been distributed within current USAID PRH priority countries. Without support from SIFPO2, PSI would not have been able to light the spark that ignited so many different PSI country teams and partners to accelerate their provision of DMPA-SC and to do so guided by a commitment to quality of care, including informed choice.

15 https://www.advancefamilyplanning.org/increasing-access-next-generation-injectables-meeting
16 https://www.path.org/articles/e2p/
HORMONAL IUD

The Hormonal IUD is one of the most effective forms of reversible contraception, offers several important non-contraceptive health benefits, and is popular in countries where it is available. This method, while decades-old technology, had nonetheless been previously inaccessible in the majority of PRH priority countries due to a confluence of commodity price, an absence of registered product in-country, and a health workforce lacking the skills to counsel on and deliver the method. From 2015–2020, SIFPO2 played a key role in the coordination platform for Hormonal IUD introduction efforts, which has now become the Hormonal IUD Access Group. SIFPO2 led pilot introductions and rigorous research in two countries to provide the evidence needed for broader market-shaping decisions by this group of partners and MoHs.

Beginning in 2017, SIFPO2 introduced voluntary Hormonal IUD services as part of a broad method mix through social franchise networks in Nigeria and Zimbabwe. PSI affiliate SFH Nigeria conducted training sessions with trainers who, in turn, built capacity among providers in over 40 franchise facilities to offer the Hormonal IUD. In Zimbabwe, PSI Zimbabwe introduced the method in six facilities in partnership with the University of Zimbabwe and supported consumer awareness for this new method. In addition, in Nigeria, SIFPO2 integrated communication on the Hormonal IUD into existing work of demand-creation agents. While in Zimbabwe, PSI incorporated information on the method into ongoing social media campaigns, radio shows, and events at tertiary schools.

In total, 3,305 women in Nigeria and 662 women in Zimbabwe chose a voluntary Hormonal IUD method over the course of the almost 4-year pilot. SIFPO2 conducted longitudinal studies with Hormonal IUD adopters and providers, as described in the Leading with Evidence section of this report. The results of SIFPO2’s Hormonal IUD acceptability research contributed to the global learning agenda and subsequent significant scale-up decisions at the global and national levels. For example, USAID and United Nations Population Foundation (UNFPA) initiated processes to add Hormonal IUD products to their global procurement catalogs; the British Foreign, Commonwealth and Development Office ring-fenced funding for Hormonal IUD procurement; and the MoH of Nigeria worked with SIFPO2 and others to develop a national scale-up plan for the Hormonal IUD.

INCREASING ACCESS TO UNDERUTILIZED LARC AND PMS

In addition to new method introduction, SIFPO2 delivered important work expanding access to existing methods, including historically underutilized LARCs and PMs. Strategies employed ranged from supporting innovative service delivery models and task-sharing to training and QA/QI support for introduction of voluntary tubal ligation and vasectomy. Further, SIFPO2 undertook work to ensure LARC removals were accessible and built into programming models.

In Niger, SIFPO2 piloted a rural outreach model that incorporated task-sharing of voluntary LARC methods to lower-level cadres and collaborative mobile outreach
models with service delivery by both MoH staff and PSI/Niger staff. The pilot took place across 18 designated health areas in Doutchi and Tibiri Districts, Southeast Niger. Through core investments in Year 4, Year 5, and Year 6, SIFPO2 supported 201 mobile outreach events in Niger, providing 5,278 voluntary contraceptive methods as well as 273 LARC removals services to clients and illustrating an approach to service delivery that has been subsequently supported through USAID Mission field support funding. Fourteen percent of these services were provided voluntarily to youth under age 20. Dissemination of learnings from the pilot were shared through a poster at the Ouagadougou Partnership Meeting (December 2019) and a webinar through an IBP Initiative (March 2020). Further, approaches used in the core-funded activities were used to inform the design of a field support buy-in in Niger, which began in March 2020 and continued through the end of the SIFPO2 project period of performance.

To support scale-up of mobile clinical outreach, a key strategy for reaching rural populations with a full range of contraceptive options, SIFPO2 also contributed to development of PSI’s first clinical mobile outreach standard operating procedures (SOPs) in Year 4/Year 5. This manual was developed as a collaborative endeavor with input from national staff members from Madagascar, Mali, Malawi, Mozambique, Tanzania, Uganda, and Zimbabwe. This tool provides guidance for country programs to (a) strategize where mobile outreach is most needed; (b) plan and prepare strong teams and logistics requirements; (c) raise awareness within catchment communities and inform women about upcoming service days; (d) conduct high-quality service days; (e) quality assure services and systems; and (f) manage team performance and mitigate risks. In Year 5, SIFPO2 supported a similar guide for community health workers involved in task-sharing of method provision, specifically contraceptive implants as well as counseling and referrals for all methods, including implants and intrauterine devices (IUDs).

SIFPO2 was also active in supporting the introduction of voluntary PMs and dissemination of global best practices. With SIFPO2 support, PSI developed a Permanent method pre-launch checklist for utilization by any PSI country programming adding voluntary tubal ligations and/or vasectomy to its service offering. This resource was used by PSI/Guatemala, PSI/India, PSI/Malawi, PSI/Pakistan, and PSI/Uganda. In 2016, SIFPO2 supported the checklist utilization by PSI/Tanzania, providing them with a more extensive road map to strengthen and revise their clinical QA system prior to launching tubal ligation services at the end of 2016.

SIFPO2 was an active participant in the Global Implant Removals Task Force, a forum for USAID, Bill & Melinda Gates Foundation, and other donors to collaborate with implant manufacturers and IPs on best practices related to implant removals through voluntary FP programming. Through the ‘Difficult Removals workstream’, PSI developed and disseminated flow chart guidelines for clinicians on decision-making related to attempted removal vs. referral for deep or otherwise difficult removals. SIFPO2 also supported Jhpiego in developing a continuing medical education video on managing difficult removals, discussed further in the Quality Assurance section of this report.

**AT A GLANCE**

Through core investments in Year 4, Year 5, and Year 6, SIFPO2 supported 201 mobile outreach events in Niger, providing 5,278 voluntary contraceptive methods as well as 273 LARC removals services to clients and illustrating an approach to service delivery that has been subsequently supported through USAID Mission field support funding.

SIFPO2 continuously worked to elevate best practices and share lessons learned on LARC and PM programming through global forums, including serving as secretariat for the LARC and PM community of practice and co-chairing the vasectomy subgroup. In addition, PSI co-chaired or participated in several technical meetings on key LARC and PM topics. For example, in July 2016, PSI co-hosted the 1-day
technical consultation titled Expanding access to long-acting reversible contraceptives and permanent methods through task-sharing. The 68 meeting participants represented USAID/Washington, USAID/Ethiopia, USAID/Nigeria, the Bill & Melinda Gates Foundation, the World Health Organization (WHO), the World Bank, the MoH of Nigeria, two academic institutions, four private industry partners (Bayer, Bioceptive, Merck, and Laerdal Global Health), and 16 IPs involved in FP programs.

AT A GLANCE

As the SIFPO2 project period ends, PSI is delivering ECPs in 17 countries at a global volume of approximately 4 million units per year, an increase of three countries (from 14 countries) and of approximately 300,000 units per year (from 3.7 million units per year) from the 2015 baseline. That PSI was able to stimulate this growth without any additional donor investments in ECP specifically, and during an era of declining support for social marketing programs, is a testament to the capacity of SIFPO2 to stimulate progress and sustainability.

RESPONDING TO CLIENT DEMAND FOR ECP ACCESS AND INFORMATION, INCLUDING FOR ON-DEMAND USE

SIFPO2 undertook work to strengthen access to ECPs, a method growing in popularity, especially among younger and unmarried women. Clients have historically faced several barriers to ECP access and utilization, including stigma and misconceptions around ECPs and an absence of comprehensive training and information on ECPs for both public and private healthcare providers. SIFPO2 initiated its ECP work in Year 2 with a strategy that identified key barriers to ECP access and approaches to combatting those barriers. This strategy also paved the way for PSI to introduce its ECP brand Pronta1 (LNG 1.5mg) to provide a high-quality, affordable ECP product in markets where there was a defined need. PSI’s global ECP programming has grown substantially in large part due to SIFPO2 investments in the enabling environment for method introduction and scale-up, e.g. technical assistance and guidance for introducing the method into social marketing programs, production of training and medical detailing materials for pharmacy/drug shop sellers of ECPs, and research on client experiences and preferences for access to and use of the method. As the SIFPO2 project period ends, PSI is delivering ECPs in 17 countries at global volume of approximately 4 million units per year. This is an increase of three countries (from 14 countries) and of approximately 300,000 units per year (from 3.7 million units per year) from the 2015 baseline. That PSI was able to stimulate this growth without any additional donor investments in ECP specifically, and during an era of declining support for social marketing programs, is a testament to the capacity of SIFPO2 to stimulate progress and sustainability.

Under SIFPO2, PSI conducted qualitative research among users of ECPs in Ghana and Zambia. Many study participants were engaged in ‘on-demand’ use and reported liking that ECPs can be taken only when needed. ‘On-demand’ use refers to planned or intentional use of ECPs as the contraception method. This is in contrast to ‘emergency use’ where ECPs are used in response to failure of another method or after unprotected sex. PSI developed a manuscript titled Supporting contraceptive choice in self-care: Exploring beliefs and attitudes towards ECPs and on-demand use in Accra, Ghana and Lusaka, Zambia that summarizes the results of the studies. This has been submitted to journals for peer review in 2021. Utilizing the insights that emerged, PSI developed communication messages and tested them among consumers in Ghana, Kenya, Uganda, and Zambia. Message themes include ECPs’ safety as a method used more frequently than once per month, the overall safety of ECPs and how method use does not harm future fertility, and user-control/planned ECP use. In the final quarter of SIFPO2, PSI disseminated these communication messages across the PSI network and will share more widely within the FP community of practice.
EXPANDED METHOD CHOICE FOR POSTPARTUM FP METHODS

Women in their immediate postpartum period are typically offered only a limited number of FP methods from which to choose. This is despite the fact that, for some women, their facility-based delivery may be among their only interactions with a health facility during their postpartum period. In Mali, 70% of postpartum women report an unmet need for contraception. To help address this gap, in Year 3, SIFPO2 supported PSI/Mali to pilot a new healthcare device—the dedicated postpartum IUD (PPIUD) inserter—which replaces the technique of using Kelly forceps for voluntary IUD insertion for women in the immediate postpartum period (within 48 hours of delivery). Protocols for use of the device come from those used in the USAID Saving Lives at Birth demonstration project in India, where rigorous evaluation demonstrated safety, efficacy, and acceptability of the device for use in delivering PPIUD. As well as eliminating the need for forceps, the dedicated PPIUD inserter increases a provider’s ability to know whether the PPIUD is correctly placed by elongating the insertion tube, which is firm but bends to accommodate the shape of the postpartum uterus and has a longer string that is visible after PPIUD insertion. The Mali pilot was initiated in close consultation with the MoH, whereby PSI HQ trained eight PSI/Mali staff and MoH staff trainers in 2015 for onward cascade training to other providers. The training was well-received by MoH and providers, who were enthusiastic about the ease of use of the new inserter. Providers noted the simplified IUD insertion process and the logistical convenience of not needing specialized equipment (e.g. Kelly forceps) in the delivery room.

As the first intervention using the dedicated inserter in Sub-Saharan Africa, the Mali pilot provided important lessons for the introduction and scale-up of PPIUD services throughout the region. In total, the SIFPO2-supported pilot enabled training of midwives and obstetric nurses in 47 private sector facilities and 38 public sector facilities in Mali. From October 2015 to September 2016, more than 1,400 women opted to receive PPIUDs following counseling and eligibility screening.

Qualitative findings from this work were reported in the GHSP Helping Postpartum Women in Mali Achieve Their Fertility Intentions: Perspectives From Introduction of the Dedicated Postpartum IUD Inserter18. This pilot showed strong acceptability and preference among providers for the dedicated PPIUD inserter versus the forceps insertion technique. Providers cited ease, speed, and reduced associated risks as benefits of the dedicated inserter, which gave providers more confidence to provide the voluntary PPIUD service. In 2016, Organisation Haïtienne de Marketing Social sur la Santé/PSI Haiti launched a pilot to introduce the dedicated PPIUD in Port-au-Prince, Haiti, utilizing lessons learned from the successful Mali pilot. Lessons learned from both countries were incorporated into the LARC and PM community of practice technical consultation on postpartum FP in September 2017. Through SIFPO2, PSI worked to scale-up awareness of and access to voluntary PPIUD, especially through the use of the dedicated inserter, in the context of access to broad method mix suitable for postpartum women. During the SIFPO2 period of performance, PSI introduced PPIUD into 11 countries, with the catalyst being the SIFPO2-funded pilots in Mali and Haiti.

AT A GLANCE

Through SIFPO2, PSI worked to scale-up awareness of and access to voluntary PPIUD, especially through the use of the dedicated inserter, in the context of access to broad method mix suitable for postpartum women. During the SIFPO2 period of performance, PSI introduced PPIUD into 11 countries, with the catalyst being the SIFPO2-funded pilots in Mali and Haiti. Specifically in Mali, from October 2015 to September 2016, more than 1,400 women opted to receive PPIUDs following counseling and eligibility screening.

18 https://www.ghspjournal.org/content/6/3/515
EQUITY

SIFPO2 undertook a range of measures to increase equity in the provision of FP services and healthcare broadly, from increasing access and quality of care provided for youth to strengthening the provision of financing for more equitable access to services. In addition to advancing equity within PSI programs, SIFPO2 sought to advance the science and practice of equity measurement in the global health community, in particular by convening stakeholders for the subsequent creation and application of the global EquityTool¹⁹.

From 2015, SIFPO2 led a consultative process with other agencies to agree to a strategy to simplify the process by which healthcare stakeholders could measure the relative equity of clients. At the time, measures of equity relied on absolute poverty indicators or asking clients over 30 questions to compare answers to information provided by Demographic Health Survey. Both options posed challenges, including the costs of asking so many questions to clients to measure relative equity. As a result of a consultative and evidence-based review, an alternative wealth index was created, requiring on average 66% fewer questions than were previously asked of clients. The simpler and shorter set of questions made the measurement of equity easier, faster, and more affordable for programs, helping stakeholders more precisely understand and adapt an intervention’s impact. Comparable data on equity across organizations is also useful for stakeholders interested in understanding how total markets impact across wealth quintiles. Metrics for Management (M4M), one of the stakeholders in the consultation, subsequently translated this methodology into the EquityTool.

Figure 3. Illustration of a standard EquityTool dashboard

To date, the EquityTool has been developed for 60 countries and has been adopted by diverse organizations, from Living Goods to International Rescue Committee. In PSI, country teams now routinely use the EquityTool to understand wealth profiles of the clients served by an intervention. Across PSI, 20 countries incorporate the EquityTool into routinely fielded annual client exit interviews. With the support of SIFPO2, PSI also uses an interactive data dashboard to display aggregated EquityTool data by country and allows for layering of other data, such as age or contraceptive use, to help teams make evidence-informed decisions about new and existing programs. See Figure 3 for an illustration of the EquityTool dashboard.

¹⁹ https://www.equitytool.org/development/
The EquityTool has been used to support important new research, including with SIFPO2 support, the 2019 paper *Who serves the poor?* An equity analysis of public and private providers of family planning and child health services in Kenya. This study showed that social franchises are more effective than previously believed at serving the poor, and that while public facilities still reach proportionally more poor clients, private providers remain an important source of FP services. This study, alongside the 2017 SIFPO2-funded report *Assessing provision and equity in low and middle-income country health markets*\(^\text{20}\) and a report on the relationship between wealth and use of health services in the private sector\(^\text{21}\), also provided further evidence that people’s relative wealth does not uniformly dictate their health-seeking behaviors. Where — or even whether — they seek services will vary across different health areas. For example, in some countries, the public sector is favored for treatment for children; in other countries, the private sector holds a large advantage. The same countries that favor the public sector for childhood illness may not necessarily favor it for FP services. This has important implications for effective resource allocation across different health areas.

SIFPO2 played a critical role in helping the global health community and national stakeholders develop approaches that are more sensitive to relative equity and help advance a stronger Total Market Approach.

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**AT A GLANCE**

The EquityTool has also been made fully compatible with DHIS2, thus making it accessible to the global health community, including national governments, and has been adopted by platforms such as mWater and Indikit, resulting in over 2 million user surveys to date.

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\(^\text{20}\) https://www.researchgate.net/publication/320384464_ASSessing_PROvision_AND_equity_in_low_and_Middle_income_country_Health_Markets_a_study_from_Kenya
RESULT 2
INCREASED SUSTAINABILITY OF COUNTRY-LEVEL FP AND OTHER HEALTH PROGRAMS
SUB-RESULT 2.1
FINANCING MECHANISMS THAT IMPROVE SUSTAINABILITY OF FP AND OTHER HEALTH SERVICES IMPLEMENTED OR LEVERAGED

FINANCIAL SUSTAINABILITY

Many of SIFPO2’s early initiatives that focused on sustainable financing have their roots in the 2014 Global Conference on Social Franchising for Health, which considered the financial sustainability of social franchises as a key theme. Ideas under discussion included the need for stronger links to national health insurance, business training of franchisees, increasing franchisor cost recovery from franchisees, and greater focus on product sales. PSI’s global provider networks and growing social enterprise activities offered a ready proving ground to test these concepts, and activities under this area largely fell into the following categories: country-level positioning for FP financing opportunities, leaning into a social enterprise approach to social franchising for FP, and exploring the feasibility and viability of innovative FP financing mechanisms.

POSITIONING FOR FINANCING OPPORTUNITIES THROUGH GREATER PUBLIC-PRIVATE ENGAGEMENT

Under this area, PSI engaged R4D to build the capacity of PSI-affiliated country teams to better understand health financing concepts and position for external financing opportunities for funding health service provision through the private sector. The assumption was that stronger engagement between private FP service provision and local public funders could lead to expanded access to voluntary FP services and products as well as increased financial sustainability for networked providers and country platforms. Due to a mix of factors relating to political and operational contexts, this support was provided to PSI-affiliated teams in Cambodia, Kenya, Nigeria, Tanzania, and Uganda.

Table 1. Highest-priority public-private engagement options developed with PSI country teams

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<td>Work with <strong>government contracts</strong>: Contract with Council Health Management Teams (HMTs)/Regional HMTs through Service Level Agreements to provide priority FP/RH and primary healthcare services.</td>
<td>Develop a maternal health <strong>public-private partnership</strong> with the Kampala Capital City Authority (KCCA).</td>
<td>Franchising in primary healthcare: Add a new tier of full and/or partial public sector franchisees via <strong>public-private partnerships</strong>.</td>
<td>Help develop and implement <strong>routine accreditation protocols</strong> for private facilities by the public sector.</td>
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22 https://www.msaworldwide.com/Financial_Sustainability_in_Social_Franchise_Programs.pdf
For each country, R4D provided an in-depth analysis on potential health financing sources and mechanisms within the context of the health market. R4D then worked alongside country leads to determine each platform’s key sustainability challenges and to identify financing options, such as leveraging public sector health insurance schemes, local government contracts, and private health insurance schemes. The process resulted in tailored roadmaps of immediate-, medium-, and long-term options for enhancing the financial sustainability of each country’s FP network. From those roadmaps, a priority option was pursued. Table 1 below shows these identified priorities for four of the five countries.

In Cambodia, Nigeria, and Uganda, SIFPO2 initiated analyses and relationships that eventually led to progress against each priority option from Table 1. For example, in Uganda, SIFPO2 guided discussions between PSI/Uganda and Kampala City Council Authority to develop a public private partnership to expand access to maternal, reproductive and child health services through PSI-supported facilities. While these discussions did not lead to a partnership directly funded with SIFPO2 support, they informed future discussions between KCCA and USAID/Uganda, culminating in a MCH-related concept note that then informed an eventual USAID/Uganda-funded partnership in 2018 called the **Maternal and Newborn Health (MaNe) Kampala Slum project**. In Lagos State, **SFH Nigeria** successfully facilitated the development of a contracting mechanism to manage five public model centers for primary healthcare.

In a separate but related activity in Year 6, R4D led the development of an October 2020 report outlining potential scenarios for progressively integrating FP and MCH commodities financing into routine health financing mechanisms in Ghana, including the Ghanaian National Health Insurance Authority benefits package. The report was the culmination of collaboration of the Country Contact Group, which included USAID and USAID/Ghana, UNFPA, the Ghana Health Services, and the Ghanaian National Medicines Pricing Committee.

The R4D-PSI partnership succeeded in several areas: developing a stepwise process for understanding complex health financing concepts; transferring capacity in health financing landscaping to country-level private FP networks; supporting facilitation and engagement with public sector counterparts; articulating diverse options for private actor contributions to health goals beyond service delivery; and translating those options into a realistic and coherent health financing roadmap to follow within the context of a mixed health system. These steps were captured in a **program guide**, intended as a practical manual for local FP network manager audiences. The support helped each country team take incremental steps towards this role in their respective markets, as discussed in this SIFPO2 report providing insights on engaging the private sector within national stewardship and financing systems for FP. This work was shared in a number of global forums, including the Health Policy Plus (HP+) project’s FP Financing Reference Team and its key FP financing conference in 2018, Global Health Mini University events, and the International Health Economics Association.

**LEANING INTO SOCIAL ENTERPRISE APPROACHES TO FP SOCIAL FRANCHISING**

The **Tunza Social Enterprise** model is one next-generation approach PSI developed to increase the financial sustainability of social franchising as a means to increase access to equitable, quality healthcare in the private sector.

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23 https://www.harpnet.org/project/the-kampala-maternal-newborn-health-project/
27 http://www.healthpolicyplus.com/FP-SSA.cfm
SIFPO2 contributed to the evolution of this model, which aims to slowly reduce social franchise networks’ need for donor subsidy by providing four pillars of support: (1) improved business systems, (2) clinical quality improvement, (3) increased demand for services, and (4) affordable quality products and services.

SIFPO2 supported the Tunza team in Uganda and Malawi to implement a new client management system, which provides financial insight for clinic managers that helps them manage costs and identify revenue drivers and enables Tunza to track incremental revenue gains generated during program participation. Tunza clinics, in turn, contribute a percentage of incremental gains in the form of fees to increase sustainability of the model. This system was linked to PSI/Uganda’s DHIS2 dashboards in 2017, and reports generated were used to provide business support to franchisees, such as how to calculate the number of added clients they would need to break even or generate a profit, even when offering client discounts.

SIFPO2 also funded analysis of the prospects for a regional buying network to link buyers to select distributors in exchange for volume discounts and improved credit and delivery terms. Under SIFPO2, PSI developed inventory best practice materials to help standardize the way in which commodities and consumables are received and inventoried. By the end of SIFPO2, the Tunza team was in discussions with two distributors in Malawi to provide volume discounts. In Kenya, the Tunza team was exploring partnership at the end of SIFPO2 with two existing group purchasing organizations: Medsource and Maisha Meds.

Like many investments designed to create sustainable approaches to equitable, quality, private sector service delivery in low-income and middle-income countries, the Tunza Social Enterprise has answered and addressed some critical issues for sustainable approaches to social franchising. What do providers value in such partnerships? What will providers pay for to acquire this value? What is the associated health impact of such relationships? SIFPO2 recognizes that Tunza Social Enterprise has not been able to answer all these questions with sustainable solutions at scale and thus has equally provided numerous lessons learned for PSI and others to take forward.

However, through its investments in proof of concept for the Tunza model, SIFPO2 catalyzed over $3.5 million in other donor funding for Tunza Social Enterprise networks in East Africa, including through private philanthropy investment via PSI’s Maverick Collective in Tunza, Kenya and Uganda; funding from the Dutch government for Burundi; funding from DFID for Somaliland; and support from KfW for Malawi. The story and value of Tunza Social Enterprise will continue to grow beyond the lifetime of this award.

AT A GLANCE
SIFPO2 supported the design of the first healthcare DIB focused on reducing maternal and neonatal mortality in Rajasthan, India.

EXPLORING INNOVATIVE FP FINANCING MECHANISMS
SIFPO2 supported the design of the first healthcare Development Impact Bond (DIB) focused on reducing maternal and neonatal mortality in Rajasthan, India. This DIB, called the Utkrisht Impact Bond, seeks to avert 10,000 maternal and newborn deaths by financing increased access to high-quality antenatal care, institutional delivery, and post-partum family planning services. The DIB represents a partnership between PSI and UBS Optimus Foundation, Palladium, HLFPPT, USAID, and MSD for Mothers. In 2016, SIFPO2 contracted with Social Finance, an organization with expertise working as a neutral intermediary, to consult with stakeholders and structure the DIB. With Palladium managing overall implementation, PSI now contributes as an IP under non-SIFPO2 funding.

STRENGTHENING FP SOCIAL FRANCHISING AND FP WORKFORCE

Social franchising is an evidence-based best practice utilized in FP/RH programming to support independently owned and operated clinical providers to add voluntary FP methods, such as LARCs, to their service offering to clients and strengthened overall clinical quality and business operations. Through SIFPO2, PSI strengthened and evolved its social franchising model to improved quality, cost-effectiveness, and sustainability. Activities focused on strengthening the FP workforce in the private sector and on testing support approaches, with results disseminated in various regional and global forums. SIFPO2 also supported the growth and refinement of the social franchising practice through contributions to knowledge and measurement within the global community of practice. Highlights of work on strengthening FP workforce, including through social franchising are outlined below.

STRENGTHENING CLINICAL QUALITY

Clinics that are members of PSI’s social franchise networks receive training and supportive supervision on FP counseling, insertion and removal of implants and IUDs, and other dimensions of QA/QI from PSI’s in-country Quality Assurance staff. SIFPO2 enabled PSI to develop and promote continuing medical education videos that demonstrate high-quality FP counseling, insertion and removal of implants and IUDs, and postpartum IUD provision that can be utilized through the HNQIS supportive supervision tool. Developed in consultation with QA officers from five country platforms, these videos provide on-the-job coaching support with animated illustrations to demonstrate proper technique. Additional details of QA/QI support to social franchise providers are described in the Quality Assurance section of this report.

Recognizing that quality of care encompasses facility-wide processes, structures, and elements of clinical governance, PSI and SIFPO2 partner PharmAccess collaborated in Uganda to pilot the SafeCare accreditation approach in select social franchise facilities. This collaboration included partnership with the Uganda Healthcare Federation, whose staff were trained and licensed to scale-up the SafeCare approach in-country at a significantly reduced cost in comparison with internationally provided support and oversight. In total, 47 franchisees in Uganda implemented the SafeCare approach, and 25 of these sites achieved measurable quality improvement in structural and operational quality against the SafeCare standards by the end of the pilot. Six sites reached a level of pre-accreditation against the International Society for Quality in Health Care (ISQua) quality standards for low resource settings. The pilot offered valuable lessons learned, particularly that without external drivers to incentivize quality in the private sector—such as reward through third-party payments or sanction through regulation—private providers are likely to remain hesitant to embrace and invest in QI initiatives.

STRENGTHENING COST EFFICIENCY AND BUSINESS SKILLS FOR SUSTAINABILITY

SIFPO2 delivered country-level activities in support of improved efficiency and business acumen, in harmony with the global community of practice’s emphasis on sustainable models for franchising support as articulated by stakeholders at the 2014 Global Conference on Social Franchising.

Key among these activities were design and launch of the Tunza social enterprise model, described in the Financial Sustainability section of this report. In the specific area of cost efficiency and business skills, PSI supported Tunza providers in development of their business skills and ability to use data for business decision-making. This included providing

31 https://www.psi.org/publication/securing-third-party-financing-through-accreditation-level-quality/
classroom-based business training, facilitating access to financing for business expansion, and managing and utilizing client data through clinic management system software to improve client flow and records, inventory management, revenue tracking, and link to DHIS2 to provide management dashboards.

**STRENGTHENING THE GLOBAL SOCIAL FRANCHISING COMMUNITY OF PRACTICE**

SIFPO2 enabled PSI and partners to meaningfully contribute to the growing and dynamic practice of social franchising. Over the course of the project, PSI SIFPO2 participated in the Social Franchise Metrics Working Group, including co-facilitating a 2015 meeting that focused on quality metrics for social franchising and resulted in *Quality metrics in family planning: Past, present, and future*. PSI SIFPO2 participated in global meetings of social franchise practitioners, donors, and other stakeholders, including the 2014 Global Conference on Social Franchising in Cebu, Philippines, and the 2017 Social Franchise Meeting in Accra, Ghana.

As previously highlighted, in the 2014 meeting in the Philippines, the global community underscored the importance of a long-term vision for social franchising sustainability. PSI and MSI wrote a joint *Op Ed* after the conference focused on linking sustainability to efforts toward universal health coverage, and both organizations contributed to a GHSP focus on social franchising: *Social franchising: A blockbuster to address unmet need for family planning and to advance toward the FP2020 goal*.

In 2017 in Accra, Ghana, USAID’s Sustaining Health Outcomes through the Private Sector (SHOPS) Plus convened a multi-project meeting of social franchising practitioners and USAID stakeholders to focus on quality and sustainability in franchising approaches. Presentation topics included monitoring and measuring quality, health financing, contracting with governments to provide voluntary FP services, and obtaining business improvement loans. PSI’s participants from more than 10 countries presented on a variety of subjects. In particular, this global workshop highlighted PSI’s strategic purchasing work in Kenya (demonstrating the linkages between the social franchise private facilities and public financing schemes); the evolution of the Tunza social franchise model in East Africa into a social enterprise; and several other PSI programs that emphasize the importance of integrating FP within an integrated service delivery approach.

Over the course of the project, SIFPO2 supported PSI’s sharing of lessons learned and best practices, including social franchising discussions in multiple webinars and briefs co-authoring of the USAID High-Impact Practices *brief* on social franchising.

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34 https://www.ghspjournal.org/content/3/2/147
35 http://www.fphighimpactpractices.org/briefs/social-franchising/
A DEEP DIVE INTO LESSONS LEARNED ABOUT SOCIAL FRANCHISING

In 2021, PSI continues to advance social franchising as a strategy to deliver effective, sustained health impact at scale. While the past decade of social franchising programmatic experiences has demonstrated the model’s ability to leverage private sector resources for health impact, experiences under SIFPO2 have also shown that the financial sustainability of the fractional social franchising model should be adapted to face the challenges of the next decade.

At the Global Social Franchising conference in 2014, the hope and expectation of many stakeholders was that third-party payers, public or private, would build upon the foundations laid through social franchising and create a pathway for sustainable financing of social franchising as a key vehicle to ensure equitable access to quality health services through the private sector. To some extent, this happened, with public purchasers contracting social franchise networks of PSI affiliates in Kenya and Nigeria to provide essential health services and other examples as described in the section of this report on sustainable financing.

However, the pace of change in health financing is typically slow, and the fiscal space for many governments has shrunk rather than expanded this past decade. Meanwhile, the private sector is not always a priority for public purchasers, although there are signs of change in several lower-middle and middle-income countries, with India and Indonesia providing recent additional examples of public payment for services provided by the private sector.

These experiences invite new adaptations in social franchising and approaches to strengthening private sector engagement in healthcare delivery, both to efficiently allocate support to the private sector and also to be less dependent on donor subsidy to sustain such work in both the short and long-term.

PSI will continue to provide support to private providers in the provision of quality health services; this is a proven vital way to increase equitable access to quality FP/RH and other health services. However, with the support of SIFPO2, the approaches to supporting private providers has been adapted within PSI to reflect the following lessons and approaches:

- The recognition that while fractional franchising delivers health impact and strengthens a health market to provide quality healthcare to a greater number of people, this model is more dependent on donor subsidy and thus may be more suitable to a market in the early stages of development, such as in a ‘fragile state’.

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36 https://www.ghspjournal.org/content/3/2/180
In lower-middle to middle-income countries, such as the large economies of East Africa, models such as the Tunza Social Enterprise and other enterprise approaches show promise, but how to create formal public-private partnerships and sustain such investments are as varied as the contexts in which such work is undertaken. There is a path to sustainability for such approaches, but it will likely be over a 10-year horizon and rely on the continued strengthening of these health markets’ capacity to coordinate beneficial public and private partnerships.

As illustrated in the section of this report on HNQIS, PSI advanced better targeting of resources that support providers in the provision of quality FP/RH services. This has resulted in a more efficient use of subsidy in all health markets.

Strengthening links between the public sector and these networks of private providers is critical so that there is increasing alignment and sustainability beyond the lifetime of any one project. SIFPO2 has supported the increased sharing of data and approaches to quality of care between public and private sector in several countries.

There is increasing focus on the intermediary models that play a key role in facilitating public and private partnerships in healthcare, particularly in middle-income countries. With USAID support, social franchising has continued to evolve, and now PSI increasingly speaks of healthcare networks as a term to describe the networking and support to private providers in providing equitable access to quality FP/RH while simultaneously reflecting the diversity of approaches that are most suitable each context.
SUB-RESULT 2.2
CAPACITY OF LOCAL PARTNERS TO PROVIDE QUALITY FP AND OTHER HEALTH SERVICES BUILT

QUALITY ASSURANCE/QUALITY IMPROVEMENT

PSI’s clinical FP service delivery encompasses support to large-scale provider networks, including 11,000 private sector health facilities across more than 20 countries delivering over 8 million voluntary FP services per year. Within these networks, SIFPO2 support has contributed to a robust and unified approach to QA/QI that elevates both client-centered care and health system strengthening in FP service delivery.

Over the course of the project, QA/QI approaches have been institutionalized at the country level with a view to sustainable, country-led QA/QI for FP and other priority health areas. Broadly speaking, SIFPO2’s accomplishments in strengthened QA/QI approaches have been made possible through three main areas of investment: (1) strengthening PSI and national quality of care systems, (2) developing new tools and evidence to advance client-centered care, and (3) deepening the QA/QI capacity of local leaders. Examples of this work include:

ENHANCED THE SUSTAINABILITY OF PSI’S QA/QI AUDIT SYSTEM FOR FP SERVICE DELIVERY IN PRIVATE AND PUBLIC SECTOR NETWORKS

An important component of the quality of care framework that guides PSI’s QA/QI interventions is an annual audit that provides accountability to provider networks providing FP services. With SIFPO2 support, PSI developed comprehensive QA/QI Audit Guidelines that support PSI network members to execute annual internal and external audits of private and public sector FP networks. The guidelines were translated into French, Portuguese, and Spanish, and include PSI’s global standards for client-centered care, provide the rationale and objectives of the audit exercise, and give programs a step-by-step guide for planning, implementing, and assessing the results of their audits within a continuous quality improvement framework. The guidelines were disseminated to PSI network members across the PSI global network and have become an institutionalized practice across PSI for supporting private and public sector FP service delivery. Often, audits include MoH officials who accompany auditors and actively participate in debrief sessions when QA/QI action plans are developed, strengthening shared accountability and coordination between the private and public sector.

In addition, PSI trained local PSI QA leaders to lead audits in other PSI country programs as a way to enhance the sustainability of QA/QI across the organization. By the end of SIFPO2, PSI surpassed its SIFPO2 Performance Management Plan (PMP) goal of having over 85% of all external QA audits led by a local PSI QA staff member; in 2019, 100% of external audits were led by a PSI staff member. This was a significant shift for the organization, moving from audits led by external consultants to audits led by local PSI expert QA/QI staff as standard practice.

AT A GLANCE

SIFPO2 activities described above strengthened the quality and standardization of over 44 QA/QI audits in 16 countries, which included detailed auditing of over 800 facilities over the project’s period of performance. The results of these audits inform national, regional, and global quality of care priorities for a much broader network of providers.
ADAPTED PSI’S AUDIT TOOL FOR USE BY A MOH IN NATIONAL FP AUDITS

SIFPO2 supported the adaptation of PSI’s QA Scorecard for use and integration MoH systems. For example, PSI’s network member, PSI/Ethiopia, adapted the scorecard for use in Ethiopia’s national public health system, including rural health posts during clinical FP audits. Through PSI/Ethiopia’s active participation and leadership role in the MoH Quality of Care Technical Working Group, PSI/Ethiopia presented its adapted clinical audit tools to the Quality of Care Directorate; the process to adopt the tool by December 2020 was initiated (due to disruptive national events, this is still pending final approval). The adapted version of PSI’s QA/QI system framework and scorecard evaluates both PSI’s support to an MoH across 40 global quality of care standards as well as its success in enhancing the MoH’s capacity to oversee quality of care across the entire health system. Other examples of use of the tool by the public sector include in Mali and Mozambique, where social franchising approaches include support to public sector facilities. Moving forward, this tool will serve as an essential guide for PSI network members extending their QA/QI best practices from private sector networks providing FP services to supporting QA/QI in the public sector.

ENHANCED THE PROFESSIONAL DEVELOPMENT OF LOCAL QA LEADERS

SIFPO2 support catalyzed the transition of local PSI QA leaders from staff that receive technical assistance from PSI/HQ to staff that form a part of PSI’s global quality of care leadership team. Through SIFPO2 support, PSI selected a QA regional lead from each geographic region (West and Central Africa, East Africa, Southern Africa, Asia, Latin America and the Caribbean) to support local PSI QA/QI programs. QA regional leads provided expert QA/QI support to FP programs, leading trainings, conducting audits, and disseminating best practices in clinical FP service delivery. By the end of the project, SIFPO2 had leveraged additional funding from other donors, allowing for a full-time, East Africa-based clinical advisor and senior clinical advisor to join PSI’s HQ quality of care team. This represents an important part of PSI’s commitment to prioritizing the capacity-strengthening and hiring of local FP leaders as a standard practice.

DEVELOPED GLOBAL QUALITY OF CARE STANDARDS FOR INTEGRATED CARE

PSI led a consultation across its global network to extend its FP global QA standards to apply to PSI’s HIV, sexually transmitted infection (STI), cervical cancer, malaria, and integrated healthcare service delivery. As a newly instituted organization-wide minimum standard, in 2019, 33 PSI network members supporting service delivery across health areas through public and private sector networks developed quality of care plans aligned to PSI’s new global QA standards, falling under five domains of quality: technical competency, client safety, information exchange, interpersonal connection and choice, and continuity of care. This shift aligns PSI’s quality of care systems across sectors, services, and health areas, with a priority focus on standards that advance client-centered care.

DEVELOPED A GLOBAL QUALITY OF CARE FRAMEWORK FOR SELF-CARE

This framework guides implementers, MoHs, researchers, policymakers, and donors in ensuring the highest quality standards in self-care interventions designed with clear linkages into a health system. The framework contains specific considerations for self-care and applies to a range of interventions beyond FP, including human papillomavirus (HPV) self-sampling and HIV self-testing. PSI disseminated the framework to the global community of practice in July 2020. It has been used in quality of care system strengthening activities for DMPA-SC, the Caya diaphragm, and HIV self-testing. In addition, in Uganda, the self-care framework has been adapted by the MoH in support of its DMPA-SC pilot.
QUALITY OF CARE FRAMEWORK FOR CLIENTS AND PROVIDERS IN THE DELIVERY OF SELF-CARE

WHO CONCEPTUAL FRAMEWORK FOR SELF-CARE INTERVENTIONS

- Self-care for health & well-being
- Key principles
- Places of access
- Enabling environment
- Accountability

ELEMENTS OF WHO FRAMEWORK CRITICAL FOR QOC IN SELF-CARE

- Health care clients
- Digital technologies and platforms
- Regulated health workforce
- Health sector accountability

QUALITY OF CARE DOMAINS FOR SELF-CARE

- Technical Competency
- Client Safety
- Continuity of Care
- Interpersonal Connection & Choice
- Information Exchange

UPDATED OR DEVELOPED NEW CLINICAL SERVICE DELIVERY PROTOCOLS AND DISSEMINATED THEM TO 25 PSI NETWORK MEMBERS TO INFORM FP SERVICE DELIVERY IN THE PRIVATE SECTOR

Updated protocols also supported PSI network members providing FP services in the public sector, serving to highlight where national FP protocols might deviate from international guidelines and best practices to guide PSI advocacy efforts. PSI updated protocols for IUD, implant and tubal ligation, and emergency contraception service delivery protocols to include the WHO’s medical eligibility criteria for repeated use. PSI developed new clinical service delivery protocols for FP service delivery through mobile outreach.

CONDUCTED A RESEARCH STUDY TO UNDERSTAND THE CORRELATION BETWEEN THE QUALITY OF SERVICES AND FP OUTCOMES IN SOCIAL FRANCHISES IN UGANDA

As highlighted in the earlier section on Leading with Evidence, PSI and partners led in creating and delivering the Assessing Service Quality and Contraceptive Discontinuation (ASQ-D) study, a 12-month prospective cohort study of service quality and contraceptive discontinuation among clients in social franchise networks in Uganda. The study assessed franchised facilities on aspects of structural and process quality using a Bruce-Jain
Quality of Care Framework (Quick Investigation of Quality) and conducted exit interviews with FP clients from 30 facilities. Analyses included an investigation into whether the Method Information Index (MII), a proxy measure for the quality of counseling that women receive that measures the extent to which women are given information when they receive voluntary FP services, is correlated with contraceptive discontinuation. A main result was that women who received a full score on the MII (a score of 3), a proxy that these women received good counseling, were less likely to discontinue their method than women who received lower-quality counseling, represented by lower MII scores. This suggests that good quality counseling is a critical component to ensuring that women are satisfied and continue with their method of choice, an outcome that now influences PSI’s prioritization of high-quality counseling across its FP interventions. The study was published in Global Health Science and Practice in October 2020, with initial findings presented at the International Conference on Family Planning in 2018.

37 https://www.ghspjournal.org/content/8/3/442.short
At the start of the project, PSI’s TMA lens focused extensively on cost recovery for condom markets. However, SIFPO2 was the key catalyst in fostering the broader and deeper understanding of TMA that now shapes PSI’s work. SIFPO2 activities in TMA included skills transfer to local field staff, new ways to generate and interpret market data, foundational market analyses from which to build key interventions, and convening an expanded community of practice through USAID’s TMA Working Group sessions.

Among SIFPO2’s TMA-related global goods is the Use Need Explorer Tool[^38], which encapsulates PSI’s Use/Need organizational methodology to analyzing

[^38]: https://www.psi.org/modern-contraception-use-need-explorer-tool/
and interpreting local market data and identifying key market failings to address. For example, as described in the ‘Leading with Evidence’ section of this report, through this methodology, PSI found that there were a significant number of wealthier, urban women in Ghana who had an unmet need for voluntary FP and presented this to key local stakeholders. In 2018, the Ghana Health Service referenced this finding\(^{39}\) as an unexpected yet important element to consider in future FP strategies. SIFPO2 also supported the conceptualization of the behavioral ecosystem\(^{40}\) shown in Figure 4 below that influences the journeys of health consumers. These concepts eventually evolved into PSI’s Keystone Design Framework\(^{41}\), which now underpins all programming at PSI.

In Year 5, SIFPO2 assumed the responsibility of convening the USAID TMA Working Group. SIFPO2 proactively sought to expand participation beyond the established membership and included discussion of market development-related programming in a range of health areas, such as childhood pneumonia, HIV, malaria, and Zika. The sessions served as a showcase for new data tools providing greater clarity on the total market, and sessions presented approaches and concepts related to TMA, such as market shaping, managing markets for health, and self-care from a TMA perspective.

SIFPO2 also carried out country-level work that helped address failings in local health markets or were catalytic to others’ efforts. In Year 1, SIFPO2 carried out a TMA analysis in Senegal and built the capacity of local partner ADEMAS to better understand and action TMA concepts. This work laid steps to support future efforts undertaken by the SHOPS Plus project to improve public-private engagement in Senegal\(^{42}\). SIFPO2 also supported a partnership with Accenture Development Partners in Year 1 to conduct a market assessment in Southeast Asia on options to grow the total FP market in the region. PSI then used Accenture’s findings to address an identified market need for a third generation, affordable oral contraceptive pill (OCP) for third wealth quintile clients in Cambodia, as evidence suggested second generation OCP side-effects were contributing to significant discontinuation rates. PSI subsequently used its own resources to support the introduction of a third generation OCP product to market, in partnership with a manufacturer in the region. In Years 3 and 4, SIFPO2 supported PSI/Nepal to conduct a consumer study collecting user insights relating to FP method preference and market failings among unmarried and sexually active women (15–24 years, including males) and newly married women and girls (20–24 years) from rural, urban, and urban slum areas. Insights from the study\(^{43}\) were organized in detailed consumer journey maps for each market segment, and PSI/Nepal is taking the recommendations forward in its youth programming. In Year 5, PSI/Ethiopia requested SIFPO2 TMA support to conduct a broad market landscaping exercise, including focus groups with key intended beneficiaries composed of unmarried and married couples in three national regions. Results from these consultations were fed into a user-centered design exercise to prototype an intervention for married couples ages 20–24 years who seek to postpone childbearing through access of voluntary FP products and services.

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\(^{39}\) https://www.popcouncil.org/event/delivering-contraceptive-choice-convenience-and-control

\(^{40}\) https://www.psi.org/2018/05/engaging-influencers-sbcc-2018/

\(^{41}\) https://www.psi.org/keystone/

\(^{42}\) https://www.shopsplusproject.org/sites/default/files/resources/Public-Private Engagement_q.pdf

A DEEP DIVE INTO LESSONS LEARNED ABOUT TMA

The experiences of SIFPO2 have been that the USAID community of practice engaged in TMA has made large strides this past decade. Knowing how to analyze a market accurately and in-depth before designing a solution that will ‘develop’ a strong total market has become second nature for many Implementing Partners to USAID, and this knowledge has been shared and used far beyond this community of stakeholders. The core and field support-funded work of SIFPO2 reflects this evolution.

In the past, some market actors, including PSI, might have seen themselves as the primary actor responsible for delivering solutions. Historically, PSI did this through the lens of creating choice and agency for consumers. However, like many actors in the field of global health, PSI has increasingly recognized there is a broad church of actors that can give consumers what they want, and in many markets, these capacities exist locally or regionally. PSI has been changed by the USAID ethos of TMA, and SIFPO2 played a significant role in this.

To illustrate the above progress, a broad range of tools exist and are now readily available for public consumption to measure what is happening in a market, as identified through the work of the USAID TMA Working Group. Having better market data will be a continuous journey for all who work in global health; but there many milestones indicative of progress in gathering and using market data this past decade, and SIFPO2 has benefitted from and contributed to this progress.

Meanwhile, a range of organizations, including PSI, that may have previously been inclined to provide a pre-determined ‘solution’ to a problem, whether that was social franchising or social marketing, are now more sensitive and flexible about which solution and which actor best serves the identified goals for ‘developing’ a given health market. Social franchising and social marketing have both evolved to be more effective tools for TMA and examples of this are illustrated in this report. In addition, PSI has changed its entire system of measuring the organization’s impact from a focus on disability-adjusted life years (DALYs) and CYP, which reflected PSI’s direct impact, to metrics that reflect stronger total markets and consumers being given greater agency, choice, and voice.
SO WHERE DOES TMA STAND IN 2021, AS SIFPO2 CLOSES OUT?

As outlined above, the data is far more readily available to all working in global and national health to provide situation analyses based on a good understanding of a total market. This is a critical foundation for any intervention in the market.

Especially with the advancement of digital technologies, new sources of data and new understanding of markets will continue to be needed and evolve.

That many people live in a world of ‘mixed health systems’, public and private, has been recognized at the highest level, with the WHO initiating a strategy for engaging private health service delivery through governance in mixed health systems. This emerging conversation about the pathways to ‘strong mixed health systems’ may be a direction that TMA leans into in the decade ahead, while needing to keep at heart the focus on private sector engagement that TMA also provided.

TMA has evolved and inspired deeper reflection and positive action in relation to ‘Market Development’ and ‘Market Shaping’. The future of TMA, based on lessons learned from SIFPO2, may pivot to a focus on generating a more meaningful understanding of private sector engagement within a total market, leaning towards a world that aims to build strong mixed health systems, leaning in on what consumers want and the capabilities of individuals to act as agents of change, and fully leveraging digital technologies to support these goals.

PROBLEMS AND OBSTACLES ENCOUNTERED DURING IMPLEMENTATION

As with any project that operates on such a scale, several challenges were faced during SIFPO2’s implementation, from the global to the national. Examples include the 2019 government shut-down in the USA, political instability in multiple countries, natural disasters, and the effect of the COVID-19 pandemic on programs around the world.

The challenges with the U.S. government’s 22-day shut-down and the resulting suspension of project activities were addressed through the helpful flexibility and support from USAID staff around the world who worked collaboratively with the SIFPO2 team to modify workplans and extend implementation timelines as appropriate.

Several SIFPO2-supported countries experienced political turmoil or natural disasters during implementation that resulted in service delays or disruptions requiring workplan modifications. Mozambique’s cyclone Idai delayed surge workplan implementation activities in 2019. Project closeout activities in Mali were delayed due to the August 2020 coup, which closed government offices and restricted mobility of project staff.

A significant number of activities planned for 2020 were suspended, postponed, or modified due to the COVID-19 pandemic. Notably impacted were community-level demand-creation activities, data collection/verification activities as well as clinical service provision affecting FP, voluntary male medical circumcision (VMMC), and HIV testing services (HTS) service delivery. To address these challenges, SIFPO2 staff worked in consultation with network partners and USAID Missions to amend project workplans where necessary, prioritizing the most critical activities and adapting approaches to enable service delivery efforts to reduce the possibility of COVID-19 transmission. Most ongoing programs shifted community mobilization and demand-creation strategies toward an increased reliance on digital interventions and the use of social media. Several countries, such as Malawi, Mali, Mozambique, and Niger also revised standard site-based and mobile outreach SOPs around client screenings, client flow, service provision, and data collection in the context of COVID-19.
LESSONS LEARNED

This final report has woven lessons learned into the fabric of the report and included deeper dives into learnings in social franchising and TMA specifically, as these two areas were areas of particular importance to the approach of SIFPO2 2014–2021. However, the nature of SIFPO2 is that as work was piloted, as research was undertaken, as innovations were tested at country level, adaptations were made to ensure the greatest return on investment. These lessons contributed to wider lessons learned, including:

The value of collaboration. Working collaboratively requires investment, trust and shared ownership of a collective endeavor. The work of PSI SIFPO2 in supporting scale-up in access to Hormonal IUD and DMPA-SC are illustrative of the importance and value of collaboration. This work benefited from collaboration with many partners, to whom the success of SIFPO2 is equally indebted. The caveat is this collaboration takes time and resources by all stakeholders, including USAID. In both these examples, the role of USAID and PRH specifically was pivotal to fostering effective collaboration.

The value of planning the approach to scale-up. The reality of scale-up is that it is rarely uniform — what works for one market or consumer can easily require a different approach in another. However, reflecting at key moments on the ExpandNet approach to scale-up did allow the project to tailor its approaches to the desired form of scale and to recognize that sometimes the innovations and opportunities for scale-up do occur spontaneously and should be seized upon with the same vigor as the approach required for vertical or horizontal institutional scale-up efforts.

The value of innovation and taking calculated risks. The mid-term evaluation of SIFPO2 raised questions about PSI’s commitment to digital health, particularly regarding how well up to 2017 these technologies had been fully integrated on the ground. This was a valid question that PSI and SIFPO2 were seeking to make progress on. The midterm evaluation of SIFPO2 stated that it was suggested that “PSI’s emphasis on digital health and technological innovation for program reporting and QA is ground-breaking, although subject to some limitations associated with capacity and connectivity in the field.” During the COVID-19 pandemic, many countries have relied on these nascent digital technologies to bolster the capacity of health systems to provide healthcare, and USAID enabled PSI networks around the world to respond more effectively to COVID-19 to continue to support and provide healthcare through innovations in digital health.

Finally, a lesson learned from SIFPO2 that PSI will carry into future awards is the value of aligning core investments to field support-funded initiatives. This is not always possible — sometimes the needs for a global good will differ from what a USAID Mission or country team needs or can do — but to see core investments increasingly layered more strategically on top of field support would likely increase the value of both in a global award such as SIFPO2.

45 https://expandnet.net/
46 https://storymaps.arcgis.com/stories/350fde3db5b34498a04662675709787d
SIFPO2
OTHER CORE INITIATIVES
In September 2018, SIFPO2 received $5.3 million in core surge funding to support voluntary FP service delivery activities in Liberia, Madagascar, Mali, and Mozambique. In May 2020, PSI received additional supplemental funding specifically to support COVID-19 prevention activities implemented in Ghana. PSI made a concerted effort to elevate reflections on USAID High Impact Practices in the design delivery of these initiatives, as highlighted in the reports below.

LIBERIA

The additional 2019 core funds allowed PSI/Liberia to provide technical support to the Family Health Division of the MoH to implement voluntary FP service delivery strengthening and demand-creation activities in Liberia from February 2019–March 2020. The objectives of these SIFPO2 investments are highlighted below.

Objective 1: Increase knowledge and capacity of public sector providers of the Family Health Division of the MoH of Liberia to provide a full range of voluntary FP services

This healthcare workforce investment in Liberia provided technical support to the MoH’s Family Health Division to enable the publication of the first comprehensive National Family Planning Training Curriculum for the country. The curriculum, based heavily on USAID’s Training Resource Packet for Family Planning, offers a comprehensive clinical introduction to FP counseling and the administration of voluntary short-term, long-acting, and permanent contraceptive methods.

In December 2019, the newly adopted training curriculum was used to train a cadre of 34 national-level master trainers to provide instruction to county-based trainers of trainers in all 15 counties of Liberia. PSI/Liberia distributed 35 training kits to be used during technical trainings that were designed to ensure competency and consistency in FP service delivery, as well as 485 IUD insertion kits to be used by trained providers in the provision and removal of long-term methods.

Objective 2: Increase access to accurate information about the benefits of FP and available voluntary FP services and increase voluntary uptake among underserved women, men, and youth in Liberia

PSI/Liberia implemented a health communications initiative to engage women of reproductive age, their partners, and youth with culturally appropriate messaging and services. The strategy was built upon a far-reaching radio and social media platform, including a youth-led call-in radio show, live social media broadcasts, and facilitated listening clubs for targeted youth audiences. During the intervention, 558 radio spots were broadcast and a Facebook campaign reached 184,000 users. A survey conducted with 68 participants reflected a high level (93%) recall of key messages conveyed during the programs.

MADAGASCAR

PSI/Madagascar provided mobile services for voluntary FP through engagement with both the public sector and key partners. Mobile services included the provision of underutilized LARCs (n = 25,241) as part of a wide range of contraceptive method options as well as LARC removal services, demand-generation activities, and health provider trainings.

SIFPO2 activities in Madagascar were implemented in 12 remote and underserved regions. Mobile outreach activities and resources were successfully transitioned to the USAID ACCESS project and will continue under that mechanism.
Some highlights of achievements made possible with SIFPO2 funding follow, organized by key objectives of the workplan.

Objective 1: Develop a high-quality mobile outreach platform

In January 2019, PSI/Madagascar equipped five mobile clinics with the materials needed to perform mobile clinical events across the supported regions. PSI/Madagascar also provided technical support to the MoH in conducting a national commodity quantification exercise to guide future commodity purchases.

Mobile clinic staff trainings addressed previously identified gaps in knowledge and practice among public providers in the provision of these methods and were intended to help expand the number of methods that were offered by these providers both during and after mobile clinic events.

Objective 2: Ensure high-quality service delivery

As part of routine SIFPO2 activities, PSI/Madagascar implemented a QA system that ensured services were provided according to global standards and consistent with national protocols. An internal quality audit conducted in the fall of 2019, resulting in a score of 78%, prompted adjustments to infection prevention practices to further improve quality standards. PSI/Madagascar has streamlined the process and committed to making wait times as short as possible for clients attending mobile outreach activities.

To ensure quality of demand-generation activities, PSI/Madagascar’s medical and communication teams collaborated to develop messaging around common myths and misconceptions associated with voluntary FP methods, especially LARC.

Objective 3: Expand access to quality LARC services for women of reproductive age and youth in rural areas

In addition to the provision of over 25,000 LARC services, provided in the context of informed choice, mobile outreach teams also provided 46 IUD removals and 729 implant removals during this period. These removals included LARCs that were inserted by PSI/Madagascar and other partners.

Objective 4: Ensure follow-up care

PSI/Madagascar mobile units through SIFPO2-supported public health facilities have strengthened follow-up care, including LARC removals, through the training and supervision of front-line providers. Client records created during the delivery of mobile services were stored at the public health facilities for follow-up. Clients also received a list of phone numbers and locations of LARC-trained providers in the region as part of their client post-service support package.

USAID High Impact Practices applied in this intervention in Madagascar
MALAWI

At the request of the Malawi Ministry of Health’s Reproductive Health Directorate and USAID Malawi, PSI/Malawi invested funds to build upon KfW-supported sexual and reproductive health (SRH) services in eight districts and provide comprehensive outreach services in Lilongwe and Machinga. These USAID investments supported the following components:

- Social marketing activities through private sector channels, including Tunza social franchise clinics;
- Community-based distribution agents, working in hard-to-reach areas, brought short-acting methods to clients and end supported effective referral for clients choosing LARCs and permanent methods;
- Mobile outreach services providing integrated reproductive health services, offering a wide range of contraceptive methods including short-acting, LARCs and permanent methods.

As the table below shows, these combined efforts generated a high number of CYPs directly supported by USAID in the intervention areas.

In addition, as part of the Child, Early and Forced Marriage (CEFM) initiative, PSI/Malawi provided integrated services to adolescent girls and young women with a view to preventing, and mitigating the negative effects of, CEFM. PSI/Malawi worked within a consortium of partners, each providing separate

### SIFPO2 MALAWI SPECIAL APPROPRIATION AT A GLANCE

Scale-up of mobile outreach services in 2 districts and support to private providers in 8 districts contributed to 590,745 CYPs provided

Community-based distributors provided for rural communities, counseling, short-acting methods, and LARCs/PMs through effective referrals

The Youth Alert (YA!) Radio Platform aired over 77 radio programs covering various FP/RH topics

<table>
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<tr>
<th>DISAGGREGATION</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<td><strong>221,328</strong></td>
<td><strong>135,015</strong></td>
<td><strong>125,934</strong></td>
<td><strong>108,468</strong></td>
<td><strong>590,745</strong></td>
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<td>Short-acting FP methods</td>
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<td>Long-acting FP methods</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>125,934</strong></td>
<td><strong>108,468</strong></td>
<td><strong>590,745</strong></td>
</tr>
</tbody>
</table>

USAID High Impact Practices applied in this intervention in Malawi
but complementary packages of interventions. PSI’s role within this consortium was focused on the delivery of voluntary FP/RH services that are accessible to adolescent girls and young women in underserved areas. Advocacy with the Ministry of Education also resulted in the endorsement of an addendum to the in-school life skills curriculum to include voluntary FP and encouraging discussions around contraceptive use.

MALI

SIFPO2-supported activities commenced in Mali in November 2018 and concluded on September 30, 2020. Throughout the 23 months of workplan implementation, SIFPO2 in Mali strengthened access to voluntary FP by improving access to information, products, and services and by improving the quality of service delivery in Association Nationale des Cliniques ProFam (ANC ProFam) clinics and the public sector. Activities were implemented in close collaboration with national, regional, and district partners.

In the final 6 months of implementation, SIFPO2 in Mali transitioned to closeout as necessitated by the COVID-19 pandemic and a coup d’état resulting in the dissolution of the government. Despite these challenges, significant achievements were made during SIFPO2 Year 6. In conjunction with the Ministry of Public Health and Social Action, SIFPO2 conducted an analysis on the reasons for and experiences of implant removals in the intervention zones. Key findings from this analysis, including the average costs of implant removals, were shared with national-level MoH staff in early 2020.

At the national level, SIFPO2 in Mali led the revision of the national provider training curriculum on contraceptive technology as part of a collaborative effort with partner nongovernmental organizations (NGOs).

Specific outputs and achievements, grouped by objective, are as follows.
Objective 1: Increase access to health information and the quality of voluntary FP products and services among poor women, men, and young people

Interpersonal Communication Agents trained by PSI/Mali created demand for voluntary FP services and raised awareness about the range of voluntary FP options so that women can make informed choices about use.

Activities by youth peer mobilizers took place in universities and vocational training centers around the ANC ProFam clinics, particularly those that provide youth services. These youth activities reached 6,137 people, of whom 4,826 were referred to youth clinics.

Grins, traditional Malian social clubs, provide a venue for discussion events focused on the FP/RH of young people, including the use of voluntary FP and the prevention and treatment of STIs.

The 26 husbands schools conducted voluntary FP demand-generation activities in the community. Quarterly meetings of the 26 coaches were also held, and the coaches actively participated in the International Women’s Day events in March 2020 by supporting demand generation for cervical cancer screening.

Objective 2: Improve the quality of service delivery between (a) the ANC ProFam network of private sector franchised clinics, and (b) public sector providers in partner Centres de Santé Communautaire

PSI/Mali supervisors conducted supervision of providers at both public and private facilities. Some challenges, including ensuring a separate room for FP counseling, remain difficult to overcome in specific health facilities.

Mobile outreach services continued to be an important part of voluntary FP service delivery during Year 6, and particularly in traditional gold mining areas. In total, 18,140 voluntary FP services were provided through the mobile outreach services in Year 6.

MALI AT A GLANCE

| 118 | Health centers supported. |
| 1,390 | Providers trained. |
| 59,000 | Reached. |
| 24,510 | Clients chose modern FP. |

USAID High Impact Practices applied in this intervention in Mali
MOZAMBIQUE

PSI/Mozambique’s surge-funded activity under SIFPO2 supported strategic interventions with high-impact potential for improving voluntary FP outcomes in Mozambique. The activity built upon PSI/Mozambique’s in-country programmatic experience as well as market gaps identified through a total market assessment undertaken by UNFPA, PSI/Mozambique, and the MoH in 2016. PSI/Mozambique contributed to SIFPO2’s global aims through increased awareness of and access to a broad range of voluntary FP methods and quality service delivery within the public sector for women, including youth, within the context of informed choice. Implementation focused on increasing knowledge, information, and demand for voluntary FP services; improving provider capacity to counsel and administer a full range of voluntary contraceptive methods; equipping health facilities with the necessary equipment to perform a full range of voluntary FP services; and improving provider quality and motivation through ongoing supportive supervision visits.

Objective 1. Strengthened linkages between the private sector and the national health system of Mozambique

This intervention achieved visible increases in voluntary FP uptake, particularly for LARCs, as chronicled in this brief outlining the successes of its mobile, on-the-job training model. Under the second objective, PSI/Mozambique sought to better understand the role of the private sector in the provision of voluntary FP and other primary health care services in the cities of Maputo, Matola, and Nampula. The resulting research involved geo-mapping of private health outlets, and identification of supply and demand-side opportunities and constraints across the value chain. A final report recommended and prioritized potential synergies/complementarity between the private sector and the national health system with a view to strengthened engagement for national FP and primary care objectives. At SIFPO2’s close, PSI/Mozambique organized a series of sensitization and action planning meetings with the MOH and USAID/Mozambique to address the report’s recommendations post-SIFPO2.

MOBILE OUTREACH SERVICES

SUPPORTIVE POLICIES
(PRIVATE SECTOR LANDSCAPE TO INFORM FUTURE ENGAGEMENT)

USAID High Impact Practices applied in this intervention in Mozambique

Photo credit: Eliasaph Diassana, Consultant Photographe
GHANA (COVID-19)

PSI/Ghana and partner TFHO implemented a rapid intervention over a 6-month period focusing on increasing Ghana’s local capacity to produce hand sanitizer products and disposable face masks for preventing transmission of COVID-19 and to help scale-up distribution. The project was designed with the following objectives.

Objective 1. Increase the local production capacity, distribution, and use of hand sanitizers and personal protective equipment (e.g., medical-grade face masks) in Ghana and regionally in West Africa

TFHO joined together with two manufacturers of hand sanitizer products in Ghana to ensure a steady supply of quality and affordable sanitizer products across the country. Guidance was provided on options to increase production capacity and improve product quality. As a result, total installed production capacity for the two manufacturers increased, and new SOPs were developed for each manufacturer.

TFHO implemented brand-specific demand-creation activities to drive sales of hand sanitizer and expand distribution and also engaged the services of a research firm to conduct three waves of nationwide retail audits. The audit included a total of 617 retail outlets, including pharmacies, over-the-counter medicine sellers, supermarkets, malls, grocery shops, gas stations, and corner shops.

TFHO supported Ethical Apparel and its local partner Maa Grace Garment Industries, Ltd, (MGIL) based in Koforidua, to expand its operations to include an ISO-certified medical-grade face mask/surgical mask production unit, and to explore the export of these masks to other neighboring countries. TFHO also supported the purchase and installation of a cleanroom to produce the masks.

GHANA AT A GLANCE

900,000
Liters of hand sanitizer distributed.

10 MILLION
People reached.

300%
Increase in hand sanitizer production capacity.

Photo credit: Unitaid Eric Gauss.
SPOTLIGHT

LOCAL MANUFACTURING IN GHANA

The COVID-19 pandemic resulted in massive supply chain disruptions of personal protective equipment (PPE) and other critical medical supplies. African countries were often behind other buyers when competing with higher income nations for PPE procurement.

To address this challenge, Total Family Health Organization (TFHO) in Ghana, a network member of PSI, supported a large garment manufacturer’s pivot to PPE and two large alcohol distillers’ pivot to sanitizers. TFHO bolstered infrastructure improvement, product development, market analysis, and marketing strategy to help scale up production of PPE to 1 million units per month and of sanitizers to 30,000 liters per day. Scale-up of local manufacturing not only increased the supply of critical products but also sustained employment and built resilient supply chains.
USAID FIELD SUPPORT, DREAMS AND ZIKA INTERVENTIONS UNDER SIFPO2

Funds obligated through SIFPO2 by USAID Missions were used to maximize health impact across Africa, Asia, Latin American, and the Caribbean. A diverse array of health programs were designed and implemented over the life of the project to expand availability and access to quality FP services and other critical health services for underserved communities. A summary of this work follows.

BENIN

Initially with USAID/Benin field support and later a program income-funded workplan, PSI’s network member Association Béninoise pour le Marketing Social (ABMS) increased modern voluntary FP method uptake within the context of informed choice through key social franchising and social marketing interventions throughout Benin. ABMS’s SIFPO2 fields support operated from October 2014 – June 2018, and its program income workplan overlapped, from June 2017 – June 2020. All activities focused on three primary elements: increasing access to integrated voluntary FP and maternal health services through the private sector; increasing demand for integrated voluntary FP and maternal health services and products; and improving the quality of health services delivered in Profam franchise clinics.

SIFPO2 supported up to 70 Profam clinics to offer a comprehensive package of integrated services, including voluntary FP, HIV and MCH services in line with MOH recommendations. In later years, SIFPO2 supported Profam clinics to add child health services related to neonatal health, malaria, diarrhea, pneumonia and nutrition. In 2018, ABMS introduced the HNQIS tool into QA and supervision across the network. Two mobile clinics also provided a range of voluntary FP counseling and integrated services in areas with limited access to quality health service provision. Under SIFPO2, more than 23,000 women (including more than 9,000 youth) received voluntary FP services at Profam clinics and almost 54,000 women (including more than 19,000 youth) accessed voluntary FP services through mobile clinics.

Under SIFPO2, ABMS used social marketing approaches to increase demand for integrated FP/MCH products within the context of informed choice, including the Laafia brand of voluntary FP products, Prudence Plus condoms, Aquatabs, and Orasel-Zinc. SIFPO2 also supported demand generation through mass media outlets, Facebook, and ABMS’s toll-free hotline (Ligne Verte), which fields thousands of calls per month on a wide range of health issues and gender-based violence. To complement these activities, ABMS deployed mobile video unit (MVU) sessions and interpersonal communication (IPC) agents in the communities served.

USAID/Benin further leveraged ABMS’s health communications expertise through SIFPO2 funding for targeted communication campaigns. During SIFPO2, ABMS taught almost 800 owners of small businesses including medicine shops on the dangers of selling, purchasing, and using counterfeit or substandard ACTs, and reached almost 17,000 women and

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47 https://abmsbj.org/
48 https://abmsbj.org/prudence-plus/
49 https://abmsbj.org/aquatabs/
50 https://abmsbj.org/orasel-zinc/
51 https://abmsbj.org/ligne-verte/
52 https://abmsbj.org/unite-de-video-mobile-mvu/
caregivers with similar information. During the Ebola emergency starting in 2015, ABMS secured more than 22,000 radio spots on Ebola preparedness and prevention and reached more than 57,000 people with related messaging at community level. Starting in 2016, ABMS also worked closely with the MOH and other partners to develop communication tools and sensitize more than 500 local and religious leaders on the national introduction of DMPA-SC within the context of informed choice.

Throughout SIFPO2, ABMS worked towards greater integration of its data and QA systems with the public sector, as well as improved sustainability of its social franchising operations. While quality improvement processes in the early years of SIFPO2 focused on internal PSI supervision sessions, in later years ABMS undertook joint supervision sessions with public sector counterparts. Over the course of SIFPO2, ABMS rolled out the ‘ANC Profam’ (Association Nationale des cliniques Profam), a Profam provider network association, which provided capacity building in business management, business counseling, and mentoring in an effort to reduce donor subsidy in future years. ABMS also worked closely with the PSSP (Plateforme du Secteur Sanitaire Privé du Bénin), a private sector coordination mechanism, to better align its contributions with other partners in the total market.

CAMBODIA

The SIFPO2 project, PSI/Cambodia and local affiliate, Population Services Khmer (PSK), provided support for private providers within the ‘Sun Quality Health Network’ (SQHN) in the fields of HIV, FP, and child survival, as well as supporting a ‘Total Market’ initiative to transition vital FP products from being dependent on donor-subsidy, to being unsubsidized, sustainable, accessible, quality FP products available in Cambodia.

Result 1: Increase the supply of and demand for modern methods of voluntary FP and RH services

PSI/Cambodia and PSK strengthened FP markets through interventions that impacted supply, demand, and an enabling environment. During this intervention PSK conducted supportive supervision to SQHN providers, ensuring all providers met agreed minimum quality standards. In addition to quality checks and on-the-job skills coaching, these visits used ‘Provider Behavior Change Communication’ to encourage providers to support clients to access voluntary LARC methods, in the context of informed choice. Community mobilizers were engaged and in the final year of the intervention successfully referred 530 women (out of 6,323 clients contacted), who subsequently all visited a SQHN provider for FP services. As a result of these efforts, walk-in FP clients to the SQHN providers increased by 25% in the final quarter of the intervention. Meanwhile, at a macro level, with SIFPO2 support, PSK undertook and shared ‘Total Market’ analyses with a broad range of national stakeholders, contributing to the 2016-2020 Cambodia Reproductive Health Commodity Security Strategy Action Plan and the 2017-2020 National Strategy for Reproductive and Sexual Health in Cambodia.

54 https://psspbenin.org/statics/about
**Result 2: Increase sustainability of commodity supply for HIV prevention and FP**

During this intervention, PSI/Cambodia and PSK strengthened the condom market by ensuring condoms and lubricant were available at guesthouses and other high-risk venues as well as launching the OK Plus Condom brand with lubricant at a cost-recovery price. Extensive efforts were also made to strengthen the market for oral contraceptive pills (OCP). For example, support was provided to a major distributor ‘Mega Lifesciences’ to expand their coverage to new outlets. From September 2015 to August 2016, Mega Lifesciences expanded their range of FP products to 232 new outlets, reaching a total of 2,749 outlets nationwide. Meanwhile, PSK’s sales of Eva Marvelon OCP, an unsubsidized second generation OCP offered at a mid-level price point, continued to surpass projections.

Inspired by the TMA analyses undertaken through SIFPO2 and using its own funds, PSK partnered with a pharmaceutical company based in India (Jai Pharma) to develop a third generation OCP brand and launch plan, aiming for a price that is affordable to wealth quintiles two and three in Cambodia. The launch of this OCP, called Meuri, helped to fill a gap identified through the analyses that revealed 95% of the OCP market in Cambodia was comprised of the identical ‘older generation’ of contraceptive pills, such as ‘OK’ pill and ‘Srey Pich’, the public sector brand. Launched in 2020, sales of Meuri have suggested the demands for the product is strong and that Meuri has added a valuable and sustainable contribution to the FP market in Cambodia.

In addition to interventions outlined above that strengthened private sector engagement in strong FP markets in Cambodia, PSK organized ‘family planning trade events’ in three locations (Phnom Penh, Battambang, and Siem Reap) to support strong FP commodity markets by sharing with key customers the different product features and benefits, and encouraging retailers to carry a broader range of products for clients. PSK invited condom companies including Okamoto, Romantic and Durex to join the FP events free of charge, where they gave out free samples, highlighted their products in a joint presentation, and carried out promotional activities.

In addition, through outreach to major commercial sector players, PSK noted that a key concern regarding high-risk venues was the reluctance of many owners to carry and display condoms — which may be seen by law enforcement as a sign that their venue allows sex trafficking. PSK met with National Center for HIV/AIDS, Dermatology and STD (NCHADS) and National Aids Authority (NAA) separately to identify way to motivate high-risk venue owners to stock and sell condoms at their venues. NAA agreed to an endorsement recognizing entertainment establishment owners in the agenda/work plan of the government’s 100% condom use program. The results of these efforts are illustrated with the condom sales figures at the top of this page during the year of this intervention.

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>GUESTHOUSES COVERED</th>
<th>% COVERED</th>
<th>TOTAL CONDOMS SOLD</th>
<th>CONDOMS SOLD TO HIGH-RISK VENUES</th>
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<tbody>
<tr>
<td>Q1</td>
<td>1,288/1,351</td>
<td>95%</td>
<td>3,036,000</td>
<td>815,454</td>
<td>27%</td>
</tr>
<tr>
<td>Q2</td>
<td>1,348/1,351</td>
<td>99%</td>
<td>3,727,000</td>
<td>670,236</td>
<td>18%</td>
</tr>
<tr>
<td>Q3</td>
<td>1,348/1,351</td>
<td>99%</td>
<td>1,879,000</td>
<td>568,236</td>
<td>30%</td>
</tr>
<tr>
<td>Q4</td>
<td>1,346/1,351</td>
<td>99%</td>
<td>4,035,000</td>
<td>703,008</td>
<td>17%</td>
</tr>
</tbody>
</table>
**Result 3: Increase appropriate acute respiratory infection (ARI)/pneumonia and diarrhea treatment**

PSI/Cambodia and PSK worked with the network of ARI/pneumonia clinics to generate demand for and ensure high-quality services and supplies to treat pneumonia, ARI, and diarrhea. PSK conducted assessments, conducted refresher trainings, and aired local and national radio spots to increase demand for and correct use of pneumonia and diarrhea treatments.

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

PSI provided extensive capacity-building assistance to PSK to continue its long-term investment in PSK systems, processes, and people and to ensure achievement of the SIFPO2 project workplan and deliverables. This included intensive financial and global governance training, developing an audit charter and internal audit plan, and implementing a new organizational strategic plan.

**Result 5: Expand choice for safe water options in Kampong Speu**

PSK expanded the use of existing clean water solutions by improving households’ access to a variety of options, supporting the selling of water filters, and encouraging providers to discuss prevention of waterborne diseases. The capacity was strengthened of the ‘kiosk management committees’ in improving the overall quality of their services and to increase demand for the O-We Water brand of safe drinking water. PSK also recruited IPC agents to deliver clean water messages and to encourage the adoption of a clean water solution among households Kampong Speu province. A TMA analysis was also undertaken examining the functions, players, relationships, and incentives within the sanitation marketplace in Cambodia to identify key market failures and constraints that could inform interventions.

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**DOMINICAN REPUBLIC**

USAID Dominican Republic began in 2010 to partner with PSI network member SFH to reduce HIV and STI rates. A crucial component of this partnership was a national condom social marketing initiative. After the project closed in 2016, USAID Dominican Republic provided additional funding through SIFPO2 to transfer key activities to the MoH to ensure the continuity of access for most at-risk populations. This included assessing continuing barriers to condom use and demand as well as strengthening the capacity of MoH staff to manage and distribute condoms and lubricants.

**Result 1: Identify condom availability gaps**

SFH conducted an analysis of the condom market using data from both the private and public sectors to identify market gaps and develop potential responses. The resulting conclusions were condensed and presented to the local USAID Mission, authorities from the National Health Service, President’s Emergency Plan for AIDS Relief (PEPFAR) authorities, and local IPs.
Objective 1: Increase the availability of quality health services and products related to voluntary FP, MCH, Water, Sanitation, and Hygiene (WASH), and HIV/AIDS

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

Result 2: Strengthened national and regional services capacity for managing the condom supply chain

SFH staff’s analysis for the MoH and Regional Health Departments calculated the total market for condoms to calculate national-level demand more accurately. SFH staff served on the national Reproductive Health Supplies Committee (DAIA), supporting the drafting and revision of the country’s 2018–2020 National Condom Strategy.

Result 3: Support in the transition of the condom social marketing program

SFH initiated the first delivery of generic condoms to the MOH’s National Health Service ‘Region II’ warehouse, to be distributed to the region’s health centers. The pilot effort was monitored to ensure condom access and availability remained consistent. SFH continued to serve as the transitional steward, disbursing to other community-based IPs according to need until an alternative USAID IP took on this role.

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

PSI/ASF focused on increasing the knowledge of and demand for HIV products and services through social and behavior change communication (SBCC), including IPC and mass media. PSI/ASF also engaged priority audiences in discussions about their FP options and diarrhea prevention and treatment.

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

PSI/ASF reinforced the functions and actors that underpin the health market by capacity strengthening a broad range of commercial and non-governmental local organizations, to support product distribution, communicate with communities and collaborate with the government to jointly implement and supervise activities.

DEMOCRATIC REPUBLIC OF THE CONGO

With SIFP02 support, the Association de Santé Familiale (ASF) contributed to the achievement of the MoH’s strategic goals and USAID’s Country Development and Cooperation Strategy for the DRC. PSI/ASF applied a market development approach to improve health outcomes for people with the greatest unmet need for FP and RH products and services. ASF dovetailed SIFP02 efforts with those of the National Program for Reproductive Health and other projects to achieve three objectives outlined below.

Result 2: Strengthened national and regional services capacity for managing the condom supply chain

SFH staff’s analysis for the MoH and Regional Health Departments calculated the total market for condoms to calculate national-level demand more accurately. SFH staff served on the national Reproductive Health Supplies Committee (DAIA), supporting the drafting and revision of the country’s 2018–2020 National Condom Strategy.
In 2017, the final year of SIFPO2 in DRC, ASF, the PSI affiliate in DRC provided:

**SIFPO2 DRC AT A GLANCE**

- **8,000** IUD Insertions
- **56,000** 5-year implants
- **23 MILLION** Male condoms
- **1 MILLION** Female condoms
- **6.5 MILLION** Water purification tablets/packs
- **300,000+** Individuals reached with RP information at community levels by ICP agents
- **300,000** DMPA-IM and 150,000 DMPA-SC
- **1.3 MILLION** Cycles of oral contraceptives
- **13,000** Cycle beads
- **45,000** Emergency Contraceptive pills
- **200,000+** Mothers or caregivers of children Under-5 received support on diarrhea prevention and treatment

**ESWATINI**

In addition to field support funds, PSI eSwatini received DREAMS funding through SIFPO2 to implement condom distribution and social and behavior change programming in eSwatini from March 2016–September 2020.

**Objective 1: Increase access to a core package of tailored, evidence-based interventions intended to increase uptake of HIV and sexual and reproductive health (SRH) services for AGYW**

Through the DREAMS initiative, PSI/eSwatini collaborated with Pact and Health Communication Capacity Collaborative to address structural determinants that increase girls’ risks of HIV acquisition and/or early or unintended pregnancy.

PSI/eSwatini focused on providing youth-friendly mobile HIV and SRH services to high-risk populations, operating five mobile units, four DREAMS on Wheels units, and another unit, under a unique public-private partnership scheme in Matsapha district. All five units provided HTS, referrals to antiretroviral treatment, prevention of mother-to-child transmission, tuberculosis screening, STI treatment, FP provision, prevention information and referrals, and condom education and distribution, while increasing risk perception and reducing vulnerabilities to HIV. A mix of oral, injectable, and implant contraceptives were provided free of charge, with referrals provided for other methods.

The four regional Mobile DREAMS on Wheels Units provided services from project onset until April 2018, when the mobile units and the DREAMS on Wheels brand were transitioned to Pact, who will continue with a USAID grant for services to orphaned and vulnerable children.

**Objective 2: Increased access to and demand for condoms**

PSI/eSwatini conducted community-based promotion and distribution of free condoms to youth and key populations as well as supporting demand-creation and promoting the use of condoms among
youth through an integrated branded marketing strategy known as “Got it? Get it.” PSI/eSwatini supported the MoH in finalizing and disseminating the National Condom Strategy, and in developing condom distribution tools to be used by partners, including NGOs, CBOs, and governmental partners. In addition, condom outlets were re-sensitized to ensure shopkeepers respected the client’s right to condom access and confidentiality. PSI/eSwatini participated in the eSwatini International Trade Fair in 2018 to reach young people with activities including sports and entertainment, distributing condoms, and providing testing services. Promotional activities were also conducted in densely populated areas and around school premises, reaching men and women with condom messages.

In fiscal year 2018, PSI/eSwatini distributed over 17 million condoms before transitioning its condom distribution strategy to increase the proportion of commodities distributed by partners such as NGOs and CBOs, allowing PSI/eSwatini to focus on distribution to retail outlets that are strategically positioned to reach the general population, namely Key Populations and youth.

Objective 3: Improve access to effective information and support for behavior change to reduce risk and vulnerability to HIV

PSI/eSwatini utilized the core minimum package of standardized prevention interventions in 36 non-DREAMS districts and the industrial town of Matsapha. Social media, including Facebook and WhatsApp groups, were used for HIV prevention messages. PSI/eSwatini also developed a toll-free helpline integrated with the social media platforms to improve referrals and information sharing with service beneficiaries.

Objective 4: Support to the MoH to steward the total market for condoms, including promotion and intentional free distribution resulting in increased sustainable condom use

PSI/eSwatini gave support to the MoH for a TMA analysis which provided key insights into the revision of the national condom distribution strategy. A partner mapping exercise determined the partners’ ability to collect commodities from MoH clinic management system. Consequently, PSI/eSwatini supported the MoH to develop a national distribution plan for free condoms and dispatched 6,428,500 condoms to partners as the plan was being developed.

In 2019, aiming to promote a more sustainable condom market, PSI/eSwatini increased efforts to stimulate the commercial condom market and reduce the number of outlets distributing free condoms while continuing to promote condoms on social media, operate the 1212 hotline, and operate a Facebook page that facilitates condom access and use. In addition, the same year, PSI/eSwatini began a partnership to implement a commercial sector strategy with a view to increasing the commercial condoms sector in the country. Social media was used throughout the year and was an important virtual platform to reach the intended audiences. Radio, newspaper, and television advertisements were produced and placed in all the local media promoting access and use of condoms.

SIFPO2 ESWATINI AT A GLANCE

Mobile units reached 43,000 clients, conducted HIV testing and indexing, made referrals to care, visited workplaces and shopping centers, and counseled HIV self-testers.
In October 2015, SIFPO2 launched a social marketing project for family planning, child health, and WASH products in Ghana. The three-year project was designed to address supply side and demand side factors to strengthen availability and uptake of voluntary family planning products and services and other key health areas and ensure sustainability through establishing a local, Ghanaian social marketing organization to carry on the work after the project’s conclusion. Specifically, the project included three main objectives:

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

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

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

In implementing the project, PSI Ghana partnered closely with Ghana Health Services (GHS) in support of the Government of Ghana’s FP 2020 commitment to increasing access to and uptake of modern contraceptives. To inform programming, SIFPO2 conducted a TMA-informed market development approach (MDA) analysis, which included key informant interviews, secondary analysis of Ghana DHS 2014, and a multi-stakeholder workshop to present, discuss, and sense-check findings. Among the findings that informed subsequent programming under objectives 2 and 3 were that rural women over 35 were underserved with FP product and service choice; that urban, middle-class women were less likely to use modern methods than would be perhaps expected, due to fear of side effects; and that emergency contraception was a rapidly growing product category, especially among younger users. With the benefit of this evidence base to design subsequent work, highlights from the project’s three main objectives included the following.

**Objective 1: Increased availability of quality health products in the private sector**

TFHO focused on increasing essential health commodities and stepped up distribution of FP, MCH, and WASH commodities across the nation, as well as deployed a robust distribution model to involve carefully selected pharmaceutical wholesalers and certain nontraditional retail outlets. Two new MCH products were introduced: one for treatment of acute diarrhea in children and one for umbilical cord care of newborns. TFHO’s own socially marketed brand of sanitizer gels and solutions was also introduced. These measures have led to a sustained increase in the availability of essential health commodities and higher sales volumes across the nation. TFHO also prepared for the launch of its own brand of male condom, finalized a contract manufacturing agreement for oral rehydration salts packaged with dispersible zinc tablets, and secured approval from the Ghana Food and Drugs Authority on regulatory requirements. TFHO’s reorganization of its distributorship model under its WASH portfolio, augmented by a nationwide training of over 625 local artisans and masons, created a record jump in sales of SATO pans.

By 2019/2020, despite being an organization in its infancy, TFHO was already making substantial and sustainable contributions towards expanding access to critical health products in Ghana, with an estimated impact of 1.4 million CYPs annually and 475,000 DALYs averted.

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

PSI Ghana, and later TFHO, introduced a range of evidence-based demand creation and awareness raising activities for voluntary family planning products and services, MCH and WASH products. Activities included radio jingles and billboards and regular participation in media platforms such as popular radio talk shows where TFHO technical experts talked about SRH topics and took listener questions. Health promotion days included participation in a range of
Objective 3: Create a local organization to build technical and organizational capacity to independently carry out social marketing in Ghana

An important component of the project was the establishment of a fully independent local NGO, Total Family Health Organization (TFHO). In 2018, PSI Ghana transitioned operations to the new entity, TFHO, with strong support provided in the months preceding for systems development, governance structures, and relationship building with key domestic and international stakeholders. For example, SIFPO2 support helped TFHO develop a procurement manual, M&E standards, internal policies, and a five-year business plan, which included investing in staff capacity-building and raising the new organization’s profile through partnerships. The culmination of these efforts led to TFHO successfully securing a transition award from USAID Ghana, a 5-year, $5 million USAID/Ghana Health Marketing Activity. Since then, TFHO has successfully attracted other donor investment and begun to develop a reputation as a strong implementer and partner of choice in Ghana. TFHO continues to forge partnerships and engage in key stakeholder engagements with the Mission and other IPs to ensure complementarity of efforts.

Table: TFHO Commodities by type distributed between Oct 2019-Sept 2020

<table>
<thead>
<tr>
<th>COMMODITY</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Contraceptive Pill cycles</td>
<td>1,938,975</td>
</tr>
<tr>
<td>Condoms</td>
<td>22,824</td>
</tr>
<tr>
<td>FamPlan - vials</td>
<td>1,085,777</td>
</tr>
<tr>
<td>DMPA-SC</td>
<td>9,134</td>
</tr>
<tr>
<td>Aquatabs - Tablets</td>
<td>1,298,300</td>
</tr>
<tr>
<td>Chlorhexidine 25g</td>
<td>49,990</td>
</tr>
<tr>
<td>Chlorhexidine 10g</td>
<td>49,790</td>
</tr>
<tr>
<td>SATO pans (toilets)</td>
<td>11,793</td>
</tr>
<tr>
<td>Hand Sanitizer Gel</td>
<td>21,761</td>
</tr>
<tr>
<td>Hand Sanitizer Solution</td>
<td>7,600</td>
</tr>
</tbody>
</table>
GUATEMALA

Through SIFPO2, PSI’s Central American regional counterpart, the Pan American Social Marketing Organization (PASMO), provided support to Guatemala’s Ministry of Public Health and Social Assistance (MoH) to improve reproductive maternal newborn child health and nutrition services in 69 health facilities in 30 prioritized municipalities.

The goal was to reduce maternal mortality and chronic malnutrition both by increasing the use of modern FP methods among rural indigenous women and by increasing the number of providers of quality, integrated FP and MCH services.

PSI/PASMO facilitated information sharing, ensured the use of standardized norms and guidelines for service delivery, and advocated for increased FP support at the national and community level.

PSI/PASMO also focused on building the capacity of providers to offer voluntary FP services and monitored compliance with QA standards. Training and certification activities included training in LARC delivery methods and anti-discrimination training.

In addition, PSI/PASMO focused on increasing the demand for LARCs within the context of informed choice through IPC activities and national communication campaigns. IPC agents implemented promotion activities to create awareness of FP and informed and voluntary demand for FP services. IPC agents also provided accurate information on side-effects and the relative advantages and disadvantages of methods to address method discontinuation.

SIFPO2 GUATEMALA AT A GLANCE

- **245** Supportive supervision visits conducted with 136 MCH and FP service providers.
- **17** “Youth friendly” spaces developed at public sector health facilities.
- **117** Providers trained in LARC provision.
- **415** Providers trained in anti-discrimination.
- **20** Service providers trained to address the SRH needs of youth.
- **70** IPC agents were supervised, monitored, and evaluated by project master trainers during 146 supervisory visits, ensuring the provision of high-quality FP information and referrals.
- **4,295** Developed a mass media campaign targeting men; radio messages were broadcast in Spanish and six Mayan languages.
LIBERIA

From July 2019–March 2020, the USAID Mission in Liberia enlisted PSI to provide technical and administrative support to the MoH’s Extended Program of Immunizations to introduce the new and underutilized measles-containing vaccine, second dose (MCV2), and HPV vaccines into the country’s routine immunization program.

Objective 1: PSI/Liberia will facilitate improved access to new and underutilized vaccines to children and adolescents through support to the Division of the Extended Program of Immunizations of the MoH of Liberia.

In this role, PSI/Liberia supported the implementation of community engagement activities and the execution of a communication risk assessment conducted in Liberia’s 15 counties. PSI also provided administrative and logistical support for the reproduction of immunization and vaccine cards distributed under the activity.

MALAWI

Beginning in 2015, USAID/Malawi began working with SIFPO2 to increase access to and uptake of Youth Friendly Health Services across a broad range of health areas, integrate HIV and FP/RH services and reduce new HIV infections among AGYW ages 15–24. This programming was expanded to increase availability and access to condoms and Voluntary Male Medical Circumcision (VMMC).

Objective 1: Increase enrollment in HIV treatment and care and voluntary FP services.

To increase youth and adolescent enrollment in HIV treatment and care services, HIV services were integrated into existing FP clinical outreach services and additional outreach teams were established specifically to provide HIV Testing Services (HTS), with additional HTS also supported through private sector social franchise clinics.

SIFPO2 MALAWI AT A GLANCE

Vaccine uptake promotion campaign activities conducted in all 15 counties.

Reproduced and delivered 54,468 child health vaccination cards and 153,240 HPV vaccination cards.

Objective 1: Increase enrollment in HIV treatment and care and voluntary FP services.

14 outreach teams and 25 Tunza clinics provided HTS to approximately 33,000 clients.

VMMC services to 13,370 Men.

600 Youth listening clubs in 13 districts distributed 561,000 Condoms.

National anti-GBV campaign launched in FY’20 with 168 Radio spots aired.

17+ MILLION Male condoms distributed per year.

FP services provided to 210,000 Women.
PSI/Malawi supported eight Blantyre and Machinga-based clinical outreach teams providing voluntary FP services in 10 priority districts and with SIFPO2 resources, expanded their service offerings to integrate HTS and referrals into the provision of FP services. In addition, 25 clinics of the Tunza Family Health Network were provided with additional training in the integration of HIV service delivery within their existing voluntary FP services.

PSI/Malawi worked in collaboration with treatment, psychosocial, and client education partners to facilitate voluntary linkage of clients after a positive result. The program added case managers to testing teams and actively engaged 393 community-based distribution agents in the distribution of HIV self-testing kits, provision of referrals for wrap-around support, and provision of voluntary FP services.

PSI/Malawi used SBCC approaches to reduce HIV vulnerability among youth and demand-creation activities to increase uptake of HIV treatment and care and voluntary FP services. One pillar of this effort is PSI’s YA! Program, which consisted of YA! Mix, a radio magazine show, supported by 622 YA! Youth listener clubs located in 10 implementing districts.

To illustrate the effects of interventions in terms of HIV testing and referral, the table above from 2017 provides a snapshot of the impact supported through SIFPO2 and reported to USAID/Zimbabwe and PEPFAR that year.

Subsequently, that year PSI/Malawi referred 100% of the 4,008 HIV positive clients for confirmatory testing, treatment and care and added case managers to support newly identified people living with HIV (PLHIV). Linkage rates increased up to 74% in Machinga and over 50% across other districts.

In terms of FP/RH specific results the same year:

• 32,631 clients voluntarily accessed a broad range of FP options in the context of informed choice through outreach services and 20,745 clients were reached through Community Based agents in the Lilongwe District, while the integrated teams outside of Lilongwe served 242,868 clients with FP

• 31,412 clients voluntarily accessed a broad range of FP options through Tunza clinics across the Central and North regions of Malawi.

• Combined, KfW and SIFPO2 contributed to the provision of 791,925 CYPs in the year Oct 17-Sep 18.

The scale and nature of the integrated outreach services is provided via this table on the next page, illustrating services provided 2017-18:

Objective 2: Increasing access to commodities for HIV prevention

PSI/Malawi contributed to condom and lubricant availability and accessibility through various channels, working closely with several partners to improve supply chain logistics for those products, and distributed over 20 million male condoms each year. PSI/Malawi condom officers conducted refresher trainings and supervision visits to health facilities to build capacity around best practices in condom inventory management and storage. A Malawi condom landscape analysis was conducted to examine both market breadth and depth. PSI/
Malawi developed a comprehensive 5-year business plan that optimizes market volumes, cost structure, and pricing to increase cost recovery.

**Objective 3. Implement VMMC services through demand-creation and service delivery**

PSI/Malawi used various demand-creation strategies to reach men in six districts, especially those aged 15–24 years, with demand-creation messages. PSI/Malawi organized a VMMC campaign in all six districts. Demand-creation strategies included community entry meetings, van mobilization, TOC mass shows, whistle-stop activities, motivational talks, and football events, and deployment of 330 community mobilizers responsible for conducting IPC sessions with potential clients and possible influencers of the clients.

**Objective 4. Expand services to adolescent AGYW through DREAMS**

Through SIFPO2 funding for DREAMS, PSI/Malawi expanded integrated SRH services to AGYW in two districts, integrating key HIV services with FP/RH outreach services, increasing the number of AGYW and male partners who are tested and know their HIV status, linking youth living with HIV to care and treatment programs, and supporting risk reduction activities among youth. All teams provided HTS, and the integrated teams provided a broad range of FP options and GBV screening and referrals. All providers were trained in youth-friendly service delivery. Outreach teams provided male condoms to promote dual protection. In COP 2018, PSI/Malawi was assigned resources to lead the adaptation and localization of the national anti-GBV “Every Hour Matters” campaign for Malawi. Activities included a workshop for key stakeholders to gain buy-in and a message development workshop with results used to develop materials for an awareness campaign, which was officially launched with the national press in attendance. Outdoor and radio broadcasters were engaged to run campaign spots nationally and locally in communities where high incidents of GBV cases have been registered. Special GBV programming was generated on both television and radio in the Chichewa language focusing on the role of gatekeepers, available reporting channels, services available for survivors, and the community's role in the fight against gender-based violations.

In 2019, PSI received funding from USAID to develop a database that tracks the number of AGYW that have completed the DREAMS primary package of evidence-based services or interventions.
NIGER

With SIFPO2 field support funding (March 2020–February 2021), PSI/Niger provided mobile outreach services for voluntary FP and support to public health centers. Mobile services included the provision of a wide range of contraceptive method options, LARC removal services, demand creation activities, and training for healthcare providers. SIFPO2 activities in Niger were implemented in the remote and underserved region of Zinder, in the districts of Magaria, Doungas, Gouré, and Damagaram Takaya.

Objective 1: Train 125 public sector providers

SIFPO2 in Niger trained 100 public sector providers such as doctors, nurses, and midwives in contraceptive technology and youth-friendly services. An additional 25 community health agents based at rural health posts were also trained in contraceptive technology. Provider training included LARC insertions and removals, in which many of these providers had little or no prior training. All 100 public sector providers were also trained in the provision of healthcare services to youth, and 25 community health agents based in rural health posts (which are often the primary contact for clients between or without mobile outreach services) were also trained in contraceptive technology.

Objective 2: In collaboration with trained public sector providers, conduct mobile outreach activities in the region of Zinder

PSI/Niger equipped 15 mobile teams with the necessary supplies, materials, and equipment to carry out mobile outreach events and organized and supported 15 mobile outreach events and 120 field outings. These took place at 50 primary health facilities and 25 rural health posts and services were integrated with Niger’s public health systems provision of prenatal consultations and childhood immunizations.

Objective 3: Foster public sector engagement and collaboration throughout the project duration to ensure both buy-in and skills transfer for sustained impact

PSI/Niger and the regional public health management team made joint supervision visits to supervise the providers who had been trained in contraceptive technology and evaluate their technical competency in client safety, informed choice, privacy and confidentiality, and continuity of care.

PSI/Niger technical staff and community actors collaborated to develop messages that addressed rumors and misconceptions associated with voluntary FP methods, and in particular with LARCs. These messages were used by community health workers to raise awareness of the importance of voluntary FP in general and the mobile outreach events in particular. SIFPO2 in Niger also carried out community mobilization activities using posters and other sensitization materials printed in collaboration with community health workers at the local level.
Objective 4: Ensure real-time collection and analysis of service delivery and quality data (including DHIS2)

As part of the routine activities of SIFPO2, PSI/Niger has implemented a QA system that ensures that services are provided according to global standards and in accordance with national protocols. All SIFPO2 intervention sites used HNQIS to assess of service quality at fixed health facilities as well as during mobile services. Continuous challenges include the availability of sterilizers and adequate waiting rooms/space for both fixed and mobile sites.

Objective 5: Provide technical assistance to Development Food Security Activities and Health Service Delivery Project partners for religious leader approach and financial capacitation approach

The PSI Zinder coordination team conducted regional-level meetings with Save the Children and Catholic Relief Services (CRS) to present the projects and activities and the areas of intervention and to enable the organizations to coordinate on their respective coverage zones.

In the field, the PSI supervisors were in contact with their counterparts at Save the Children and CRS regarding activities that include mobile clinics and community-based distribution, and PSI often collaborated with these actors to offer voluntary FP methods.

SOMALIA

In July 2017, PSI/Somalia was awarded funding from SIFPO2 to increase access to quality MCH services in Somalia, Puntland, and Somaliland through the private and public sectors. In collaboration with the USAID Mission and partners, PSI/Somalia leveraged its existing funding from the British government to increase coverage and improve the quality of health services through innovative approaches and to increase informed demand for these services.

Objective 1: Increased access and coverage of MCH services through private and public sector health facilities delivering the Essential Package of Health Services (EPHS)

| 11 | Outreach teams carried out monthly outreach activities by road and boat to 90 sites. |
| 70 | SSV conducted with 10 private sector social franchise clinics. |
| 139 | Health workers trained in treatment guidelines; 20 health workers trained in integrated management of childhood illnesses. |
| 60  | IPC agents trained and providing health education and promotion messages. |
| 4,139 | Children under age 5 were provided nutritional services. |
| Social marketing of | 547,200 |
| Water treatment kits, | 26,800 |
| Diarrhea treatment kits, | 1,910 |
| Pneumonia treatment kits, | 2,205 |
| OC cycles, and | 510 |
| Injectable kits. | |
| 136 | MCH QA visits made to public sector clinics. |
| 9,351 | Home visits to women of reproductive age. |
PSI/Somalia worked with sub-awardees to increase coverage of integrated health and nutrition services delivered through the public sector by scale-up of outreach services through 10 private sector clinics in the Maroodi Jeex region through affiliation with the Tunza social franchise network. PSI/Somalia and sub-awardees also worked to support the distribution of the existing socially marketed MCH commodities via the private sector in Somalia's urban and periurban markets.

**Objective 2: Support operationalization of the Health Sector Strategic Plans (HSSP II) for Federal Government of Somalia (including new states), Puntland, and Somaliland to strengthen in-country coordination, planning, and monitoring across health sector programs**

PSI/Somalia supported the development of workplans for HSSP II operational plans to establish projections and activities across sector programs and geographic regions.

**Objective 3: Increase informed demand of health services in both private and public sector**

Under this result, PSI/Somalia implemented an ‘IPC’ initiative to reach women of reproductive age and caregivers of children under age 5 with effective, tailor-made information in MCH themes, as well as initiating behavior change campaigns through mass media to create awareness of MCH and disseminate key messages.

**ZAMBIA**

PSI network partner SFH Zambia received funding from USAID through SIFPO2 to provide robust evidence to inform policy and practice on the prevailing use and access to ECPs in Zambia. SFH intended to establish critical groundwork for expanding ECP use within the context of informed choice, further diversifying the available mix of FP methods in the country. Project activities were implemented from June 2018–March 31, 2020.

**Objective 1: Gain critical insights into attitudes, knowledge, and behavior of ECP users and potential users**

Under this objective, SFH Zambia conducted a review of literature related to ECP access and use in SFH Zambia and in the African context, including a review of the regulatory environment and existing government policies around ECPs. Conclusions and recommendations informed a qualitative research protocol to explore the perspectives and practices of users and non-users of ECPs. Draft conclusions from the literature review informed the adaptation of an existing qualitative research protocol, with National Health Research Authority approval acquired to implement the study within public sector facilities.

**Objective 2: Gain a deep understanding of barriers and motivators to increased ECP provision among key stakeholders, including health authorities, providers, pharmacists, and dispensing staff**

Project staff researched the knowledge, attitudes, and practices of policy-makers and providers, including pharmacy staff, regarding ECP. In-depth interview and focus groups helped identify their level of knowledge about ECPs and existing national policies and their perspectives and potential biases toward ECPs.

**Objective 3: Gain an understanding of gaps in the market and supply chain of ECP**

SFH Zambia conducted a private and public sector market performance analysis to better understand current product availability, price points, distribution channels, and volumes. Results of the analysis were completed and shared with the MoH and the national Reproductive Health Supply Coalition as part of the broader monitoring of national FP 2020 targets.

**Objective 4: Use evidence gathered to design and pilot a catalytic intervention that will bring greater ECP access in both the private and public sector and change social norms**

SFH Zambia analyzed the knowledge, attitudes, and practice (KAP) study, and the results were presented to USAID and FP technical working group (TWG). This data and its preliminary conclusions were analyzed during a 3-day workshop attended by USAID and MoH authorities, key IPs, and youth (users and non-users of ECP). The workshop, supported by
PSI’s global marketing team, used PSI’s Keystone framework to assess the data, decide on priority areas of intervention, and design potential prototype interventions to address the findings.

Subsequently, SFH Zambia conducted a pharmacy mapping activity in Lusaka and Copperbelt, where the ‘catalytic intervention’ was expected to be implemented. Pharmacists and pharmacy attendants were provided with a job aid that discusses all methods of contraception but includes specific messaging on ECPs. A mystery client survey was proposed to assess whether private sector pharmacy staff who have received information and medical detailing about ECPs later successfully engaged with potential consumers and provided them with correct and complete information.

SFH Zambia held a 3-day catalytic intervention design workshop in July 2019, where several key stakeholders participated, including MoH officials, USAID, and UNFPA, medical store and private pharmacy representatives, voluntary FP providers, and regulatory bodies such as the Health Professions Council of Zambia and the Zambia Medicines Regulatory Authority. At the end of the workshop, an intervention was agreed upon, which focused on youth interventions through an integrated SBCC strategy.

**Objective 5: Share lessons learned for addressing ECP access and use with stakeholders in Zambia and broader global health community**

Findings of the KAP and landscaping analysis were shared with the FP technical working group in August 2019; members of this group also participated in the design workshop of the catalytic intervention. ECP training materials were developed in collaboration with the Pharmaceuticals Society of Zambia, who also proposed the addition of two chapters covering the topics of chemical, pharmacological, and pharmaceutical properties of levonorgestrel and pharmacies’ practice of dispensing ECPs. ECP provider job aids and client fliers were also developed. SFH Zambia conducted ECP trainings for pharmacists, a marketing agency, and brand ambassadors. Between October and November 2019, SFH Zambia trained 32 pharmacists in the Lusaka and Kitwe regions with the goal of increasing their knowledge of voluntary FP and RH, including ECP provision.

The subsequent intervention consisted of 16 “roadshows” in Lusaka and Kitwe township reaching around 37,500 community members. Following this intervention, SFH interviewed 28 pharmacies in communities where the roadshows were conducted (20 in Lusaka and eight in Kitwe) to assess their immediate impact. Twenty-one out of the surrounding 28 pharmacies reported an increase in ECP sales after the intervention, with young women ages 20–24 years being the largest consumers.

**LATIN AMERICAN AND CARIBBEAN (LAC) REGION**

PSI/PASMO led an SBCC initiative to support national efforts to prevent the transmission of Zika in the LAC region. The project promoted protection of self, home, and community using repellants and vector control measures by providing voluntary FP counseling and RH services to prevent unplanned pregnancies and by promoting the use of condoms as a primary measure for the prevention of sexual transmission of the virus.

**Objective 1: Increased use of personal safeguards, including the voluntary use of FP and condoms to prevent unintended pregnancy and sexual transmission of Zika among women of reproductive age, pregnant women, and their sexual partners**

Under this result, PSI/PASMO and local partners concentrated on increasing public understanding of the primary means and modes of Zika infection, the implications of infection, and the most effective means of preventing vector-borne and sexual transmission. Key activities included the dissemination of a regional mass media campaign and a school-based initiative targeting children, their families, and communities.

PSI executed a three-phase media campaign about the virus in the Central American region and promoted the voluntary uptake of FP methods. Print and video materials were made available to the MoHS for use in clinics and closed-circuit video displays. A second
phase of the campaign was implemented to address other mosquito-transmitted illnesses. A final phase of the campaign was launched in May of 2019.

An online social media engagement strategy was implemented in all four priority countries, reaching more than 79 million people. Nearly 10,000 users engaged directly with project SBCC outreach staff through online interactions during the reporting period.

**Objective 2: Developed body of evidence regarding target communities’ knowledge about Zika transmission and prevention seeking behavior to strengthen SBCC messaging and program responses at the community, regional, and national levels**

PSI/PASMO endeavored to develop a body of evidence that supports successful Zika SBCC prevention efforts in the LAC region. PSI/PASMO demonstrated the effectiveness of the project’s messaging and communication methods and continued to improve them.

**Objective 3: Increased provider knowledge about Zika and increased number of private health service providers who incorporate Zika counseling into integrated SRH services**

The project also focused on improving the knowledge and understanding of private and NGO healthcare providers of the risks of Zika infection, the most effective protection against infection, and appropriate referrals for follow-up care. A training guide, reference materials, information, education, and communication print materials and prevention kits were developed for providers for use in clinics, waiting areas, and pharmacies.

**Objective 4: Increased youth and adolescent knowledge about Zika and increased number of public educational institutions that incorporate Zika counseling into integrated SRH services**

SIFPO2 implemented specific efforts in Guatemala, El Salvador, and Honduras to engage and sensitize school-aged youth and their teachers about Zika prevention as part of the broader FP/RH issues affecting the well-being of young people, directly reaching more than 60,000 young people across three countries.

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**SIFPO2 LAC ZIKA AT A GLANCE**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>A regional social media campaign garnered more than 79 MILLION Persons reached.</td>
<td>29 Television spots produced and broadcast nationally and regionally.</td>
</tr>
<tr>
<td>49 Radio spots produced and aired locally and nationally.</td>
<td>32 Print advertisements developed and published.</td>
</tr>
<tr>
<td>A 30-chapter radio “telenovela” produced and aired.</td>
<td>Staff from 582 Private sector pharmacies sensitized.</td>
</tr>
<tr>
<td>3,126 3,126 pregnant women received counseling on Zika prevention.</td>
<td>88% Bonus airtime investment negotiated across regional, national, and local media, contributing significantly to project cost-share requirements.</td>
</tr>
<tr>
<td>49,168 Prevention kits produced and distributed to 24,043 pregnant women.</td>
<td>228,000 Print SBCC materials disseminated.</td>
</tr>
<tr>
<td>2,100 Teachers trained.</td>
<td>154 Youth change agents trained.</td>
</tr>
</tbody>
</table>
ZIMBABWE

In 2015 PSI/Zimbabwe began to integrate voluntary FP services into the service offerings of five New Start outreach teams operating under the ongoing USAID-supported DREAMS HIV prevention project. With additional SIFPO2 funding received in March 2018, the project workplan was expanded to include HTS, the provision of pre-exposure prophylaxis (PrEP), condom social marketing, and the coordination of DREAMS activities.

Objective 1 (FP): Increase access to affordable modern methods among sexually active AGYW aged 15–24 through integrated SRH/HIV service delivery at a range of entries

Four public sector health facilities (Chipinge District Hospital, Gweru Provincial Hospital, Howard Mission Hospital [Mazowe], and Emakhandeni Clinic [Bulawayo]) resumed the provision of voluntary FP services under the ProFam network. To illustrate the nature of the service delivery and impact, the tables below for the 12 months of Oct 17-Sep 18 reveal the number of people reached and the services provided in Profam clinics and at DREAMS static and mobile locations.

Objective 2 (FP): Work with DREAMS partners to increase the ability of AGYW to make informed choices about FP

PSI/Zimbabwe, working with DREAMS partners, disseminated a youth-friendly demand-creation and service delivery strategy. Values exploration training sought to better understand barriers to FP access for AGYW, and interactive tools were developed to help them understand the most suitable contraceptive options available.

Objective 3 (HIV): Increase the percentage of sexually active AGYW who know their HIV status, are screened, referred, and tracked for follow-on services

PSI/Zimbabwe employed different HIV testing modalities to reach sexually active AGYW, both at static New Start centers and in the community. High-risk AGYW were offered a screening test using an opt-out approach. Nearly half of the AGYW tested were newly identified as being HIV-positive, and a third were confirmed to have been successfully linked to HIV care and treatment services. Negative AGYW at substantial risk of contracting HIV were linked for PrEP, and those tested through PSI as the entry point to DREAMS were referred to an appropriate DREAMS component offered by other partners.
Objective 4 (HIV): Increase the percentage of potential older partners of AGYW (men 25–49) who know their HIV status and are referred for follow-on services

Community testing included testing of high-risk men and provision of SBCC resources. Uncircumcised men were counseled and referred for voluntary medical male circumcision. The number of individual males tested was much less than projected because of the high uptake of HTS, resulting in fewer clients requiring provider-delivered testing.

Objective 5 (HIV): Increase access to and uptake of PrEP among high-risk AGYW

PrEP was made available for AGYW in five DREAMS districts, four of which offer services at the fixed site through the New Start centers; PrEP enrollments and drug resupplies for the AGYW in the fifth are community-based. PSI/Zimbabwe, with other members of the PrEP TWG, trained 27 public sector service providers in Makonzi district and successfully introduced PrEP in seven public sector health facilities.

Table: Voluntary FP services by Method and District, Oct 2017-Sep 2018

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>BULAWAYO 10-14</th>
<th>CHIPINGE 10-14</th>
<th>GWERU 10-14</th>
<th>MAKONI 10-14</th>
<th>MAZOWE 10-14</th>
<th>MUTARE 10-14</th>
<th>TOTAL 10-14</th>
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<td>694</td>
<td>5,043</td>
<td>5,741</td>
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<td>Chipinge</td>
<td>1</td>
<td>153</td>
<td>796</td>
<td>950</td>
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<td>Gweru</td>
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<td>1,051</td>
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<td>56</td>
<td>172</td>
<td>228</td>
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<tr>
<td>Mazowe</td>
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<td>115</td>
<td>470</td>
<td>585</td>
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<td><strong>Total</strong></td>
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<td><strong>1,355</strong></td>
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</tbody>
</table>

AGYW who received Voluntary FP Methods, Oct 2017- Sep 2018

Table: Voluntary FP services by Method and District, Oct 2017-Sep 2018

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>BULAWAYO</th>
<th>CHIPINGE</th>
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<th>MAZOWE</th>
<th>MUTARE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clients</td>
<td>5,737</td>
<td>949</td>
<td>1,295</td>
<td>228</td>
<td>585</td>
<td>663</td>
<td>9,457</td>
</tr>
<tr>
<td>15-24 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Oral contraceptive pills (cycles)</td>
<td>3,234</td>
<td>4,032</td>
<td>6,438</td>
<td>54</td>
<td>3,444</td>
<td>1,026</td>
<td>18,228</td>
</tr>
<tr>
<td>Injectable (vials)</td>
<td>3,991</td>
<td>196</td>
<td>151</td>
<td>6</td>
<td>11</td>
<td>332</td>
<td>4,687</td>
</tr>
<tr>
<td>Implant: Implanon (3yr)</td>
<td>86</td>
<td>29</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>139</td>
</tr>
<tr>
<td>Implant: Jadelle (5yr)</td>
<td>1,065</td>
<td>52</td>
<td>51</td>
<td>12</td>
<td>0</td>
<td>156</td>
<td>1,336</td>
</tr>
<tr>
<td>Copper-T (IUCD 10)</td>
<td>44</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>17</td>
<td>72</td>
</tr>
<tr>
<td>LNG IUS (IUCD 5)</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>
Objective 6 (HIV): Ensure strong national Ministry of Health and Child Care (MoHCC) and National AIDS Council-led coordinated DREAMS and key population (KP) program implementation across partners and funding streams

Since 2016, PSI/Zimbabwe has supported two full-time KP and DREAMS coordinators at the National AIDS Council and at the MoHCC. The DREAMS and KP coordinators organized monthly meetings at the district level through point-of-contact organizations and ensured implementation of nine monthly national DREAMS meetings. To develop a minimum services package for KPs, including a provider training manual, the coordinators held consultative KPs stakeholders’ meetings and have integrated the KP agenda into the National HIV Prevention Forum. The coordinators support the decentralization of DHIS2 data use and entry to the district level for all partners.

Objective 7 (HIV): Facilitate demonstration of layering of services at a unique client level across IPs through the continued advancement of the DREAMS monitoring and evaluation system

PSI/Zimbabwe facilitated and coordinated the advancement of the DREAMS monitoring and evaluation system within the DREAMS partnership involving CRS, FACT, Africaid, CeSHHAR, FHI360, and the DREAMS Innovation Challenge partners. PSI/Zimbabwe co-facilitated monthly national DREAMS Strategic Information TWG meetings, contributed to the national DREAMS partners performance review meetings through data analysis and reporting, monitored and gave feedback on weekly data completeness to USAID and partners, and provided technical assistance to DREAMS partners through troubleshooting, routine server maintenance, and capacity-building of partners.

Objective 8 (HIV): Improve uptake of Protector Plus condoms within the total market for condoms

PSI/Zimbabwe continued to advocate for a TMA to improve national condom program sustainability and supported the Ministry of Health in the rebranding of the public sector condom. Demand-creation activities for condom use, particularly focused on young people, were undertaken through radio and digital advertising as well as special events.
Highlights from the SIFPO2 Performance and Management Plan
2014-2021

Key Highlights:

Couple Years of Protection

- PSI estimates the organization and its network partners have contributed to more than 117.43 million CYPs, over the period of SIFPO2 (2014-2021). (see Row A.) A substantial amount of these CYPs have either been directly generated through SIFPO2 funds, or facilitated through SIFPO2 investments, such as those in Quality of Care or Digital Health.[1]
- Of these, PSI reported more than 47.25 million total CYPs were generated from the provision of voluntary LARC methods. (See Row B.)
- An estimated 3.9 million CYPs were generated through social franchising among PSI network members in 2020. This represents 156% of the EOP project projection of 2.5 million. A total of 15.73 million CYPs were generated through SF efforts during the LOP. Social Franchising CYPs supported by PSI have fluctuated, which reflects various trends, such as changes in metrics and changes in funding.
- Note: PSI no longer calculates cost per CYP (2.1.1) as PSI has adapted its metrics and as of 2021, no longer tracks CYPs at a global level and is instead focusing on global metrics such as Users reached, Users supported through Digital Technology and new dimensions such as ‘policy influence’ and contributions to market coordination. PSI’s commitment to Sexual & Reproductive Health and Family Planning specifically remains as strong now as when the organization was founded 50 years ago.

Youth

- The proportion of FP services provided at PSI service delivery points to youth (< 25 years) steadily increased throughout the life of the project. This proportion has increased from a baseline of zero, where age-disaggregated data was not even systematically being captured by the organization, to a total of 39% against a LOP target of 20%. (D.)
- The number of PSI network members that monitor compliance with youth-friendly service standards had a notable increased, from zero to 29, solidly placing PSI over the endline projection of 20. (1.1.6)

Gender

- At least 12 PSI network members are contributing to efforts to address gender-based violence via a range of interventions including training of providers in screening, first line response and referrals. (1.1.9)

System Strengthening

- The number of PSI social franchise networks in which private sector providers participate in a nationally or internationally recognized quality certification scheme met the LOP target of 5 (India, Kenya, Nigeria, Uganda and Zimbabwe). (1.1.1)
- A total of 26 PSI network members introduced the Health Network Quality Improvement System tool (HNQIS) by the end of the project, from a baseline of zero. (1.1.2)
• The number of PSI network members offering e-learning/technology-based continuing medical education to their network providers increased substantially over the life of the project, from zero to 19, over an endline projection of 15. (1.1.3)
• At least 19 PSI network members are now operating a client based record system from a baseline of 4 members and a LOP target of 15. (1.1.4) and at least 19 PSI network members count on a DHIS2 system that is aligned with their national HMIS, over a LOP target of 5. (1.1.5)

Financial Sustainability

• A total of 13 PSI network members conducted a franchise profitability/financial sustainability analysis during the life of the project (2.1.2). 16 SF networks with clinics participated in credit fund, loan program or an access-to-credit scheme. (2.1.3) Nine (9) SF networks are now participating in a formal insurance/reimbursement scheme against a target of 3. (2.1.4)
• 13 PSI network members have undertaken a “Total Market Analysis” for FP products and services: Cambodia, Mozambique, Ghana, DRC, Nepal, Pakistan, Senegal, eSwatini, Ethiopia, Zimbabwe, Zambia and Ethiopia. (2.3.1)

Quality Improvement/ Quality Assurance

• 94% of private network provider scored at least 80% on PSI’s Quality Standards and 100% on Critical Care steps for IUD insertion services. (1.1.7)

South-to-South Technical Assistance

• The number of South-to-South technical assistance visits conducted by technical experts under the SIFPO2 project totaled 60 against a LOP projection of 8 visits. (2.2.2) By the end of the project, 100% of QA audits were being conducted via South-to-South exchanges. (2.2.1). This was a substantial advancement in the decentralization and localization of QA/QI.

Innovations, tools and approaches

• A total of 13 PSI network members have introduced the provision of injectables by pharmacists and/or CHWs and implants by CHWs. These include Madagascar, Zambia, Mozambique, Benin, Myanmar, Malawi, Mali, Kenya, Nigeria and Niger (Ethiopia now allows injectables to be delivered by pharmacists and implants to be provided by CHWs). (1.2.1)
• 12 countries have introduced the dedicated postpartum IUD inserter over a baseline of zero countries. (1.2.3) A total of 24 network members are now offering implants or IUDs prior to discharge post-delivery compared with a baseline of zero and a target of 10 countries. (1.2.4)
• A total of 56 technical papers/programmatic briefs/posters were presented at recognized conferences, and research publications written and disseminated against a LOP target of 35. (1.1.10)
• This PMP shows the seeds of progress in HMIS and Digital Health that become a Digital Health and enhanced Market Coordination strategy that is now central to the organization’s work and was explored more extensively in the SIFPO2 Mid Term evaluation. These investments played a substantial role in helping PSI to continue to support clients during the COVID pandemic of 2020-21.

[1] In early 2020, PSI began to move away from its reliance on CYP as a metric to show its contribution to meeting global unmet need for family planning. This change was due to in part to a desire to take a more holistic, and consumer-centric set of metrics forward into the next decade – as well as a reflection of challenges in using the CYP metric, such as accounting for continuation among users of long-term methods and addressing the challenges of converting commodity distribution data of short-term methods into user numbers.
### SIFPO 2 PERFORMANCE & MONITORING PLAN Tracking 2014-2021

Additional information to provide context to this PMP is provided in the attached ‘PMP highlights’

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Endline Projection</th>
<th>&quot;Cumulative progress to date&quot;</th>
<th>Jan-Dec 2014</th>
<th>Jan-Dec 2015</th>
<th>Jan-Dec 2016</th>
<th>Jan-Dec 2017</th>
<th>Jan-Dec 2018</th>
<th>Jan-Dec 2019</th>
<th>Jan-Dec 2020</th>
<th>Reporting Frequency Reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Annual couple years of protection (CYPs) generated from all methods across the PSI network*</td>
<td>2013 22.4 million</td>
<td>2019 25 million (annual target)</td>
<td>17.43m</td>
<td>18.28m</td>
<td>16.97m</td>
<td>17.23m</td>
<td>19.41m</td>
<td>16.56m</td>
<td>16.23m</td>
<td>12.73m</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>B. Annual CYPs generated from long-acting and permanent methods across the PSI network*</td>
<td>2013 6.4 million</td>
<td>2019 7 million (annual target)</td>
<td>47.25m</td>
<td>5.42m</td>
<td>4.3m</td>
<td>6.22m</td>
<td>8.65m</td>
<td>7.79m</td>
<td>8.92m</td>
<td>5.95m</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>C. Proportion of family planning services provided to adopters of family planning at service delivery points within PSI networks</td>
<td>2015 Not Available (not collected)</td>
<td>2019 20%</td>
<td>Not Available (not collected)</td>
<td>0.08%</td>
<td>0.1%</td>
<td>0.04%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
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<td></td>
<td>5.69%</td>
<td>2.9%</td>
<td>2.2%</td>
<td>0%</td>
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<td>Annual Jan-Dec of previous calendar year</td>
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<td></td>
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<td>24.46%</td>
<td>10.4%</td>
<td>7.9%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
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<td>26.01%</td>
<td>10.9%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
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<td></td>
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<td></td>
<td>20.87%</td>
<td>11.6%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td>12.91%</td>
<td>2.6%</td>
<td>1.1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
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<td></td>
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<td>5.31%</td>
<td>0.9%</td>
<td>0.6%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>D. Proportion of FP services provided at PSI service delivery points to youth (&lt; 25 years)</td>
<td>June 2016 Not Available (not collected)</td>
<td>2020 20%</td>
<td>Not Available (not collected)</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>13.99%</td>
<td>8%</td>
<td>8.6%</td>
<td>7%</td>
<td>13%</td>
<td>13.93%</td>
<td>13.89%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24.57%</td>
<td>24%</td>
<td>26%</td>
<td>29%</td>
<td>26%</td>
<td>23.92%</td>
<td>24.57%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>E. Annual CYPs generated through social franchising among PSI network members</td>
<td>2013 5.3 million</td>
<td>2020 2.5 million (annual target)</td>
<td>15.73m</td>
<td>7.78m</td>
<td>1.64m</td>
<td>2.54m</td>
<td>2.63m</td>
<td>2.45m</td>
<td>2.5m</td>
<td>3.93m</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
</tbody>
</table>

#### 1.1. Number of PSI social franchise networks in which private sector providers participate in a nationally or internationally recognized quality certification program

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Endline Projection</th>
<th>&quot;Cumulative progress to date&quot;</th>
<th>Jan-Dec 2014</th>
<th>Jan-Dec 2015</th>
<th>Jan-Dec 2016</th>
<th>Jan-Dec 2017</th>
<th>Jan-Dec 2018</th>
<th>Jan-Dec 2019</th>
<th>Jan-Dec 2020</th>
<th>Reporting Frequency Reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1.1</td>
<td>2013 1</td>
<td>2020 5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Due to the complexity that emerged of data collection and reporting by user status, age and method, SIFPO2 proposed in 2018 to no longer attempt to disaggregate data by user status and age.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Endline Projection</th>
<th><em>Cumulative progress to date</em></th>
<th>Reporting Frequency Reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.9 Number of PSI network members contributing to efforts to address gender-based violence during the SIFPO 2 Project</td>
<td>2013 6</td>
<td>2020 12</td>
<td>2015 8</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>1.1.10 Number of SIFPO 2 technical/programmatic briefs, and presentations/posters/papers at recognized conferences, and research publications written and disseminated</td>
<td>2013 0</td>
<td>2020 35</td>
<td>2019 10</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>1.2.1 Number of PSI network members that have introduced provision of injectables by pharmacists and/or CHWs and implants by CHWs</td>
<td>2013 1</td>
<td>2020 8</td>
<td>2019 2</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>1.2.2 Number of SIFPO social franchise networks conducting client exit surveys to measure socio-economic status during the reporting period</td>
<td>2013 3</td>
<td>2020 15</td>
<td>2019 6</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>1.2.3 Number of countries in which the PSI-designed postpartum IUD inserter is introduced</td>
<td>2013 0</td>
<td>2020 5</td>
<td>2019 12</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>1.2.4 Number of network members offering implants or IUD prior to discharge post-delivery</td>
<td>2013 0</td>
<td>2020 10</td>
<td>2019 24</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.1.1 Total net cost per CYP</td>
<td>2013 $11.34</td>
<td>2020 $8.80</td>
<td>2019 $13.13</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.1.2 Number of PSI network members who have conducted a franchise profitability/financial sustainability analysis</td>
<td>2013 1</td>
<td>2020 7</td>
<td>2019 13</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.1.3 Number of PSI social franchise networks with clinics participating in credit fund, loan program or a similar access-to-credit program</td>
<td>2013 1</td>
<td>2020 5</td>
<td>2019 16</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.1.4 Number of PSI social franchise networks whose providers can participate in a formal insurance system (be reimbursed by a formal insurance system for care delivered to patients)</td>
<td>2013 0</td>
<td>2020 3</td>
<td>2019 24</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.2.1 Percentage of QA Audits conducted on an annual basis through South-to-South exchanges of local network members</td>
<td>2012 60%</td>
<td>2020 85%</td>
<td>2019 63%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.2.2 Number of South to South technical assistance visits conducted by technical experts under the SIFPO 2 Project</td>
<td>2013 -</td>
<td>2020 8</td>
<td>2019 60</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.2.3 Percentage of PSI social franchise networks that provide services in 3 or more health areas (as defined by PSI)</td>
<td>2013 27%</td>
<td>2020 47%</td>
<td>2019 39%</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
<tr>
<td>2.3.1 Number of PSI-led technical consultations hosted by PSI (e.g. The LARC/AHP Community of Practice or multi-agency consultations relating to Youth and Gender)</td>
<td>2013 1</td>
<td>2020 5</td>
<td>2019 17</td>
<td>Annual Jan-Dec of previous calendar year</td>
</tr>
</tbody>
</table>

*In 2014, PSI adopted a 10% wastage discount for our product distribution to reflect supply chain loss between the warehouse and the client. This wastage was applied across the board to all health impact models (i.e. DALYs) but not to CYPs. CYPs from product distribution are now also discounted by 10%. As of 2019, this wastage has been applied to our historical impact data. All historical data included here has been updated to reflect the 10% wastage.