Issuance Date: April 2, 2013
Closing Date: May 16, 2013
Closing Time: 12:00 pm EST

Subject: Request for Applications (RFA) Number SOL-OAA-13-000005
Implementation Science for Strengthening Use of Evidence in Family Planning/Reproductive Health Programming (ISSUE FP/RH)

The United States Agency for International Development (USAID), the Office of Population and Reproductive Health (PRH), in the Bureau of Global Health (GH), seeks applications for a Cooperative Agreement from eligible for-profit, not-for-profit, or private voluntary organizations (PVO) (and any combination of those organizations) for a program titled "Implementation Science for Strengthening Use of Evidence in FP/RH Programming (ISSUE FP/RH)". The authority for the RFA can be found in the Foreign Assistance Act of 1961, as amended.

Any questions concerning this RFA must be submitted in writing to Franklin Goode, Agreement Specialist, via email at fgoode@usaid.gov by April 15, 2013 at 3:00 pm EST.

USAID's objective with this solicitation is: *Strategic generation, translation, and use of new and existing evidence to improve FP/RH programming worldwide.* Specifically, USAID seeks assistance to:

- Generate evidence through high quality research to increase the effectiveness of FP/RH programming;
- Synthesize and share existing and new evidence to accelerate scale-up of evidence-based FP/RH programming; and
- Provide technical assistance for use of evidence to improve FP/RH programming worldwide.

Subject to the availability of funds, USAID intends to provide approximately $150 million in total USAID funding to be allocated over the 10-year period for the ISSUE FP/RH Cooperative Agreement. USAID reserves the right to fund any or none of the applications submitted.

This RFA includes this cover letter and:

- Section I Funding Opportunity Description (Program Description)
- Section II Award Information
- Section III Eligibility Information
- Section IV Application and Submission Information
- Section V Application Review Information (Evaluation Criteria)
- Section VI Award and Administration Information

For the purposes of this RFA, the term “Grant” is synonymous with “Cooperative Agreement”; “Grantee” is synonymous with “Recipient”.

All applications must be received by the closing date and time indicated at the top of this cover letter at the place designated in the Technical Application section for receipt of applications. Applications and modifications thereof shall be submitted in envelopes with the name and address of the applicant and RFA number: SOL-OAA-13-000005.

Applicants are requested to submit both technical and cost portions of their applications in separate volumes. The award will be made to that responsible applicant(s) whose application(s) offers the greatest value.

Issuance of this RFA does not constitute an award commitment on the part of the United States Government (USG), nor does it commit the Government to pay for costs incurred in the preparation and submission of an application. In addition, final award of any resultant application(s) cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for award. Applications are submitted at the risk of the applicant; if circumstances prevent award of a cooperative agreement, all preparation and submission costs are at the applicant's expense.

The preferred method of distribution of USAID procurement information is via internet at www.grants.gov. This RFA and any future amendments can be downloaded from http://www.grants.gov. Click on “Search for Grant Opportunity,” then click on "Browse by Agency" and choose U.S. Agency for International Development, then click on the opportunity titled “Implementation Science for Strengthening Use of Evidence in FP/RH Programming”. If you have difficulty accessing the RFA, please contact the www.grants.gov Helpdesk at 1-800-518-4726 or via e-mail at support@grants.gov for technical assistance. Receipt of this RFA through www.grants.gov must be confirmed by written notification to the contact person noted below. It is the responsibility of the recipient of the grant document to ensure that it has been received from www.grants.gov in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion processes.

In the event of an inconsistency between the documents comprising this RFA, it shall be resolved by the following descending order of precedence:

(a) Section IV Evaluation Criteria
(b) Section III Application Format
(c) Section I Program Description
(d) This Cover Letter

Sincerely,

/s/

Alisa J. Dunn
Agreement Officer
Office of Acquisition and Assistance
M/OAA/GH/POP

TABLE OF CONTENTS

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AO	Agreement Officer
AOR	Agreement Officer's Representative
CA	Cooperative Agreement
CBD	Community-Based Distribution
CFR	Code of Federal Regulations
CPR	Contraceptive Prevalence Rate
EEO	Equal Opportunity Employer
FAR	Federal Acquisition Regulations
FP	Family Planning
GH	Bureau of Global Health
GHI	Global Health Initiative
HIV	Human Immunodeficiency Virus
IR	Intermediate Result
IS	Implementation Science
ISSUE FP/RH	Implementation Science for Strengthening Use of Evidence in Family Planning/Reproductive Health Cooperative Agreement
LDC	Less Developed Country
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
NGO	Nongovernmental Organization
NICRA	Negotiated Indirect Cost Rate Agreement
OAA	Office of Acquisition and Assistance
OMB	Office of Management and Budget
PAC	Post Abortion Care
PMP	Performance Monitoring Plan
PRH	Office of Population and Reproductive Health
PVO	Private Voluntary Organization
R&D	Research and Development
RFA	Request for Applications
RH	Reproductive Health
RTU	Research, Technology and Utilization Division
SO	Strategic Objective
TEC	Technical Evaluation Committee
USAID	United States Agency for International Development
USG	United States Government

SECTION I – PROGRAM DESCRIPTION

1. INTRODUCTION

The Global Health Bureau (GH) has played a critical role in expanding contraceptive availability and use worldwide, helping to increase global contraceptive prevalence from 10 percent in 1965 to 53 percent today. Despite these impressive gains, there are still 53 million unintended pregnancies annually, resulting in 25 million abortions, 590,000 newborn deaths, and 90,000 maternal deaths. These numbers highlight the importance of family planning. Strong family planning and reproductive health (FP/RH) programs are integral to achieving success in several of USAID's priority areas, including saving mothers, child survival, and fostering an AIDS-free generation.[1]

These worldwide challenges in family planning and reproductive health are reflected in USAID's Global Health Vision: *A world where people lead healthy, productive lives and where mothers and children thrive*[2]. To achieve this vision, GH has undertaken a process to strengthen its approach to **Implementation Science** and thus improve programming. GH defines implementation science as *the application of systematic learning, research, and evaluation to improve health practices, services, policy and programs in developing countries.*[3] Implementation science involves the interface of: (1) generating knowledge through activities such as implementation research, systematic reviews and data synthesis; (2) using knowledge by undertaking knowledge translation activities to improve policies, programs and services; and (3) managing knowledge by organizing knowledge to make it more accessible. The overall goal of implementation science is to advance the adoption and integration of evidence-based interventions to change practice patterns, health behaviors, and to inform public health policy decisions.[4] This approach contributes to operating principles that have been incorporated into the Global Health Initiative (GHI), especially those related to research and innovation as well as metrics, monitoring and evaluation.[5]

The goal of USAID's FP/RH programming is to is "*to enable countries to meet the family planning needs of their people*" by expanding access to high-quality FP services and information, and RH care in order to reduce unintended pregnancy and promote healthy reproductive behaviors of men and women, reduce abortion, and reduce maternal and child mortality and morbidity[6]. Within USAID GH's Office of Population and Family Planning (PRH), the division of Research, Technology and Utilization (RTU) has the mandate to lead USAID's research on FP/RH, including biomedical research and development, implementation science and operations research, and knowledge translation efforts. RTU's strategy focuses on identifying practical, scalable, culturally appropriate and sustainable solutions to decrease unintended pregnancies. Research aims to reduce critical barriers to FP use (including social,

1 USAID's Global Health Strategic Framework: Better Health for Development; FY2012-FY2016
2 Ibid.
3 USAID, Bureau of Global Health; Discovery to Scale-Up; Implementation Science in Global Health.
4 Ibid.
5 Ibid.
6 Foreign Assistance Framework; Category: Health; Sector: Family Planning and Reproductive Health http://foreignassistance.gov/SPSD.pdf

cultural and behavioral barriers), expand access to modern contraceptive methods, increase understanding of the drivers of fertility intentions and decision-making, and strengthen health systems to increase availability and quality of FP/RH services. In addition, USAID's portfolio also documents and utilizes this program learning to accelerate the introduction and scale-up of evidence-based FP/RH technologies and services.

RTU's core-funded projects are designed to address both existing and evolving research needs to provide technical leadership both globally and in the field. USAID is working across teams to identify opportunities to answer research questions of mutual interest and to minimize duplication of effort. In addition, research priorities are informed by and harmonized with other donors, resulting in an iterative and ongoing process. Synergy and coordination is achieved through global technical consultations and agreements, including participation as a donor member in the Alliance for Reproductive, Maternal and Newborn Health, the FP Research Donors' Meeting in December 2012 (Annex 7), and participation in the FP2020 and in A Promise Renewed (APR) (Annex5).

2. IMPLEMENTATION SCIENCE FOR STRENGTHENING USE OF EVIDENCE IN FP/RH PROGRAMMING (ISSUE FP/RH) PROJECT

The ISSUE FP/RH Project will be a cooperative agreement that builds on work completed by historic Program Research and Research Utilization mechanisms. As described in the previous section, implementation science encompasses *implementation research*, *knowledge translation*, and *knowledge management*.[7] This project specifically will conduct implementation research and knowledge translation for FP/RH programming. In addition, the project will contribute to knowledge management by establishing strong links with existing knowledge management efforts and projects in order to feed programmatic results into existing systems and maximize the use of evidence.

The ISSUE FP/RH project is intended to undertake short-term, medium-term and long-term studies that build upon existing research, evidence from global and bilateral programs, and service delivery experience. A successful applicant must demonstrate expertise in a range of rigorous research methodologies and be able to identify the most appropriate research questions and relevant research designs to meet the goal of this award. The applicant should also be a leader in advancing research utilization, with all studies and synthesis "beginning with the end in mind." The role of this research project is to ensure that FP/RH research informs practice responsive to country context. The applicant should demonstrate strong in-country implementation experience as the project is intended to assist countries and USAID Missions as well as USAID/Washington.

Research will be conducted to increase understanding of normative influences on both men and women in accessing and using FP/RH services. The project will build on existing evidence to explore new service delivery models and improve understanding of gender dimensions, thereby achieving goals of reaching more women and girls. Project activities will prioritize approaches to reach the "last mile" and underserved populations who are unable to access FP/RH services

7 USAID, Bureau of Global Health; Discovery to Scale-Up; Implementation Science in Global Health.

due to barriers such as inconvenience, social or economic constraints, and stigma. These underserved populations are often described in the context of the "population dividend", and may include the urban poor and youth, such as very young adolescents or married youth. The project activities will specifically align with the GHI principle of gender equality, the empowerment principle in APR and FP2020, and Agency-wide commitments mandated by the *USAID Gender Equality and Female Empowerment Policy*.[8]

The recipient must coordinate and collaborate closely with a multitude of partners, including current and future USAID-supported projects, service delivery programs, country and regional bilateral projects; other social science research efforts; biomedical research initiatives; and partners focused on health systems strengthening. It is essential for these collaborations to maximize scarce resources by leveraging co-funding among partners, augmenting other donor programs, and amplifying economies of scale. This engagement is essential for the successful scaling-up of interventions that will facilitate service delivery systems within developing countries and improve FP/RH outcomes. The recipient will partner with Ministries of Health, local researchers, research organizations, local implementing organizations, and other in-country stakeholders to conduct research. In working with these partners, the project will build in-country capacity, the results of which will be sustained long after the completion of project activities. Stakeholders will be able to determine the value added of research, to design and implement studies, and to apply evidence based programming.

The applicant can be an international organization, a developing country organization, a consortium, or some other combination of partners. The project can utilize sub-awards and memoranda of understanding to maximize collaboration and capacity building activities with local and international partners. Activities may be conducted through sub-awards, which could be competitively awarded. Sub-awards and memoranda of understanding with host country collaborators are expected to result in increased local research capacity.

The ISSUE FP/RH Project will be required to achieve results while simultaneously addressing evolving priorities and needs. This commitment will require an adequately flexible project structure. USAID recognizes that 5-year timelines for other cooperative agreements and contracts may have limited the project's ability to answer research questions that require longer-term follow-up and to achieve optimal use and scale of evidence generated. This was especially evident in the recently published evaluation of the PROGRESS Cooperative Agreement (Annex 3). Increasing the project timeline beyond 5 years is expected to enhance the project's ability to conduct research on questions that cannot be answered within shorter time frames. A longer timeline, for example, will increase the project's ability to analyze normative change subsequent to the implementation of activities, to enter into more effective and sustained engagement with Ministries and local partners, and to more effectively contribute to institutionalization of evidence-based practices by stakeholders at all levels.

The project is designed to accept all types of funding – from various sectors, as well as from donors other than USAID. Being able to accept funds from other sectors will enable the project to better address the multi-sectoral research needs that reflect the complexity of field

8 *USAID Gender Equality and Female Empowerment Policy, March, 2012*

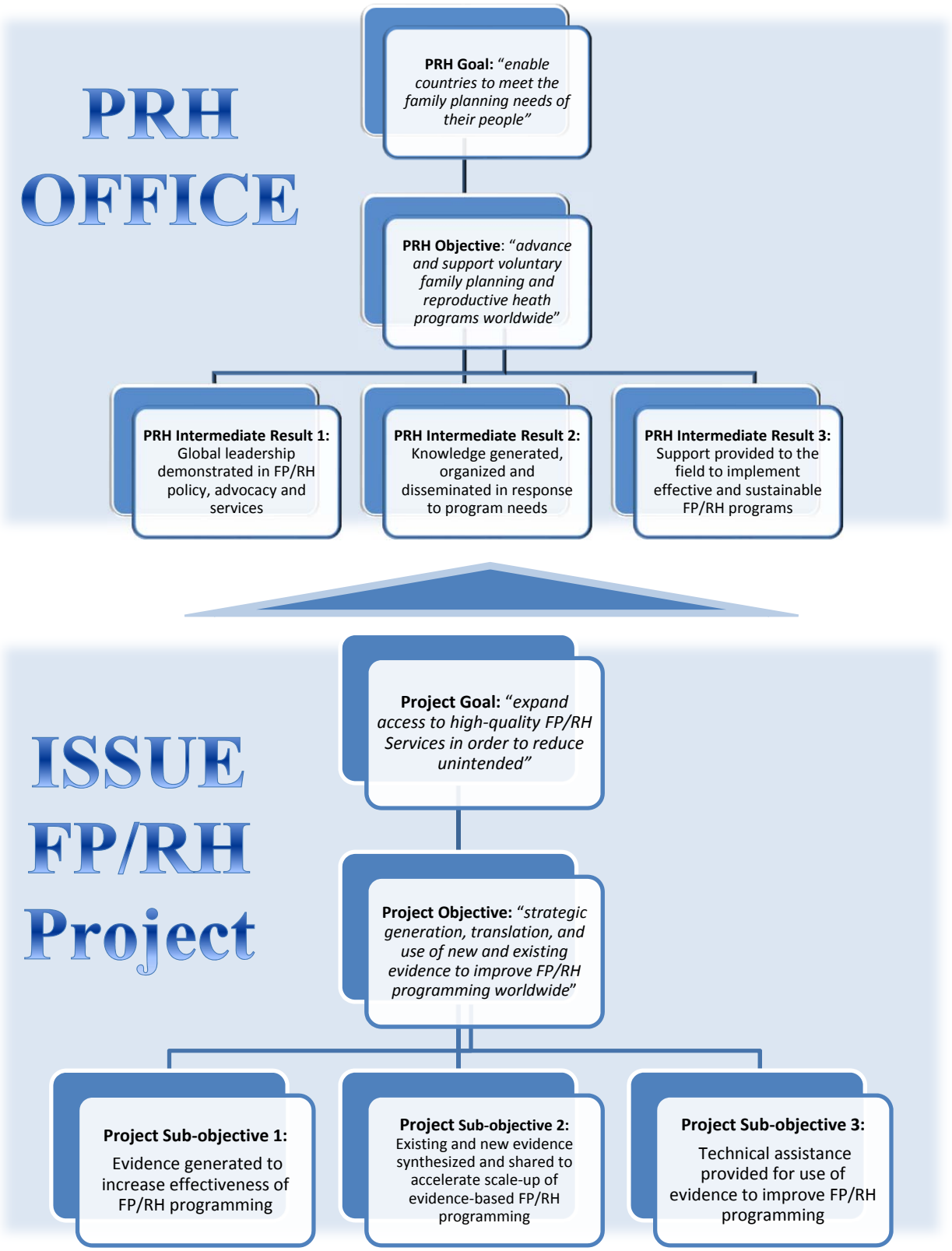
programming. All funding must be applied to research that has relevance to FP/RH goals. For example, the use of non-health funds can fund research related to the integration of FP services into non-health sector programs.

Should the opportunity arise at the request of USAID missions, the ISSUE FP/RH project will have the flexibility and the research capacity to respond to the need for increased and improved impact evaluations, as required by the USAID Evaluation Policy[9,10]. The aim of impact evaluations is to enable decision-makers who design and implement projects, programs and strategies (including USAID staff, host governments, and implementing partners) to test fundamental assumptions and introduce improvements into future efforts – which mirrors the intent of this project to provide high quality evidence about the effectiveness of FP/RH interventions. Impact evaluations utilize methods and designs that will generate high quality and credible evidence to answer the questions being asked – a clear parallel to the aims of USAID's research projects. The successful applicant will possess the capacity to apply research design and methodology to support impact evaluations.

9 http://pdf.usaid.gov/pdf_docs/pdacq800.pdf

10 According to the policy, "Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured."

3. STRATEGIC FRAMEWORK



The goal of the ISSUE FP/RH project is *to expand access to high-quality FP/RH services in order to reduce unintended pregnancy* as described in the strategic framework flowchart.

The objective of this project is to undertake *strategic generation, translation, and use of new and existing evidence to improve FP/RH programming worldwide*. Consistent with the project's sub-objectives reflected in the graphic below, this will be accomplished by advancing FP/RH research; transferring new technologies to and across PRH priority countries; and developing and testing innovative ways to measure the process and impact of scaling-up evidence-based practices. The project will contribute to global technical leadership and knowledge translation and will work with USAID and other global and local partners to do so. It will support USAID Missions to answer country-specific research questions and facilitate context-specific learning to assist countries in scaling-up evidence-based FP/RH interventions and innovations. Field-based activities will be responsive to Mission and Regional Bureau needs, especially when the research related requests will contribute to the global learning agenda.

The project's objective and sub-objectives align with the USAID/PRH results framework. (See Annex 4 for the complete framework).

The goal of the USAID/PRH framework is "*to enable countries to meet the family planning needs of their people"*; the Strategic Objective is "*to advance and support voluntary family planning and reproductive health programs worldwide*". The following are the 3 Intermediate Results (IRs) of the PRH framework:

- IR1: Global leadership demonstrated in FP/RH policy, advocacy, and services;
- IR2: Knowledge generated, organized, and disseminated in response to program needs;
- IR3: Support provided to the field to implement effective and sustainable FP/RH programs.

The following description of illustrative activities is intended to provide examples that could potentially be addressed by the project for each of the sub-objectives. ***The examples that are provided are merely illustrative. It is critical that any and all activities described by applicants in their response be feasible, realistic, within the scope of the project budget, and reflect the comparative advantage of the applicant.***

Sub-objective 1: Evidence generated to increase effectiveness of FP/RH programming.

The ISSUE FP/RH project will identify FP/RH program issues of global importance, and develop and test solutions to these issues in different contexts. This project will generate new evidence while building on previous research, including studies conducted by USAID-funded research projects such as the PROGRESS project, major service delivery projects, bilateral programs, and biomedical development projects. By focusing on design and implementation of research, it will closely complement and engage with ongoing core and bilateral projects, including service delivery projects and projects working on health systems strengthening. The project will have the flexibility to respond to emerging issues and Mission needs, while also seeking answers to critical unresolved issues of global significance. The partner will undertake research of the highest standards and with a dedication to stakeholder ownership, thereby

contributing to the global knowledge base, use of research results, and further funding of related research.

Illustrative activities include:

- Continuing to test alternative service delivery approaches to address human and financial resource constraints that limit access to family planning, especially those approaches that expand access through task sharing, referral, and integrated service delivery.
- Developing and testing innovative, effective, and efficient solutions to reach women, men, and youth at scale with information and services, including building on ongoing approaches such as mHealth, integrating FP within and outside of health programs, and other direct-to-consumer approaches to provide information and contraceptives.
- Contributing to expansion of the method mix to include existing methods that respond to consumer demand and increase use of modern contraceptives, including fertility awareness methods (FAM), long-acting and reversible contraception (LARC), and permanent methods (PM).
- Conducting acceptability and/or introduction studies for new contraceptive technologies.
- Improving understanding of the relationship between unmet need, demand, and behavior among contraceptive users and non-users.
- Conducting research on introduction and sustainable scale-up of evidence-based practices.
- Designing and implementing impact evaluations to examine the effectiveness and impact of FP interventions.
- Conducting longitudinal research to improve understanding of the effect of normative change on FP/RH outcomes; long-term impacts of FP/RH interventions; reasons for non-use of contraception, incorrect use and discontinuing use; and improving understanding of consumer demand and behavior and the disconnect between knowledge and demand.

Sub-objective 2: Existing and new evidence synthesized and shared to accelerate scale-up of evidence-based FP/RH programming.

This project builds on USAID's experience at the forefront of international efforts to promote evidence-based practices in FP/RH service delivery. For decades, donors and partners have incorporated the knowledge and experience from myriad communities of practice to synthesize and disseminate research results and promote experiential learning. Such work must continue to be synthesized as practical guidance documents and tools for field programs. A key role of this project will be to consolidate and disseminate evidence and experience across various contexts. Global technical leadership will be advanced through the production of syntheses, systematic reviews, case studies, reports and tools to accelerate the uptake of lessons learned from FP research. In addition to sharing this information through existing channels of communication, the project will contribute to identifying innovative methods of communicating the information so that is accessible to stakeholders at multiple levels, with various backgrounds and concerns. The project will facilitate integration of evidence-based practices and other key lessons from research and experience into relevant international norms, standards, guidelines and documents.

Illustrative activities include:

- Consolidating knowledge and advancing collaborative learning on the facilitators and barriers to accelerating scale-up of evidence-based practices in FP/RH.
- Consolidating, capturing and sharing experiential knowledge and practice from field programs and other projects as needed and in collaboration with other partners and stakeholders.
- Producing syntheses, systematic reviews, case studies, reports, and other innovative methods to share information on lessons learned from research and experiential learning.
- Developing and implementing innovative models for exchanging information about research results in a timely and targeted manner.
- Informing global and country-specific strategic planning with regard to family planning services and supplies, using context-specific data and appropriate methods of analysis, such as economic and cost analysis, modeling, demographic and epidemiological analysis, and spatial analysis/GIS.

The application of sub-objective 2 throughout the life of project will be influenced by advances in evidence made through activities conducted under sub-objective 1 and through new evidence provided by other research efforts.

Sub-objective 3: Technical assistance provided for use of evidence to improve FP/RH programming.

The ISSUE FP/RH project will provide USAID Missions and Regional Bureaus, global and bilateral projects, as well as other development partners, with tools and support for research and translation of evidence into programs, policies and practice. Technical assistance will respond to the priorities and realities of FP/RH programs at country and regional levels and will build sustainable capacity for evidence-informed decision-making. The applicant is also expected to support the range of partners and needs identified through GHI, FP2020, APR, and other priority setting initiatives.

- Illustrative activities include: Supporting strategic FP/RH program planning and evidence-based decision-making in response to requests from USAID Missions, Regional Bureaus, Ministries of Health, and other stakeholders, for example developing costed business plans using modeling, economic analyses, and other analysis methods.
- Supporting USAID Missions to identify and address implementation science research questions to inform improved access, availability and use of family planning and reproductive health services.
- Supporting Ministries of Health, technical working groups and other key partners at country and regional levels to translate evidence into service delivery guidelines, tools, curricula and program plans.
- Providing technical assistance to monitor and evaluate the scale-up of evidence-based practices in service delivery programs at global, regional and country levels.
- Conducting impact evaluations in response to Mission needs and consistent with USAID's Evaluation Policy.

- In response to Mission or Bureau needs, assessing the results and sustainability of ongoing or past projects and research utilization efforts.
- Providing rapid responses to research-related queries from USAID Missions, Bureaus and other partners and projects.

These illustrative examples are not specific USAID Mission requests at this time and are not a commitment of field support or core funding for these activities. Due to the responsive and flexible nature of this cooperative agreement, there will be significant opportunities to address existing and emerging requests from the field and from other partners over the life of the project.

SECTION II - AWARD INFORMATION

Cooperative Agreement Award

It is USAID's intent to award a cooperative agreement pursuant to guidance contained herein. USAID may make an award resulting from this RFA to the responsible applicant(s) whose application(s) conforming to this RFA offers the greatest value. USAID may (a) reject any or all applications, (b) accept other than the lowest cost application, (c) accept more than one application, (d) accept alternate applications, and (e) waive informalities and minor irregularities in applications received.

USAID may make an award on the basis of initial applications received, without discussions. Therefore, each initial application must contain the applicant's best terms from a technical and cost standpoint.

Neither financial data submitted with an application nor representations concerning facilities or financing, will form a part of the resulting award.

Anticipated Award Schedule

The project is expected to be awarded on or about September 30, 2013

Period of Performance

The cooperative agreement will be issued for a performance period of ten years.

Estimated Dollar Value

This RFA provides an estimate of the dollar amount for the cooperative agreement of up to $150 million ceiling over ten years.

SUBSTANTIAL INVOLVEMENT

USAID will be substantially involved during the implementation of this Cooperative Agreement in the following ways:

ELEMENTS OF SUBSTANTIAL INVOLVEMENT

1. Approval of the recipient's implementation plans, including annual workplans, reports, monitoring and evaluation plan(s), research protocols, travel, and all modifications that describe the specific activities to be carried out under the Cooperative Agreement;

2. Approval of and changes to specified key personnel;

3. Agency and recipient collaboration or joint participation (collaborative involvement in selection of advisory committee members, concurrence on selection of sub-award recipients, and/or the substantive provisions of the sub-awards).

SECTION III - ELGIBILTY INFORMATION

Eligibility

To be eligible for the Cooperative Agreement under this RFA, an organization must:

- Be a for-profit, not-for-profit, or private voluntary organization registered with USAID;
- Have demonstrated capacity in Implementation Science in developing countries;
- Have managerial, technical, and institutional capacities to achieve the results outlined in this RFA, including financial systems;
- Have the capacity and experience to collaborate with other organizations/groups in undertaking FP/RH research and research utilization;
- Have demonstrated ability to collaborate with host-country governments, non-governmental institutions and other donors to advance program research and research utilization to improve FP/RH.

Pursuant to 22 Code of Federal Regulations (CFR) 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, related to the application program and in accordance with applicable cost standards (22 CFR 226, Office of Management and Budget (OMB) Circular A-122 for not-for-profit organizations, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the application.

Cost Share

A cost share should be proposed with a minimum of 10 percent from non-USAID sources. The applicant will be evaluated on their ability to meet or exceed this cost share. Such funds may be contributed from the recipient, other multilateral, bilateral, and foundation donors, local organizations, and private businesses that contribute financially and in-kind to the implementation of activities. If partners are proposed, the cost share may be distributed among partners. The cost share, whether it be in-kind or dollars, must have a direct impact on this program.

Applications that do not meet the minimum cost-share requirement are not eligible for award consideration.

SECTION IV- APPLICATION AND SUBMISSION INFORMATION

1. PREPARATION GUIDELINES AND INSTRUCTIONS

Section I describes the parameters of the Implementation Science for Strengthening Use of Evidence in FP/RH Programming (ISSUE FP/RH) Cooperative Agreement and the instructions for submitting technical and cost applications to the United States Agency for International Development (USAID). This includes elements that applicants should consider throughout the application, the response format for the technical application, general guidelines, and the format for the cost application.

Applicants are expected to review, understand, and comply with all aspects of this RFA. Failure to do so will be at the applicant's risk.

a. Format

To facilitate the competitive review of the applications, USAID will consider only technical applications and cost applications conforming to the format prescribed in this solicitation. Technical Applications are limited to 40 pages. If an application has over 40 pages, the extra pages will not be read and, therefore, will not be considered in the evaluation of the application. Applications shall be written in English, text should be left-justified using Microsoft Word, Times New Roman, 12 point font on standard 8 1/2 x 11 inch paper (210 mm by 297mm paper), single spaced, with each page numbered consecutively, and no less than one inch margins on all sides. Supplementary materials such as full résumés of personnel, documentation of past institutional work, and relevant letters of support may be provided in attachments accompanying the technical application. There is no page limit for the attachments, although brevity is encouraged. The application itself should be sufficiently complete to stand on its own without the attachments. The technical applications must be specific, complete and concise.

The suggested format for the technical section is as follows:

- **Cover page**: Project title or proposed alternative title, request for applications (RFA) number, name of organization(s) submitting application, official signature, and contact person information: name, telephone and fax numbers, address, and e-mail address.
- **Application**: Narrative response providing the technical approach to the RFA.
    - **Executive summary** (1-3 pages)
    - **Technical approach** (36-38 pages) Technical applications must address the questions raised in Section IV: Application Preparation and the objectives described in Section I: Program Description of this document.
- **Attachments**: No page limit, but should conform to harmonized formatting.

2. TECHNICAL APPLICATION FORMAT AND CONTENT

The following elements describe the content and format of the technical response that applicants must submit to USAID for the ISSUE FP/RH Project. The Technical Evaluation Panel (TEC) will review all submissions and make recommendations to the Agreement Officer (AO) for selection while applying the Evaluation Criteria in Section V. Applicants should specifically refer to Section I, which provides the Program Description, including the Bureau for Global Health (GH) definition of Implementation Science and description of the Project Framework. Annexes included within this RFA may also provide additional technical insight. Applicants are required to follow the page limitations set out in the previous section, but still provide the necessary detail to address the following:

a. Cover Page and Executive Summary

The applicant shall provide a cover page with the information described above, including the signature of an authorized agent at the applicant institution. The applicant is permitted to revise the title of the Cooperative Agreement, but the response must reference the RFA number SOL-OAA-13-000005. The applicant can also provide a 1-3 page executive summary.

b. Overview

In this section, Applicants will provide an overview describing how they propose to achieve the ISSUE FP/RH Project's goal, objective and sub-objectives, as well as how the design will contribute to the PRH framework (Section I; Annex 4). Applicants are expected to clearly articulate a realistic and feasible overarching strategy, a brief description of expected results to be achieved in the short and long term, and the level of effort expected over time for each of the 3 sub-objectives. This section should highlight the applicant's comparative advantages and strengths in the field of Implementation Science. The applicant is free to suggest an alternative conceptual framework and/or results framework to achieve the objectives and sub-objectives of this project.

The applicant should elucidate how they will balance and influence emerging priorities at a global, regional and local level, given the ever changing landscape in the field of FP/RH

Implementation Science. Thus, the applicant should describe how they will establish and maintain global leadership leading to achievement of the objective and the sub-objectives. The applicant's experience and leadership in country contexts should be expressed in the response, including areas of leverage. The applicant should also be a catalyst in coordinating and building upon existing evidence with a wide range of partners.

c. Strategic Approach

For this next section, the applicant should refer specifically to the illustrative project framework (Section I: Program Description flowchart). Below, there are specific questions to be answered for each sub-objective. Emphasis should be put on feasibility and the potential for scale-up when responding to questions related to research priorities. This response should be realistic and mindful of the project's budget and timeline. Applicants should identify specific countries in which they might work, describing why those countries would be selected. ***Applicants are expected to take into consideration research and research translation activities being implemented or already completed by other organizations and donors to minimize redundancy and enhance synergy.***

Objective: Strategic generation, translation, and use of new and existing evidence to improve FP/RH programming worldwide

Sub-objective 1: To generate evidence to increase effectiveness of FP/RH programming
Applicants shall:

- Describe the priority research questions that will be answered by this project;
- Explain the rationale for selection of these priority research questions;
- Describe the methodologies/approaches that will be used to answer each research question. Describe which of these can be answered within 5 years and which require longer timelines given the methodologies selected;
- Explain how the project will identify and respond to emerging and evolving priorities from global, regional, and local levels;
- USAID and other donors consistently experience a challenge measuring and understanding the level of scale of practices and services in the field, including introduction of new contraceptive methods and approaches. Describe how the project will contribute to the development, validation, and/or adaptation of methodologies and indicators; and,
- USAID is continually acting to improve the quality of research funded globally and at country levels. Please describe the contribution that the project will make to this effort.

Sub-objective 2: To synthesize and share existing and new evidence to accelerate scale-up of evidence-based FP/RH programming
Applicants shall:

- Describe topics and issues that are priorities for the production of syntheses, meta-analyses, and case studies for program use;
- Explain the rationale for selection of these priorities;
- Describe the methodologies/approaches for consolidation and synthesis of research results and program experience; and,
- Demonstrate how the project will connect with existing and varied knowledge management

outlets to increase uptake of evidence-based practices.

Sub-objective 3: To provide technical assistance for use of evidence to improve FP/RH programming

Applicants shall:

- Describe priority evidence-based practices and topics that are underutilized;
- Describe the technical assistance that would be provided by this project at country, regional and/or global levels for each of these practices;
- Describe the specific countries in which the project will work to apply and scale-up packages and/or individual priority practices, considering complementary efforts by USAID and other donor projects. Please include rationale for selection; and,
- How will the project monitor progress towards the adoption and scale-up of these practices?

d. Global and Country Scenarios

Applicants shall respond to the following scenarios. Responses will be evaluated according to technical rigor, feasibility to implement, realistic expectations, and how well they address the ISSUE FP/RH Project's objective and sub-objectives. However, selection of an applicant given the country specific response does not guarantee operation in that country during project implementation.

Scenario 1

Select a research question that represents a significant gap in our understanding of how to increase access to and use of contraception among women and couples in order to prevent unintended pregnancy. Then specifically:

- Elaborate on the rationale for selecting this research question;
- Identify the critical gaps in the literature and ongoing research;
- Discuss the potential research methodologies to fill these gaps;
- Provide illustrative benchmarks and indicators;
- Discuss potential countries where these questions could be answered;
- Discuss partnerships that could be leveraged to design and implement the research (e.g. host country governments, universities and private sector partners, USAID, other US government partners, other donors, private sector partners, etc.);
- Discuss the process for knowledge translation to promote the uptake and use of research results;
- Discuss the expected impact of this research in terms of knowledge gained, potential health impacts, etc; and,
- Estimate the resource requirements needed to implement the activities outlined above.

Scenario 2

Select an evidence-based practice not yet widely implemented at scale and that has the potential to significantly increase use of FP services. (Please do not select injectables at the community level as this practice is already receiving significant attention.) Then:

- Describe the details of a plan for Implementation Science to catalyze scale-up of the selected practice(s) in one country. This might include, but not be limited to:

- The rationale for choosing the illustrative country ;
- The process of identifying partners and organizations and the types of technical assistance that will be necessary to a variety of stakeholders to ensure sustainable implementation beyond the life of the award (include an explanation of the comparative advantage of the proposed project and how it would complement work being conducted by other USAID-supported projects, both core and bilateral);
- The balance between adapting the practice and maintaining fidelity to the evidence-based model; and,
- The process for monitoring and conducting research on the expansion and institutionalization of these practices.

- Estimate the resource requirements to conduct this activity.
- Describe how this country specific plan will also feed into global and regional impact, including but not limited to identifying opportunities to accelerate efficiency and effectiveness of replication efforts.

e. Workplan and Project Monitoring Plan

Applicants shall include an illustrative work plan for core funding for the first year and an illustrative project monitoring plan (PMP) with indicators to measure the effectiveness of activities. For long term planning, applicants can approximate that one-third of all funds in out years will come from field support given a recipient's leveraging efforts with USAID Missions over the life of the project.

Applicants should describe how their PMP links to the PRH framework, illustrating the strategic objective and intermediate results (Annex 4) and how it aligns with the other initiatives including Global Health Initiative (GHI) Principles, A Promise Renewed (APR), and FP2020 (Annex 5). The PMP should include proposed/illustrative indicators with targets and benchmarks for achievement of each IR proposed by the recipient if different from the sub-objectives described in the RFA. The PMP should incorporate indicators from validated lists of standard foreign assistance indicators as appropriate.

f. Management Plan

The management plan for the ISSUE FP/RH project must specify the management and administrative arrangements for overall implementation of the program, including organizational structure, logistical support, personnel management, timely institutional review for the protection of human subjects in research and protection of data, and procurement arrangements for goods and services. A management plan for the project will need to specify clear lines of supervision, accountability, decision-making and responsibility among staff. Special attention should be paid to ensuring efficiencies in operational and financial management and in the establishment of any country offices.

Applicants should show how they propose to manage a complex set of activities in multiple countries and regions of the world in collaboration with proposed partners, and how the project will respond to Mission and other partner requests for research activities and technical assistance. Rationale for decisions about proposed partnerships should be clearly stated, describing partnerships identified in the proposal, as well as rationale for identifying partners later in the project.

Applicants should describe, in general, their existing field presence and network of in-country and global partners, and explain how they may utilize or leverage existing partnerships to initiate activities in their current or new locations and achieve measurable impact with core funds – both with regard to conducting research and to translating research results into practice. Applicants should provide a list of developing country organizations that will be prospective partners on the project, and describe a process by which other in-country organizations might be identified to develop and conduct research.

Applications shall also include the following information:

- The management and administrative arrangements for overall implementation of the program and the organizational structure, including an organizational chart;
- If partners are proposed, description of how the project will be managed to take advantage of partners' strengths and complementary skills, including co-location of staff, involvement of all staff in work plan preparation and implementation, and establishment of a cohesive team;
- Description of how the project will be branded so that it will be identified as distinct/separate from the prime organization, including the expectation of USAID co-branding requirements;
- Detailed plans for how costs will be contained, including information about cost-sharing;
- Plans to maintain quality of project activities;
- Plans on how to balance the use of USAID/Washington funds and Mission field support funds, including plans for the number and location of country offices and how the applicant will finance country offices; and
- Plans for rapid start-up of the project.

Coordination and communication with a wide range of partners – internal to USAID, public/private sector partners, other implementing organizations, and other donors – is key to the achievement of the project's strategic objective. Applications should reflect an ability to coordinate with a range of organizations and to utilize diverse human resources effectively in order to conduct the highest quality priority research and achieve broad-scale utilization of research results. Applicants should describe how they will interact and coordinate with USAID technical champions, Regional Bureaus, Missions, bilateral programs, international implementing partners, in-country partners, and with other development partners, including host country governments and non-USG supported organizations. Specificity is encouraged in describing which potential global and bilateral projects would be critical partners to achieve the results of the ISSUE FP/RH project and how these partnerships would be developed and managed.

g. Key Personnel Qualifications and Staffing Plan

Applicants are requested to develop a comprehensive staffing plan that will enable achievement of results and that demonstrates an appropriate balance of skills, accountability, and efficiency, including levels of effort and brief position descriptions. The staffing pattern will include a critical number of highly experienced technical and managerial staff sufficient to manage activities under this award. It is critical for applicants to show how the following qualifications are met by the staff proposed, taken as a whole, and how the staffing pattern is conducive to achieving results. The key qualifications for the proposed staff include skills and experience in:

- Management and administration of cooperative agreements;
- Translation of research to practice and policy;
- Research related to scale-up of evidence based practices;
- Local partnerships for research and utilization of research results;
- Conducting research, using high quality methodology and approaches

Applicants will identify four key personnel, the Director, Deputy Director, Implementation Science/Knowledge Translation Specialist, and Monitoring and Evaluation Specialist by name and position. Each will be one full-time equivalent. Applicants should explain how the key staff positions, as well as other proposed positions provide the complete set of skills listed above. It will be especially important to demonstrate access to personnel with strong skills in research methodology, as well as skills in design and implementation of efforts to ensure utilization of evidence and evidence-based practices. The staffing level and pattern may be increased or modified over time if needed to provide effective support to field programs as they evolve, rather than from the onset.

Director: The Director should be an internationally recognized researcher and thought leader with an advanced degree in the social, medical, health management sciences, or a related field. The project director should have a minimum of 15 years of experience conducting implementation research in developing countries in the area of FP/RH. This person will guide strategic planning and assure achievement of overall program results. This is a full-time position.

Deputy Director: The Deputy Director should have an advanced degree in the social/health services, medical sciences, management and administration, or a related field. This individual should have a minimum of 10 years of experience in FP/RH program management of which at least five years should be in implementing and managing large international development projects. The deputy director must have substantial administrative and personnel management experience. This is a full-time position.

Implementation Science /Knowledge Translation Specialist: This technical specialist should have an advanced degree in public health, social science, or a related field, with a minimum of 10 years of experience translating evidence into FP/RH programs and policies and at least five years leading complex FP/RH service delivery and/or Implementation Science projects in developing countries. This is a full-time position.

Monitoring and Evaluation (M&E) Specialist: The M&E specialist should have an advanced degree in public health or health management, with a minimum of 5 years of practical experience in monitoring, tracking, evaluating, and reporting on complex global projects. The M&E specialist will be responsible for developing and monitoring the PMP. This is a full-time position.

The section on personnel capability in the main body of the application will include brief statements of major duties, experience, academic background and résumés for each of the key personnel and other senior program staff proposed. Résumés for key personnel, other senior program staff, and any long-term professional staff/advisors should be included in the attachments. The application should also include some information regarding the skill sets the project management team can access within the institution beyond the key personnel. The resumes for these non-key program staff will be limited to four pages. The attachments should include letters of commitment from all senior program staff to remain with the program for at least two years post award. Also, provide a skills matrix of all senior program staff, including experts in developing countries, outlining the key project results they will contribute to and their expected LOE.

h. Institutional Capability

Applicants shall demonstrate that they have the array of skills needed to effectively address the issues within the scope of the ISSUE FP/RH project and achieve results. Likewise, applicants should have the ability to work with multiple partners and to report results and financial information efficiently. Applicants shall demonstrate their institutional ability to plan, implement, and support complex programming and the range of activities outlined in the RFA.

i. Organizational Past Performance

As an appendix, Applicant shall include Past Performance Report—Short Form (Annexes V). Applicants shall include 3 – 5 past performance examples with accompanying references that can validate that the work was accomplished. The examples must be for the past five years for current public or private sector type awards for efforts similar to the requirements of this RFA. Identify the program activities as they relate to Section I - Program Description. The reference information shall include the location, current telephone number, e-mail addresses, point of contact, award number, dollar value, and brief description of work performed. USAID expects applicants to demonstrate the following:

- Technical accomplishment in program research related to FP/RH service delivery and/or policy improvement in developing country settings, and translation and utilization of program research results.
- Ability to form strong partnerships with a range of research, advocacy and service delivery institutions/organizations in both the US and host-countries;
- High level client satisfaction that the applicant conformed to the terms and conditions of the contract/agreement/grant application and has performed in an effective, efficient, capable, reasonable and cooperative manner.

- The degree to which Applicant is reported to have been effective, efficient, capable, reasonable, and cooperative (i.e. client satisfaction)
- •Whether Applicant conformed to the terms and conditions of the contract/agreement/grant (i.e. cost control and timeliness of performance)
- Relevancy of work performed.

j. Attachments

Attachments should include relevant letters of support, i.e., letter(s) of program support from a local government, letter(s) from a partnering organization(s) expressing their commitment to engage in a partnership, as well as past performance references. Applicants may also attach supplementary information regarding the capacity of the organization and its staff.

Environmental Compliance

The Foreign Assistance Act of 1961, as amended, Section 117, requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216 http://www.usaid.gov/our_work/environment/compliance/22cfr216.htm) and in USAID's Automated Directives System (ADS) Parts 201.5.10g and 204 (*http://www.usaid.gov/policy/ADS/200/*), which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities.

To demonstrate their capability to meet all environmental compliance requirements, Applicants will submit an Environmental Capability Statement (ECS) presenting their approach to achieving environmental compliance and management, i.e., how they will implement the Programmatic Initial Environmental Examination (PIEE) (attached). This statement, which should be limited to ½ -1 page, must include a description of:

- The Applicant's approach to developing and implementing any 22 CFR 216 documentation, including provisions for an Environmental Monitoring and Management Plan (EMMP)11 to be updated and revised throughout the life of the award as detailed in the annual Environmental Status Report (ESR); and
- The Applicant's approach and staff who will provide the necessary environmental management expertise. This will include examples of past experience of environmental management of similar activities and a description of the technical expertise of identified individuals.

Applicants need to include anticipated costs for implementing and monitoring the environmental compliance activities in the budget and describe these costs in detail to the degree possible in the budget narrative.

B10. Branding & Marking Requirements

BRANDING & MARKING STRATEGY - ASSISTANCE (December 2005)

(a) Definitions

Branding Strategy means a strategy that is submitted at the specific request of a USAID Agreement Officer by an Apparently Successful Applicant after evaluation of an application for USAID funding, describing how the program, project, or activity is named and positioned, and how it is promoted and communicated to beneficiaries and host country citizens. It identifies all donors and explains how they will be acknowledged.
Apparently Successful Applicant(s) means the Applicant(s) for USAID funding recommended for an award after evaluation, but who has not yet been awarded a grant, cooperative agreement or other assistance award by the Agreement Officer.
The Agreement Officer will request that the Apparently Successful Applicants submit a Branding Strategy and Marking Plan. Apparently Successful Applicant status confers no right and constitutes no USAID commitment to an award.

USAID Identity (Identity) means the official marking for the Agency, comprised of the USAID logo and new brand mark, which clearly communicates that our assistance is from the American people. The USAID Identity is available on the USAID website and is provided without royalty, license, or other fee to Recipients of USAID-funded grants or cooperative agreements or other assistance awards or sub awards.

(b) Submission
The Apparently Successful Applicant, upon request of the Agreement Officer, will submit and negotiate a Branding Strategy. The Branding Strategy will be included in and made a part of the resulting grant or cooperative agreement. The Branding Strategy will be negotiated within the time that the Agreement Officer specifies. Failure to submit and negotiate a Branding Strategy will make the Applicant ineligible for award of a grant or cooperative agreement. The Apparently Successful Applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events and materials, and the like.

(c) Submission Requirements
At a minimum, the Apparently Successful Applicant’s Branding Strategy will address the following:

(1) Positioning
What is the intended name of this program, project, or activity?
Guidelines: USAID prefers to have the USAID Identity included as part of the program or project name, such as a "title sponsor," if possible and appropriate. It is acceptable to "co-brand" the title with USAID’s and the Apparently Successful Applicant’s identities. For example: "The USAID and [Apparently Successful Applicant] Health Center." If it would be inappropriate or is not possible to "brand" the project this way, such as when rehabilitating a structure that already exists or if there are multiple donors, please explain and indicate how

you intend to showcase USAID's involvement in publicizing the program or project. For example: School #123, rehabilitated by USAID and [Apparently Successful Applicant]/ [other donors]. Note: the Agency prefers "made possible by (or with) the generous support of the American People" next to the USAID Identity in acknowledging our contribution, instead of the phrase "funded by." USAID prefers local language translations.
Will a program logo be developed and used consistently to identify this program? If yes, please attach a copy of the proposed program logo. Note: USAID prefers to fund projects that do NOT have a separate logo or identity that competes with the USAID Identity.

(2) Program Communications and Publicity

Who are the primary and secondary audiences for this project or program?

Guidelines: Please include direct beneficiaries and any special target segments or influencers. For Example: Primary audience: schoolgirls age 8-12, Secondary audience: teachers and parents–specifically mothers.

What communications or program materials will be used to explain or market the program to beneficiaries?

Guidelines: These include training materials, posters, pamphlets, Public Service Announcements, billboards, websites, and so forth.

What is the main program message(s)?

Guidelines: For example: "Be tested for HIV-AIDS" or "Have your child inoculated." Please indicate if you also plan to incorporate USAID's primary message – this aid is "from the American people" – into the narrative of program materials. This is optional; however, marking with the USAID Identity is required.

Will the Recipient announce and promote publicly this program or project to host country citizens? If yes, what press and promotional activities are planned?

Guidelines: These may include media releases, press conferences, public events, and so forth. Note: incorporating the message, "USAID from the American People," and the USAID Identity is required.

Please provide any additional ideas about how to increase awareness that the American people support this project or program.

Guidelines: One of our goals is to ensure that both beneficiaries and host-country citizens know that the aid the Agency is providing is "from the American people. "Please provide any initial ideas on how to further this goal.

(3) Acknowledgements

Will there be any direct involvement from a host-country government ministry? If yes, please indicate which one or ones. Will the Recipient acknowledge the ministry as an additional co-sponsor?

Note: it is perfectly acceptable and often encouraged for USAID to "co-brand" programs with government ministries.

Please indicate if there are any other groups whose logo or identity the Recipient will use on program materials and related communications.

Guidelines: Please indicate if they are also a donor or why they will be visibly acknowledged, and if they will receive the same prominence as USAID.

(d) Award Criteria. The Agreement Officer will review the Branding Strategy for adequacy, ensuring that it contains the required information on naming and positioning the USAID-funded program, project, or activity, and promoting and communicating it to cooperating country beneficiaries and citizens. The Agreement Officer also will evaluate this information to ensure that it is consistent with the stated objectives of the award; with the Apparently Successful Applicant's project, activity, or program performance plan; and with the regulatory requirements set out in 22 CFR 226.91. The Agreement Officer may obtain advice and recommendations from technical experts while performing the evaluation.

MARKING PLAN – ASSISTANCE (December 2005)

(a) Definitions
Marking Plan means a plan that the Apparently Successful Applicant submits at the specific request of a USAID Agreement Officer after evaluation of an application for USAID funding, detailing the public communications, commodities, and program materials and other items that will visibly bear the USAID Identity. Recipients may request approval of Presumptive

Exceptions to marking requirements in the Marking Plan.
Apparently Successful Applicant(s) means the Applicant(s) for USAID funding recommended for an award after evaluation, but who has not yet been awarded a grant, cooperative agreement or other assistance award by the Agreement Officer. Apparently Successful Applicant status confers no right and constitutes no USAID commitment to an award, which the Agreement Officer must still obligate.

USAID Identity (Identity) means the official marking for the Agency, comprised of the USAID logo and new brand mark, which clearly communicates that our assistance is from the American people. The USAID Identity is available on the USAID website and USAID provides it without royalty, license, or other fee to Recipients of USAID funded grants, cooperative agreements, or other assistance awards or sub awards.

A Presumptive Exception exempts the Applicant from the general marking requirements for a particular USAID-funded public communication, commodity, program material or other deliverable, or a category of USAID-funded public communications, commodities, program materials or other deliverables that would otherwise be required to visibly bear the USAID Identity.

The Presumptive Exceptions are:
Presumptive Exception (i). USAID marking requirements may not apply if they would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials, such as election monitoring or ballots, and voter information literature; political party support or public policy advocacy or reform; independent media, such as television and radio broadcasts, newspaper articles and editorials; and public service announcements or public opinion polls and surveys (22 C.F.R. 226.91(h)(i)).

Presumptive Exception (ii). USAID marking requirements may not apply if they would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent (22 C.F.R.226.91(h)(ii)).
Presumptive Exception (iii). USAID marking requirements may not apply if they would undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as "by" or "from" a cooperating country ministry or government official (22 C.F.R. 226.91(h)(iii)).

Presumptive Exception (iv). USAID marking requirements may not apply if they would impair the functionality of an item, such as sterilized equipment or spare parts (22 C.F.R. 226.91(h)(iv)).

Presumptive Exception (v). USAID marking requirements may not apply if they would incur substantial costs or be impractical, such as items too small or otherwise unsuited for individual marking, such as food in bulk (22 C.F.R. 226.91(h)(v).
Presumptive Exception (vi). USAID marking requirements may not apply if they would offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities (22 C.F.R. 226.91(h)(vi).

Presumptive Exception (vii). USAID marking requirements may not apply if they would conflict with international law (22 C.F.R. 226.91(h)(vii)).

(b) Submission. The Apparently Successful Applicant, upon the request of the Agreement Officer, will submit and negotiate a Marking Plan that addresses the details of the public communications, commodities, program materials that will visibly bear the USAID Identity. The marking plan will be customized for the particular program, project, or activity under the resultant grant or cooperative agreement. The plan will be included in and made a part of the resulting grant or cooperative agreement. USAID and the Apparently Successful Applicant will negotiate the Marking Plan within the time specified by the Agreement Officer. Failure

to submit and negotiate a Marking Plan will make the Applicant ineligible for award of a grant or cooperative agreement.

(c) Submission Requirements. The Marking Plan will include the following:

(1) A description of the public communications, commodities, and program materials that the Recipient will produce as a part of the grant or cooperative agreement and which will visibly bear the USAID Identity. These include:

(i) program, project, or activity sites funded by USAID, including visible infrastructure projects or other programs, projects, or activities that are physical in nature;
(ii) technical assistance, studies, reports, papers, publications, audiovisual productions, public service announcements, Web sites/Internet activities and other promotional, informational, media, or communications products funded by USAID;
(iii) events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences, and other public activities; and
(iv) all commodities financed by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs, and all other equipment, supplies and other materials funded by USAID, and their export packaging.

(2) A table specifying:

(i) the program deliverables that the Recipient will mark with the USAID Identity,
(ii) the type of marking and what materials the Applicant will be used to mark the program deliverables with the USAID Identity, and
(iii) when in the performance period the Applicant will mark the program deliverables, and where the Applicant will place the marking.

(3) A table specifying:

(i) what program deliverables will not be marked with the USAID Identity, and
(ii) the rationale for not marking these program deliverables.
(d) Presumptive Exceptions.

(1) The Apparently Successful Applicant may request a Presumptive Exception as part of the overall Marking Plan submission. To request a Presumptive Exception, the Apparently Successful Applicant must identify which Presumptive Exception applies, and state why, in light of the Apparently Successful Applicant's application and in the context of the program description or program statement in the USAID Request For Application or Annual Program Statement, marking requirements should not be required.

(2) Specific guidelines for addressing each Presumptive Exception are:

(i), identify the USAID Strategic Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why the program, project, activity, commodity, or

communication is ‘intrinsically neutral.’ Identify, by category or deliverable item, examples of program materials funded under the award for which you are seeking an exception.
(ii), state what data, studies, or other deliverables will be produced under the USAID funded award, and explain why the data, studies, or deliverables must be seen as credible.
(iii), identify the item or media product produced under the USAID funded award, and explain why each item or product, or category of item and product, is better positioned as an item or product produced by the cooperating country government.
(iv), identify the item or commodity to be marked, or categories of items or commodities, and explain how marking would impair the item’s or commodity’s functionality.
(v), explain why marking would not be cost beneficial or practical.
(vi), identify the relevant cultural or social norm, and explain why marking would violate that norm or otherwise be inappropriate.
(vii), identify the applicable international law violated by marking.

(3) The Agreement Officer will review the request for adequacy and reasonableness. In consultation with the AOR and other agency personnel as necessary, the Agreement Officer will approve or disapprove the requested Presumptive Exception. Approved exceptions will be made part of the approved Marking Plan, and will apply for the term of the award, unless provided otherwise.

(e) Award Criteria: The Agreement Officer will review the Marking Plan for adequacy and reasonableness, ensuring that it contains sufficient detail and information concerning public communications, commodities, and program materials that will visibly bear the USAID Identity. The Agreement Officer will evaluate the plan to ensure that it is consistent with the stated objectives of the award; with the Applicant’s actual project, activity, or program performance plan; and with the regulatory requirements of 22 C.F.R.226.91 and ADS 303.3.6.3.f. The Agreement Officer will approve or disapprove any requested Presumptive Exceptions (see paragraph (d)) on the basis of adequacy and reasonableness. The Agreement Officer may obtain advice and recommendations from technical experts while performing the evaluation.
MARKING UNDER ASSISTANCE INSTRUMENTS (DEC 2005)

(a) Definitions
Commodities mean any material, article, supply, goods or equipment, excluding Recipient offices, vehicles, and non-deliverable items for Recipient’s internal use, in administration of the USAID funded grant, cooperative agreement, or other agreement or sub agreement.
Principal Officer means the most senior officer in a USAID Operating Unit in the field, e.g., USAID Mission Director or USAID Representative. For global programs managed from Washington but executed across many countries, such as disaster relief and assistance to internally displaced persons, humanitarian emergencies or immediate post conflict and political crisis response, the cognizant Principal Officer may be an Office Director, for example, the Directors of USAID/W/Office of Foreign Disaster Assistance and Office of Transition Initiatives. For non-presence countries, the cognizant Principal Officer is the Senior USAID officer in a regional USAID Operating Unit responsible for the non-presence country, or in the absence of such a responsible operating unit, the Principal U.S. Diplomatic Officer in the non-presence country exercising delegated authority from USAID.

Programs mean an organized set of activities and allocation of resources directed toward a common purpose, objective, or goal undertaken or proposed by an organization to carry out the responsibilities assigned to it.

Public communications are documents and messages intended for distribution to audiences external to the Recipient's organization. They include, but are not limited to, correspondence, publications, studies, reports, audio visual productions, and other informational products; applications, forms, press and promotional materials used in connection with USAID funded programs, projects or activities, including signage and plaques; Web sites/Internet activities; and events such as training courses, conferences, seminars, press conferences and so forth. Sub Recipient means any person or government (including cooperating country government) department, agency, establishment, or for profit or nonprofit organization that receives a USAID subaward, as defined in 22 C.F.R. 226.2.

Technical Assistance means the provision of funds, goods, services, or other foreign assistance, such as loan guarantees or food for work, to developing countries and other USAID Recipients, and through such Recipients to sub Recipients, in direct support of a development objective – as opposed to the internal management of the foreign assistance program.

USAID Identity (Identity) means the official marking for the USAID comprised of the USAID logo or seal and new brand mark, with the tagline that clearly communicates that our assistance is "from the American people." The USAID Identity is available on the USAID website at www.usaid.gov/branding and USAID provides it without royalty, license, or other fee to Recipients of USAID-funded grants, or cooperative agreements, or other assistance awards

(b) Marking of Program Deliverables
(1) All Recipients must mark appropriately all overseas programs, projects, activities, public communications, and commodities partially or fully funded by a USAID grant or cooperative agreement or other assistance award or sub award with the USAID Identity, of a size and prominence equivalent to or greater than the Recipient's, other donor's, or any other third party's identity or logo.

(2) The Recipient will mark all program, project, or activity sites funded by USAID, including visible infrastructure projects (for example, roads, bridges, buildings) or other programs, projects, or activities that are physical in nature (for example, agriculture, forestry, water management) with the USAID Identity. The Recipient should erect temporary signs or plaques early in the construction or implementation phase. When construction or implementation is complete, the Recipient must install a permanent, durable sign, plaque or other marking.

(3) The Recipient will mark technical assistance, studies, reports, papers, publications, audio-visual productions, public service announcements, Web sites/Internet activities and other promotional, informational, media, or communications products funded by USAID with the USAID Identity.

(4) The Recipient will appropriately mark events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences and other public activities, with the USAID Identity. Unless directly prohibited and as appropriate to the surroundings, Recipients should display additional materials, such as signs and banners, with the USAID Identity. In circumstances in which the USAID Identity cannot be displayed visually, the Recipient is encouraged otherwise to acknowledge USAID and the American people's support.

(5) The Recipient will mark all commodities financed by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs, and all other equipment, supplies, and other materials funded by USAID, and their export packaging with the USAID Identity.

(6) The AO may require the USAID Identity to be larger and more prominent if it is the majority donor, or to require that a cooperating country government's identity be larger and more prominent if circumstances warrant, and as appropriate depending on the audience, program goals, and materials produced.

(7) The AO may require marking with the USAID Identity in the event that the Recipient does not choose to mark with its own identity or logo.

(8) The AO may require a pre-production review of USAID funded public communications and program materials for compliance with the approved Marking Plan.

(9) Sub Recipients. To ensure that the marking requirements "flow down" to sub Recipients of sub awards, Recipients of USAID funded grants and cooperative agreements or other assistance awards will include the USAID-approved marking provision in any USAID funded sub award, as follows:

"As a condition of receipt of this sub award, marking with the USAID Identity of a size and prominence equivalent to or greater than the Recipient's, sub Recipient's, other donor's or third party's is required. In the event the Recipient chooses not to require marking with its own identity or logo by the sub Recipient, USAID may, at its discretion, require marking by the sub Recipient with the USAID Identity."

(10) Any 'public communications', as defined in 22 C.F.R. 226.2, funded by USAID, in which the content has not been approved by USAID, must contain the following disclaimer: RFA Solicitation No: SOL-OAA-13-000005

"This study/report/audio/visual/other information/media product (specify) is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of [insert Recipient name] and do not necessarily reflect the views of USAID or the United States Government."

(11) The Recipient will provide the AOR or other USAID personnel designated in the grant or cooperative agreement with two copies of all program and communications materials produced under the award. In addition, the Recipient will submit one electronic or one hard copy of all final documents to USAID's Development Experience Clearinghouse.

(c) Implementation of marking requirements.

(1) When the grant or cooperative agreement contains an approved Marking Plan, the Recipient will implement the requirements of this provision following the approved Marking Plan.

(2) When the grant or cooperative agreement does not contain an approved Marking Plan, the Recipient will propose and submit a plan for implementing the requirements of this provision within 45 days after the effective date of this provision. The plan will include:
(i) a description of the program deliverables specified in paragraph (b) of this provision that the Recipient will produce as a part of the grant or cooperative agreement and which will visibly bear the USAID Identity.
(ii) the type of marking and what materials the Applicant uses to mark the program deliverables with the USAID Identity,
(iii) when in the performance period the Applicant will mark the program deliverables, and where the Applicant will place the marking,

(3) The Recipient may request program deliverables not be marked with the USAID Identity by identifying the program deliverables and providing a rationale for not marking these program deliverables. Program deliverables may be exempted from USAID marking requirements when:
(i) USAID marking requirements would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials;
(ii) USAID marking requirements would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent;
(iii) USAID marking requirements would undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as "by" or "from" a cooperating country ministry or government official;
(iv) USAID marking requirements would impair the functionality of an item;
(v) USAID marking requirements would incur substantial costs or be impractical;
(vi) USAID marking requirements would offend local cultural or social norms, or be considered inappropriate;
(vii) USAID marking requirements would conflict with international law.

(4) The proposed plan for implementing the requirements of this provision, including any proposed exemptions, will be negotiated within the time specified by the AO after receipt of the proposed plan. Failure to negotiate an approved plan with the time specified by the AO may be considered as noncompliance with the requirements is provision.

(d) Waivers

(1) The Recipient may request a waiver of the Marking Plan or of the marking requirements of this provision, in whole or in part, for each program, project, activity, public communication or commodity, or, in exceptional circumstances, for a region or country, when USAID required marking would pose compelling political, safety, or security concerns, or when marking would have an adverse impact in the cooperating country. The Recipient will submit the request through the AOR. The Principal Officer is responsible for approvals or disapprovals of waiver requests.

(2) The request will describe the compelling political, safety, security concerns, or adverse impact that require a waiver, detail the circumstances and rationale for the waiver, detail the specific requirements to be waived, the specific portion of the Marking Plan to be waived, or specific marking to be waived, and include a description of how program materials will be marked (if at all) if the USAID Identity is removed. The request should also provide a rationale for any use of Recipient's own identity/logo or that of a third party on materials that will be subject to the waiver.

(3) Approved waivers are not limited in duration but are subject to Principal Officer review at any time, due to changed circumstances.

(4) Approved waivers "flow down" to Recipients of sub awards unless specified otherwise. The waiver may also include the removal of USAID markings already affixed, if circumstances warrant.

(5) Determinations regarding waiver requests are subject to appeal to the Principal Officer's cognizant Assistant Administrator. The Recipient may appeal by submitting a written request to reconsider the Principal Officer's waiver determination to the cognizant Assistant Administrator.

(e) Non-retroactivity. The requirements of this provision do not apply to any materials, events, or commodities produced prior to January 2, 2006. The requirements of this provision do not apply to program, project, or activity sites funded by USAID, including visible infrastructure projects (for example, roads, bridges, buildings) or other programs, projects, or activities that are physical in nature (for example, agriculture, forestry, water management) where the construction and implementation of these are complete prior to January 2, 2006 and the period of the grant does not extend past January 2, 2006.

MARKING PLAN – ASSISTANCE (December 2005)

(a)Definitions 49
RFA Solicitation No: SOL-OAA-13-000005
Marking Plan means a plan that the Apparently Successful Applicant submits at the specific request of a USAID Agreement Officer after evaluation of an application for USAID funding, detailing the public communications, commodities, and program materials and other

items that will visibly bear the USAID Identity. Recipients may request approval of Presumptive Exceptions to marking requirements in the Marking Plan.

Apparently Successful Applicant(s) means the Applicant(s) for USAID funding recommended for an award after evaluation, but who has not yet been awarded a grant, cooperative agreement or other assistance award by the Agreement Officer. The Agreement Officer will request that Apparently Successful Applicants submit a Branding Strategy and Marking Plan. Apparently Successful Applicant status confers no right and constitutes no USAID commitment to an award, which the Agreement Officer must still obligate.

USAID Identity (Identity) means the official marking for the Agency, comprised of the USAID logo and new brand mark, which clearly communicates that our assistance is from the American people. The USAID Identity is available on the USAID website and USAID provides it without royalty, license, or other fee to Recipients of USAID funded grants, cooperative agreements, or other assistance awards or sub awards.

A Presumptive Exception exempts the Applicant from the general marking requirements for a particular USAID-funded public communication, commodity, program material or other deliverable, or a category of USAID-funded public communications, commodities, program materials or other deliverables that would otherwise be required to visibly bear the USAID Identity.

The Presumptive Exceptions are:
Presumptive Exception (i). USAID marking requirements may not apply if they would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials, such as election monitoring or ballots, and voter information literature; political party support or public policy advocacy or reform; independent media, such as television and radio broadcasts, newspaper articles and editorials; and public service announcements or public opinion polls and surveys (22 C.F.R. 226.91(h)(i)).

Presumptive Exception (ii). USAID marking requirements may not apply if they would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent (22 C.F.R.226.91(h)(ii)).

Presumptive Exception (iii). USAID marking requirements may not apply if they would undercut host-country government “ownership” of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as “by” or “from” a cooperating country ministry or government official (22 C.F.R. 226.91(h)(iii)).

Presumptive Exception (iv). USAID marking requirements may not apply if they would impair the functionality of an item, such as sterilized equipment or spare parts (22 C.F.R. 226.91(h)(iv).

Presumptive Exception (v). USAID marking requirements may not apply if they would incur substantial costs or be impractical, such as items too small or otherwise unsuited for individual marking, such as food in bulk (22 C.F.R. 226.91(h)(v)).

Presumptive Exception (vi). USAID marking requirements may not apply if they would offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities (22 C.F.R. 226.91(h)(vi)).

Presumptive Exception (vii). USAID marking requirements may not apply if they would conflict with international law (22 C.F.R. 226.91(h)(vii)).

(b) Submission. The Apparently Successful Applicant, upon the request of the Agreement Officer, will submit and negotiate a Marking Plan that addresses the details of the public communications, commodities, program materials that will visibly bear the USAID Identity. The marking plan will be customized for the particular program, project, or activity under the resultant grant or cooperative agreement. The plan will be included in and made a part of the resulting grant or cooperative agreement. USAID and the Apparently Successful Applicant will negotiate the Marking Plan within the time specified by the Agreement Officer. Failure to submit and negotiate a Marking Plan will make the Applicant ineligible for award of a grant or cooperative agreement.

(c) Submission Requirements. The Marking Plan will include the following:

(1) A description of the public communications, commodities, and program materials that the Recipient will produce as a part of the grant or cooperative agreement and which will visibly bear the USAID Identity. These include:
(i) program, project, or activity sites funded by USAID, including visible infrastructure projects or other programs, projects, or activities that are physical in nature;
(ii) technical assistance, studies, reports, papers, publications, audiovisual productions, public service announcements, Web sites/Internet activities and other promotional, informational, media, or communications products funded by USAID;
(iii) events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences, and other public activities; and
(iv) all commodities financed by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs, and all other equipment, supplies and other materials funded by USAID, and their export packaging.

(2) A table specifying:
(i) the program deliverables that the Recipient will mark with the USAID Identity,
(ii) the type of marking and what materials the Applicant will be used to mark the program deliverables with the USAID Identity, and
(iii) when in the performance period the Applicant will mark the program deliverables, and where the Applicant will place the marking.

(3) A table specifying:
(i) what program deliverables will not be marked with the USAID Identity, and

(ii) the rationale for not marking these program deliverables.

(d) Presumptive Exceptions.

(1) The Apparently Successful Applicant may request a Presumptive Exception as part of the overall Marking Plan submission. To request a Presumptive Exception, the Apparently Successful Applicant must identify which Presumptive Exception applies, and state why, in light of the Apparently Successful Applicant's application and in the context of the program description or program statement in the USAID Request For Application or Annual Program Statement, marking requirements should not be required.

(2) Specific guidelines for addressing each Presumptive Exception are:
(i) For Presumptive Exception (i), identify the USAID Strategic Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why the program, project, activity, commodity, or communication is 'intrinsically neutral.' Identify, by category or deliverable item, examples of program materials funded under the award for which you are seeking an exception.
(ii) For Presumptive Exception (ii), state what data, studies, or other deliverables will be produced under the USAID funded award, and explain why the data, studies, or deliverables must be seen as credible.
(iii) For Presumptive Exception (iii), identify the item or media product produced under the USAID funded award, and explain why each item or product, or category of item and product, is better positioned as an item or product produced by the cooperating country government.
(iv) For Presumptive Exception (iv), identify the item or commodity to be marked, or categories of items or commodities, and explain how marking would impair the item's or commodity's functionality.
(v) For Presumptive Exception (v), explain why marking would not be cost beneficial or practical.
(vi) For Presumptive Exception (vi), identify the relevant cultural or social norm, and explain why marking would violate that norm or otherwise be inappropriate.
(vii) For Presumptive Exception (vii), identify the applicable international law violated by marking.

(3) The Agreement Officer will review the request for adequacy and reasonableness. In consultation with the AOR and other agency personnel as necessary, the Agreement Officer will approve or disapprove the requested Presumptive Exception. Approved exceptions will be made part of the approved Marking Plan, and will apply for the term of the award, unless provided otherwise.

(e) Award Criteria: The Agreement Officer will review the Marking Plan for adequacy and reasonableness, ensuring that it contains sufficient detail and information concerning public communications, commodities, and program materials that will visibly bear the USAID Identity. The Agreement Officer will evaluate the plan to ensure that it is consistent with the stated objectives of the award; with the Applicant's actual project, activity, or program performance plan; and with the regulatory requirements of 22 C.F.R. 226.91. The Agreement

Officer will approve or disapprove any requested Presumptive Exceptions (see paragraph (d)) on the basis of adequacy and reasonableness. The Agreement Officer may obtain advice and recommendations from technical experts while performing the evaluation.

3. COST APPLICATION FORMAT

The following sections describe the documentation that applicants for an assistance award must submit to USAID prior to award in order for an Agreement Officer (AO) to make a determination of responsibility. While there is no page limit for this portion, applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

a. Budget

Applicants must include a ten-year budget with accompanying narrative which provides in detail the total costs for implementation of the program proposed. The information from the detailed budget must then be included on the Standard Form 424 and 424A which can be downloaded from the USAID web link http://www.usaid.gov/procurement_bus_opp/procurement/forms/ (Standard Form 424) and (Standard Form 424A).

If the Applicant has established a consortium or another legal relationship among its partners, the Cost/Business application must include a copy of the document that specifies the legal relationship between the parties. This document should include a full discussion of the relationship between the Applicants including: identification of the lead Applicant with whom USAID will work for purposes of Agreement administration; identification of the Applicant responsible for accounting; discussion of how the Agreement effort will be allocated among the parties; and specification of the express agreement of the principals thereto to be held jointly and severally liable for the acts or omissions of the other.

Over the life of the project, in addition to USAID funds, Applicants are expected to contribute, from their other sources, no less than 10 percent of the amount obligated by USAID for the implementation of this program. Contributions can be either cash or in-kind and can include contributions from the U.S. NGOs, local counterpart organizations, project clients, and other donors (not other USG funding sources). Information regarding the proposed cost-share should be included in the SF 424 and the Cost Matrix as indicated on those documents. The cost-share, and the feasibility of the cost-sharing plan, should be discussed in the budget narratives to the extent necessary to realistically access these sources and funds. Applications that do not meet the minimum cost-share requirement are not eligible for award consideration. It should be noted that there is no separate/additional evaluation criteria category for cost share because cost-share is included within cost-effectiveness.

To support the proposed costs, please provide detailed budget notes/narrative for all costs that explain how the costs were derived. The following provides guidance on what is needed:

- The breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices;
- The costs associated with external, expatriate technical assistance and those associated with local in-country technical assistance;
- The breakdown of all costs according to each partner organization involved in the program.
- The breakdown of the financial and in-kind contributions of all organizations involved in implementing this cooperative agreement; and,
- Potential contributions of non-USAID sources to this cooperative agreement as cost share.

The cost application should contain the following budget categories:

- Salary and Wages: Direct salaries and wages should be proposed in accordance with the Applicant's personnel policies;

- Fringe Benefits: If the Applicant has a fringe benefit rate that has been approved by an agency of the U.S. Government, such rate should be used and evidence of its approval should be provided. If a fringe benefit rate has not been so approved, the application should propose a rate and explain how the rate was determined. If the latter is used, the narrative should include a detailed breakdown comprised of all items of fringe benefits (e.g., unemployment insurance, workers compensation, health and life insurance, retirement, FICA, etc.) and the costs of each, expressed in dollars and as a percentage of salaries;

- Travel and Transportation: The application should indicate the number of trips, domestic and international, and the estimated costs. Specify the origin and destination for each proposed trip, duration of travel, and number of individuals traveling. Per Diem should be based on the Applicant's normal travel policies;

- Equipment: Estimated types of equipment (i.e., model #, cost per unit, quantity);

- Supplies: Office supplies and other related supply items related to this activity;

- Contractual: Any goods and services being procured through a contract mechanism;

- Other Direct Costs: This includes communications, report preparation costs, passports, visas, medical exams and inoculations, insurance (other than insurance included in the Applicant's fringe benefits), equipment, office rent abroad, etc. The narrative should provide a breakdown and support for all other direct costs; and

- Indirect Costs: The Applicant should include a current negotiated indirect cost rate (NICRA) from a cognizant government audit agency. Applicants who do not currently

have a NICRA from any agency of the United States government (USG) shall also submit the following information:

- Copies of the applicant's financial reports for the past three years, which have been audited by a certified public accountant or other auditor satisfactory to USAID;
- Projected budget, cash flow, and organizational chart; and
- A copy of the organization's accounting manual.

b. Negotiated Indirect Cost Rate Agreement

Include a current Negotiated Indirect Cost Rate Agreement (NICRA). Applicants who do not currently have a NICRA from an agency of the United States Government (USG) should instead submit the following information:

- Copies of the applicant's financial reports for the previous three year period, which have been audited by a certified public accountant or other auditor satisfactory to USAID;
- Projected budget, cash flow and organizational chart; and,
- A copy of the organization's accounting manual.

c. Certifications and Representations

See Annex 2 for required certifications and representations.

d. Additional Documentation

Applicants must submit any additional evidence of responsibility deemed necessary for the AO to make a determination of responsibility. The information submitted must substantiate that the applicant has:

- Adequate financial resources or the ability to obtain such resources as required during the performance of the award;
- The ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the applicant, non-governmental and governmental;
- A satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance;
- A satisfactory record of integrity and business ethics; and
- Otherwise qualified and eligible to receive a grant under applicable laws and regulations (e.g., Equal Opportunity Employer (EEO)).

Applicants that have never received a grant, cooperative agreement or contract from the U.S. Government are required to submit a copy of their accounting manual. If a copy has already been submitted to the U.S. Government, the applicant must advise which Federal Office has a copy.

3. GENERAL INSTRUCTIONS

Applicants are expected to review, understand, and comply with all aspects of this RFA. Failure to do so will be at the applicant's risk.

Unnecessarily Elaborate Applications

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this RFA are not desired and may be construed as an indication of the applicant's lack of cost-consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

Submission Guidelines

Applications must be received at the place designated and by the date and time specified in the cover letter of this RFA and further described below. Applications that are submitted late or are incomplete will not be considered in the review process. Applications received by the deadline will be reviewed for responsiveness to the specifications outlined in this RFA. These specifications (i.e. technical selection criteria and evaluation procedures for applications) are addressed in Section V.

Applications shall be submitted in two separate parts: (a) technical application and (b) cost or business application. Applicants must submit an original and five copies of the technical application and an original and one copy of the cost application. All copies of the technical and cost applications must be placed separately in sealed envelopes clearly marked on the outside with the following words "RFA No. SOL-OAA-13-000005 Volume 1 – Technical Application" or "RFA No. SOL-OAA-13-000005 Volume 2 - Cost/Business Application". In addition to the above mentioned hard copies, the application must also be submitted electronically via CD-ROM. Applicants will retain for their records one copy of the application and all enclosures that accompany their application.

The applicant shall sign the application and print or type its name on the cover page of the technical and cost applications. Erasures or other handwritten changes must be initialed by the person signing the application. Applications signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

Applicants must submit the full application package (hard copies of both technical and cost applications) to the following address:

By US Mail:
Franklin Goode
Agreement Specialist
US Agency for International Development
Office of Acquisition & Assistance, M/OAA/GH/POP
1300 Pennsylvania Avenue, N.W.SA-44, Room 553-H
Washington, D.C. 20523-7900

By Courier Service/Hand Delivery:

Mr. Franklin Goode
Agreement Specialist
USAID, M/OAA/GH/POP
Federal Center Plaza
301 4th Street, SW, Room 553-H
Washington, DC 20024
Telephone: 202-567-5316

Faxed applications will not be considered; however, applications may be modified by written or faxed notice, if that notice is received by the time specified for receipt of applications.

Applicants who include data in their applications that they do not want disclosed to the public for any purpose or used by the US Government except for evaluation purposes must:

(a) Mark the title page with the following legend:
"This application includes data that shall not be disclosed outside the US Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this application. If, however, a grant is awarded to this applicant as a result of - or in connection with - the submission of this data, the US Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the US Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets __ ."

(b) Mark each sheet of data it wishes to restrict with the following legend:
"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."

Explanation to Prospective Applicants

Any prospective Applicant desiring an explanation or interpretation of this RFA must request it in writing. Oral explanations or instructions given before award of a cooperative agreement will not be binding. Any information given to a prospective Applicant concerning this RFA will be furnished promptly to all other prospective applicants as an amendment of this RFA, if that information is necessary in submitting applications, or if the lack of it would be prejudicial to any other prospective applicant.

Applicants may submit questions related to this RFA in writing. All questions, must be received by April 15, 2013 3:00 p.m. EST Questions must be sent to Franklin Goode, Agreement Specialist via e-mail at fgoode@usaid.gov. The SUBJECT line must read "Questions for Implementation Science for Strengthening Use of Evidence in FP/RH Programming RFA"

Oral explanations or instructions given before award will not be binding. Any information given to an applicant concerning this RFA will be furnished promptly to all other applicants as an amendment of this RFA, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other applicants.

Acknowledgement of Amendments to the RFA

Applicants shall acknowledge receipt of any amendment to this RFA by signing and returning the amendment. USAID must receive the acknowledgement by the time specified for receipt of applications.

Authority to Obligate the Government

The Agreement Officer (AO) is the only individual who may legally commit the United States Government to the expenditure of public funds. No costs chargeable to the proposed cooperative agreement may be incurred before receipt of either a fully executed cooperative agreement or a specific, written authorization from the AO.

Authorized Geographic Code

The project is authorized to procure other items covered in the schedule by Geographic Code 937 - Any area or country including the cooperating country, but excluding the foreign policy restricted countries. If the applicant seeks waivers to apply alternative Geographic Codes, those shall be undertaken during award phase.

Cooperative Agreement Award

The Government may, without discussions or negotiations, award an agreement resulting from this RFA to the responsible Applicant whose application conforming to this RFA offers the best proposal, and that includes a calculation of costs that are reasonable and clearly explained. Therefore, the initial application should contain the Applicant's best effort from a technical standpoint, with reasonable allocation of costs. The Government may reject any or all applications, accept other than the lowest cost application, and waive informalities and minor irregularities in applications received.

Although technical evaluation factors are significantly more important than cost factors, the closer the technical evaluations of the various applications are to one another, the more important cost considerations become. The Agreement Officer may determine what a highly ranked application based on the technical evaluation factors would mean in terms of performance and what it would cost the Government to take advantage of it in determining the best overall value to the Government.

Individuals and Organizations Associated with Terrorism

The applicant is reminded that US Executive Orders and US law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts/subawards issued by the recipient under this agreement.

Foreign Government Delegations to International Conferences

Funds in this agreement may not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a public international organization, except as provided in ADS Mandatory Reference "Guidance on Funding Foreign Government Delegations to International Conferences [http://www.info.usaid.gov/pubs/ads/300/refindx3.htm] or as approved by the AO.

Reporting Requirements

Upon award of the project, USAID will work with the recipient to finalize performance measures and the method of program evaluation to effectively measure, monitor, and assess the project’s progress and impact. The format for reporting requirements will be established as part of the recipient’s work plan. In addition, the cooperative agreement shall require the recipient to provide Mihira Karra (AOR) in USAID/Washington a programmatic report quarterly that summarizes activities undertaken, lessons learned, progress made/results achieved, trends,

challenges, expenditures and pipeline, any delays in implementation, any substantial changes to the technical design or research and other projects undertaken, any changes in excess of 10 percent of the fully loaded costs of research and other projects undertaken, any changes of FTEs, etc. under the agreement.

SECTION V - SELECTION CRITERIA

All technical applications will be evaluated in accordance with the Technical Evaluation Criteria set forth below. Applicants must note that these criteria serve to: (a) identify the significant matters which applicants must address in their applications and (b) set the standard against which all applications will be evaluated. **To facilitate the review of applications, applicants must organize the narrative sections of their applications in the same order as the selection criteria.**

Thereafter, the cost application of all applicants submitting a technically acceptable application will be evaluated for general reasonableness, allowability and allocability. To the extent that they are necessary (if award is based on initial applications), negotiations will then be conducted with all applicants whose applications, after discussion and negotiation, have a reasonable chance of being selected for award. An award will be made to the applicant whose application offers the greatest value for cost and other factors considered.

The applicant's cost share contribution will be reviewed for its contribution to the objectives of the program and to verify that the applicants meet the standards set in 22 CFR 226.23 for U.S. organizations, or the Standard Provision entitled "Cost Sharing" for non-U.S. organizations (See 22 CFR 226.23; and Standard Provisions for Non-U.S. Nongovernmental Recipients).

TECHNICAL EVALUATION CRITERIA (Total: 100 points)

1. TECHNICAL UNDERSTANDING AND APPROACH (TOTAL: 40 POINTS)

a. Overall Approach and Sub-objectives (20 points)

The technical application demonstrates overall merit (clarity, analytical depth, responsiveness and feasibility) of approach and strategies to achieve the program's objective and sub-objectives, in response to questions in Section I. The application demonstrates thorough understanding of the interrelations among the sub-objectives. The application demonstrates excellent understanding of the process of implementation science - including a technically sound research agenda and forward thinking plans for addressing evolving priorities; feasible and innovative methodologies; appropriate and efficient methodologies to measure scale-up; strong articulation of areas of existing evidence and synthesis needs to influence service delivery; a thorough understanding of opportunities for and barriers to scale-up of evidence-based practices; and demonstrated knowledge of country contexts and strong rationales for selection of countries and

practices for scale-up. The application demonstrates considerable experience directly related to the objective of this project, globally and in USAID's PRH priority countries, and plans for strong collaborative relationships with relevant partners. The application describes specific major results expected to be achieved by this project. The application shows responsiveness to the needs of USAID Washington and Missions.

b. Scenarios (10 points total – 5 points per scenario)

For each scenario, the application includes: the specific question/practice(s) selected; strong rationale for choosing the question/practice(s) and the country for implementation; a thorough understanding of the process and partnerships to be developed; a description of the comparative advantage of the applicant; an understanding of the process to gather lessons learned to inform translation, replication and scale-up; and the resource requirements to conduct these activities.

c. Performance Monitoring (10 points)

The application provides a clear and realistic illustrative workplan for core funding for the first year and a rigorous and feasible illustrative project monitoring plan (PMP) that can be used to monitor activities, collect program performance data and measure progress toward results. The PMP should include life-of-program results with intermediate benchmarks and indicators. The type and level of proposed results to be achieved under each sub-objective (or new proposed framework) should be ambitious, appropriate and achievable.

2. MANAGEMENT APPROACH
(TOTAL: 10 POINTS)

a. Program and Personnel Management (5 points)

The proposed management and administrative arrangements for implementation of the program including: personnel management and lines of supervision (i.e. organizational structure); arrangements for timely institutional review of research proposals for the protection of human subjects in research; logistical support and procurement arrangements for goods and services; and dissemination of publications and communications are well thought out and appropriate for this project. An organizational chart is included that will show the overall staffing plan and plans for satellite offices in countries or regions. The application describes how the central office and country/regional offices will collaborate with proposed partners and coordinate with USAID Bureaus, Missions, bilateral programs, other USAID-funded contractors and cooperating agencies to respond to Mission, government, and USAID/Washington requests for research activities and technical assistance. The application discusses the project branding strategy to be further developed after award. Feasible plans are presented for a rapid start-up of the project.

b. Financial Management (5 points)

The application demonstrates a sound approach for financial management including: how applicant will contain costs; how financial disbursement to in-country partners is managed; and where approval authority is located for expenditures of Mission and core funds. The application will provide clear and feasible plans for leveraging field support funds with a goal of increasing the proportion of field support relative to core funds over the life of the project. Likewise, the application will clearly outline how developing country government resources (funding and in-kind) and other donor funding will be leveraged to support research, utilization and capacity development. Applicants must describe their routine accounting methods and procedures and how they will routinely monitor and report financial data to USAID for the purposes of planning, budgeting and preparation of accurate pipeline and accrual reports. The application will clearly state what proportion of overall resources (all-source funding) available to the ISSUE FP/RH project, in support of a portfolio of activities, will be designated for sub-agreements to developing country partners. The application defines a cost share of a minimum of 10 percent.

3. STAFFING AND KEY PERSONNEL
(TOTAL: 40 POINTS)

a. Key Personnel (20 points)

The proposed key staff have the requisite experience and skills to meet or exceed requirements described in Section I. They must have the required technical expertise in implementation science and experience in management, design, implementation, monitoring, and evaluation of complex research programs. Key staff must show evidence of strong leadership skills and ability to build collaborative relationships. Expertise and attributes will be verified in part on past performance and references provided in annexes, and may be verified through interviews, at the discretion of the TEC panel.

b. Other Proposed Technical Personnel (20 points)

The staffing pattern, number and type of positions described are responsive to technical requirements and required skill sets. An organizational chart is provided which demonstrates an optimal configuration for required skills, efficiency and cost containment. Proposed technical or organization specialists have technical and operational experience in the subject areas for which they are proposed. A functional team approach is clearly described.

4. INSTITUTIONAL CAPABILITY (5 POINTS)

The application demonstrates the capacity of the organization(s) to undertake a complex and diverse project, as described in this RFA. Organizations must show an ability to develop performance monitoring plans contributing to USAID results reviews and operational plans. Applicants should have demonstrated capacity to accurately track and report in a timely fashion financial data for the purposes of planning, budgeting and reporting the status of activities.

Applicants should demonstrate the ability to identify appropriate sub-grantees and sub-contractors, to allocate the time each partner will devote to the project, and to minimize non-productive costs. Applicants' should have demonstrated capability to work with multiple partners and to build the capacity of developing country individuals, organizations and institutions to conduct implementation research and apply these findings to improve programs. Applicants should have a track record of excellent working relationships with developing country governments and institutions.

5. PAST PERFORMANCE (5 POINTS)

Applicants will be evaluated on past performance over the past five years. Applicants should have a demonstrated track record in achieving measurable results, documenting and reporting results as well as benchmarks toward achieving results, and communicating results and implementation experiences effectively and in a timely fashion. Applicants must provide a detailed self-assessment of institutional capability and past performance. Applicants must provide 3-5 references, and the TEC panel can interview the references and other knowledgeable individuals at their discretion. Firms lacking relevant past performance history shall be given a "neutral" past performance rating that neither rewards nor penalizes those applicants.

Summary of Points for Technical Evaluation Criteria:

Technical Understanding and Approach	40 points
Management Approach	10 points
Staffing and Key Personnel	40 points
Institutional Capability	5 points
Past Performance	5 points
Total	**100 points**

ANNEXES

Annex 1 – Mandatory Standard Provisions
Annex 2 – Affirmation of Certifications
Annex 3 – Conscience Clause Implementation (Assistance) – Solicitation Provision
Annex 4 - Standard Form 424
Annex 5 – Past Performance Short Form
Annex 6 - Initial Environmental Examination and Environmental Determination
Annex 7 – Evaluation of Program Research for Strengthening Services (PROGRESS) Project
Annex 8 – PRH Results Framework
Annex 9 – GH/PRH Overview of Initiative Principles: Global Health Initiative (GHI), FP 2020, and A Promise Renewed

Annex 10 –High Impact Practices (HIPs) in Family Planning
Annex 11 –Background Document for 2012 FP Research Donors' Meeting

Annex 1 – Mandatory Standard Provisions

Mandatory Standard Provisions for U.S. Nongovernmental Recipients:
http://www.usaid.gov/policy/ads/300/303maa.pdf

Annex 2 – Affirmation of Certifications

Affirmation of Certification**:** **http://www.usaid.gov/policy/ads/300/303sad.pdf**

Annex 3 – Conscience Clause Implementation (Assistance)

CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) – SOLICITATION PROVISION (FEBRUARY 2012)

(a) An organization, including a faith-based organization, that is otherwise eligible to receive funds under this agreement for HIV/AIDS prevention, treatment, or care—

(1) Shall not be required, as a condition of receiving such assistance—

(i) to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or

(ii) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and

(2) Shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements for refusing to meet any requirement described in paragraph (a)(1) above.

(b) An applicant who believes that this solicitation contains provisions or requirements that would require it to endorse or use an approach or participate in an activity to which it has a religious or moral objection must so notify the cognizant Agreement Officer in accordance with the Mandatory Standard Provision titled "Notices" as soon as possible, and in any event not later than 15 calendar days before the deadline for submission of applications under this solicitation. The applicant must advise which activity(ies) it could not implement and the nature of the religious or moral objection.

(c) In responding to the solicitation, an applicant with a religious or moral objection may compete for any funding opportunity as a prime partner, or as a leader or member of a consortium that comes together to compete for an award. Alternatively, such applicant may limit its application to those activities it can undertake and must indicate in its submission the activity(ies) it has excluded based on religious or moral objection. The applicant's proposal will be evaluated based on the activities for which a proposal is submitted, and will not be evaluated favorably or unfavorably due to the absence of a proposal addressing the activity(ies) to which it objected and which it thus omitted. In addition to the notification in paragraph (b) above, the applicant must meet the submission date provided for in the solicitation.

(End of Provision)

Annex 4 – Standard Form 424

http://www.usaid.gov/forms/sf424.dpf

Annex 5 - Past Performance Report – Short Form

PERFORMANCE REPORT - SHORT FORM
PART I: Award Information (to be completed by Prime)
1. Name of Awarding Entity:
2. Award Number:
3. Award Type:
4. Award Value (TEC): (if subagreement, subagreement value)
5. Problems: (if problems encountered on this award, explain corrective action taken)
6. Contacts: (Name, Telephone Number and E-mail address)
6a. Agreement/Contract Officer:
6b. Technical Officer (AOTR/COTR):
6c. Other:
7. Recipient:
8. Title/Brief Description of Product/Service Provided:
9. Information Provided in Response to RFA/RFP No. :
PART II: Performance Assessment (to be completed by Agency)
1. How well Recipient/Contractor performed:
1a. Quality of product or service, including consistency in meeting goals and targets, and cooperation and effectiveness in fixing problems. Comment:
1b. Cost control, including forecasting costs as well as accuracy in financial reporting. Comment:
1c. Timeliness of performance, including adherence to schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient operation of tasks. Comment:
1d. Customer satisfaction, including satisfactory business relationship to clients, initiation and management of several complex activities simultaneously, coordination among subawardees and developing country partners, prompt and satisfactory correction of problems, and cooperative attitude in fixing problems. Comment:
1e. Effectiveness of key personnel including: effectiveness and appropriateness of personnel for the job; and prompt and satisfactory changes in personnel when problems with clients

where identified. Comment:
2. Specify instances of good or poor performance, especially in the most critical areas. Comment:
3. List significant achievements and/or problems. Comment:

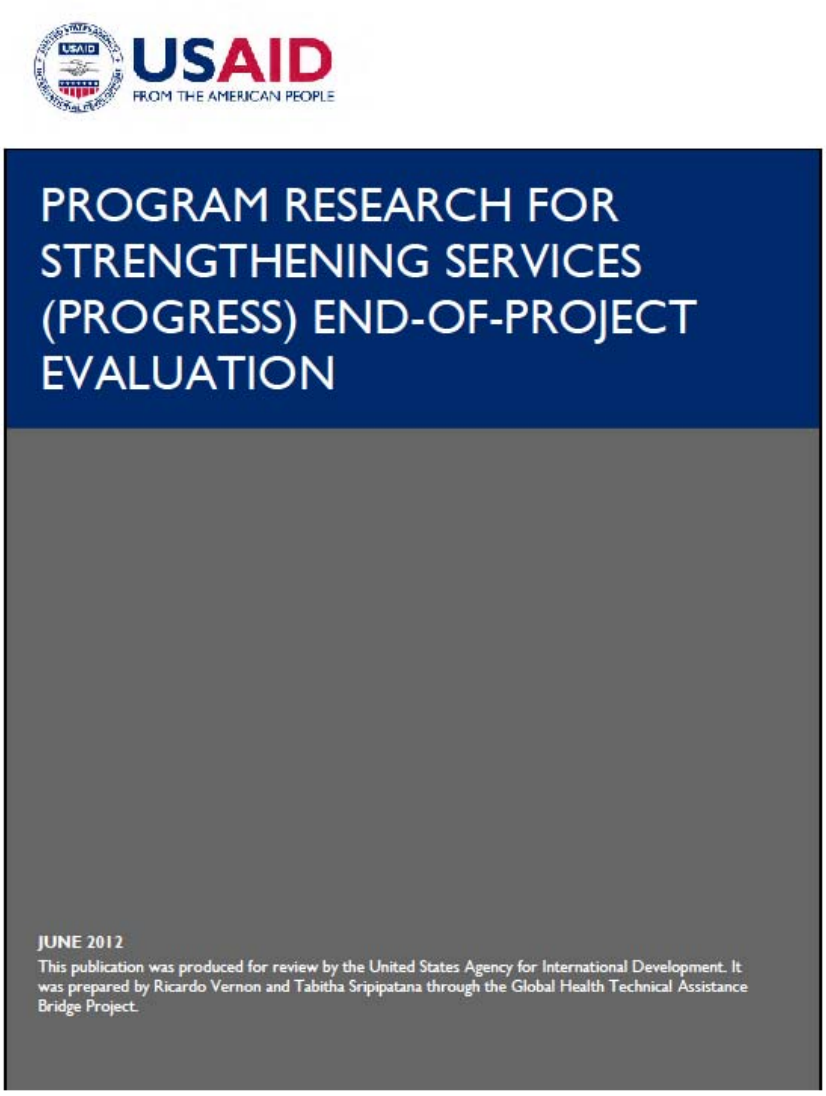
[Note: The actual dollar amount of subagreement, if any, (awarded to the Prime) must be listed in Block 4 instead of the Total Estimated Cost (TEC) of the overall contract. In addition, a Prime may submit attachments to this past performance table if the spaces provided are inadequate; the evaluation factor(s) must be listed on any attachments.]

Annex 6 - Initial Environmental Examination and Environmental Determination

The Initial Environmental Examination and Environmental Determination will be provided through a RFA amendment, within a few days.

Annex 7 – Evaluation of PROGRESS Project

Source: USAID Development Clearinghouse http://pdf.usaid.gov/pdf_docs/PDACT952.pdf



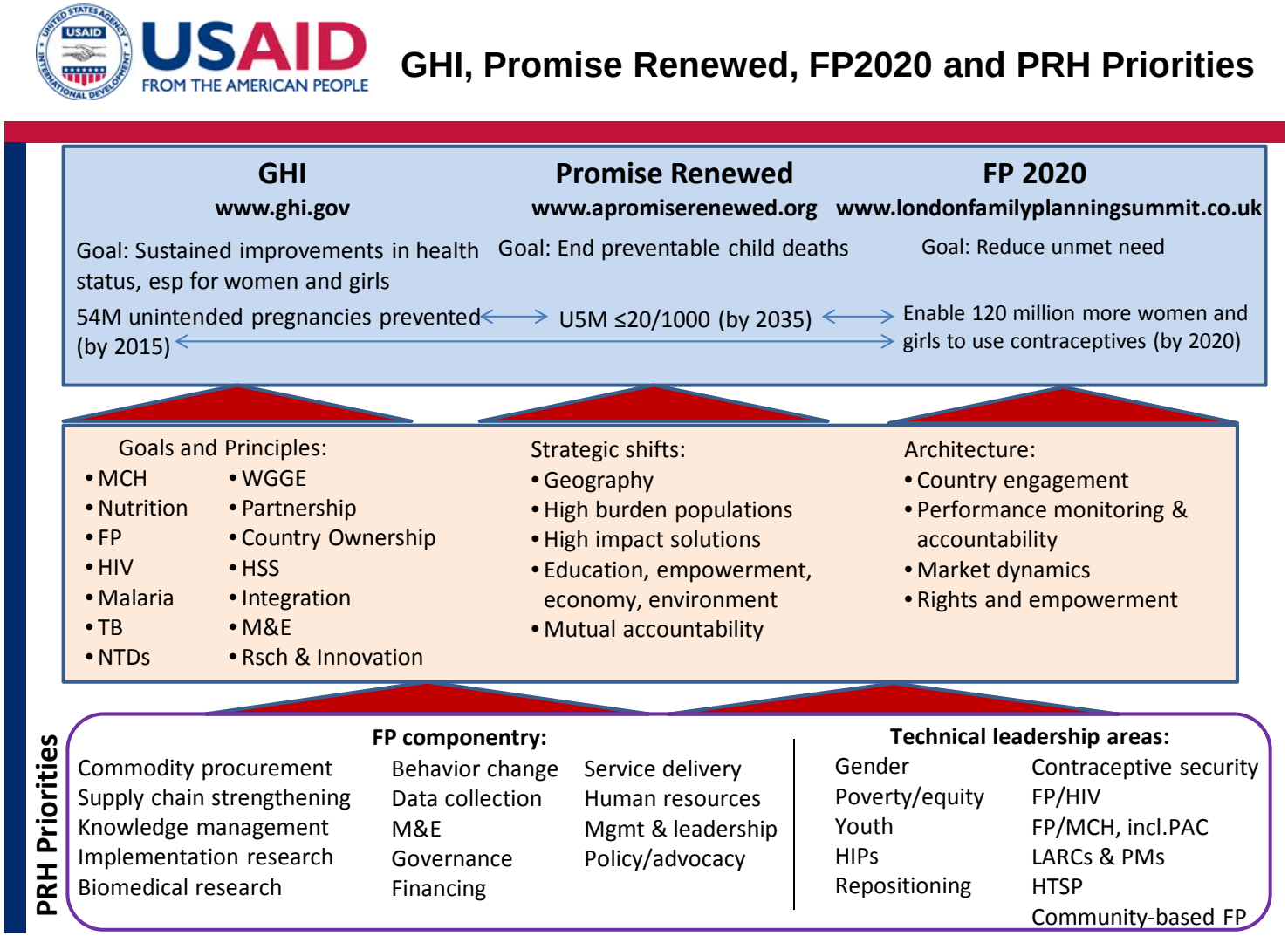
Annex 8– PRH Results Framework (August 1, 2012)

PRH Results Framework and Indicators

<u>Goal Statement</u>: To enable countries to meet the family planning needs of their people
<u>Strategic Objective</u>: To advance and support voluntary family planning and reproductive health programs worldwide

IR 1.0: Global leadership demonstrated in FP/RH policy, advocacy, and services	**IR 2.0: Knowledge generated, organized, and disseminated in response to program needs**	**IR 3.0: Support provided to the field to implement effective and sustainable FP/RH programs**
1.1 Elevate FP/RH on international agenda	2.1 Support innovation through biomedical research, health systems and social sciences research, and implementation science, drawing on field experience and global knowledge	3.1 Provide direct and virtual technical expertise to the field
1.2 Promote best practices and standards-setting	2.2 Develop and evaluate innovative tools, technologies, and approaches to improve program effectiveness	3.2 Establish and manage procurement mechanisms that are responsive to mission needs
1.3 Create, nurture, and participate in global partnerships, including with non-traditional partners	2.3 Capture, evaluate, synthesize and package information to support evidence-based practice	3.3 Create partnerships to advance field programs, including public-private, south-to-south and academic institutions
1.4 Lead USG strategic direction and linkages	2.4 Support population-based surveys, other data collection and analysis	3.4 Develop sustainable sources for commodities
1.5 Leverage FP/RH resources globally	2.5 Develop, test and validate metrics for program monitoring and performance	3.5. Assist field in building local capacity for strengthening health systems
	2.6. Strengthen performance and impact evaluations	

Annex 9 – GH/PRH Overview of Initiative Principles: Global Health Initiative (GHI), FP 2020, and Promise Renewed
Source: Office of Population and Reproductive Health, October 2012



Annex 10 – High Impact Practices in Family Planning (HIPs)

Source and additional information available at: http://www.fphighimpactpractices.org/

High Impact Practices in Family Planning

"Promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths" ~Lancet 2006

What are High Impact Practices?

High Impact Practices (HIPs), when scaled up and institutionalized, will maximize investments in a comprehensive family planning strategy. This list is ***not*** intended to constitute or replace a strategy, which should be informed by the *Elements of Success in Family Planning Programming* and driven by country context.

How are practices identified and selected?

In an effort to support the renewed focus on evidence-based programming a Technical Advisory Group (TAG) was formed. The TAG is made up of over 25 international experts in family planning research, programming, and implementation identified from donor agencies, research institutions and service delivery organizations. The TAG meets at least once a year to review evidence and make recommendations on updating and implementing High Impact Practices.

Create an Enabling Environment

Creating an Enabling Environment facilitates implementation of HIPs in service delivery. The following HIPs are identified based on expert opinion and demonstrate correlation with improved health behaviors and/or outcomes. These outcomes include improvements in unintended pregnancy, fertility, or one of the primary proximate determinants of fertility (increased modern contraceptive use, delay of marriage, birth spacing, breast feeding).

- Galvanize **commitment** to family planning through advocacy and policy development.
- Develop, implement, and monitor **supportive government policies**.
- Support **financing** for family planning services and supplies at the national and local levels.
- Invest in **contraceptive security** by developing an effective supply chain, supportive policies and regulations, financing, coordination and planning, and commitment.
- Ensure **contraceptive choice** by making a wide range of family planning methods available.
- Implement a systematic, evidence-based **health communication strategy** that includes communication through multiple channels to enable people to make voluntary and informed health care decisions.
- Develop in-country capacity to **lead and manage** family planning programs.
- Advocate to keep **girls in school**.

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

USAID FROM THE AMERICAN PEOPLE

Updated November 7, 2012

High Impact Practices in Family Planning

High Impact Practices in Service Delivery

HIPs in service delivery are identified based on demonstration and magnitude of ***impact*** on service utilization, including contraceptive use and continuation; and potential application in a wide range of settings. Consideration is also given to the evidence on ***replicability, scalability,*** and ***sustainability.*** The TAG recognizes the importance of ***cost-effectiveness*** and notes the lack of data on cost and cost-effectiveness. The TAG recommends this area as a high priority for future research.

The role of the TAG is to categorize service delivery practices based on the strength and consistency of the evidence-base. The categories (*Proven, Promising, Emerging*) are based on criteria used by the World Health Organization Department of Child and Adolescent Health as part of a similar exercise.[i]

Proven: Sufficient evidence exists to recommend widespread implementation, provided that there is careful monitoring of coverage, quality and cost, and operations research to help understand how to improve implementation.

- Train, equip and support **community health workers (CHW)** to provide a wide range of family planning methods. In addition to pills and condoms, CHW can safely and effectively provide EC,* injectables, SDM†, and LAM† and refer for LAPMs†.
- Provide family planning counseling and services at the **same time** and **location** where women receive **services related** to spontaneous or induced **abortion**.
- Support distribution of a wide range of family planning methods and promotion of healthy contraceptive behaviors through **social marketing.**

Promising: Good evidence exists that these interventions can lead to impact; more information is needed to fully document implementation experience and impact. These interventions should be promoted widely, provided that they are being carefully evaluated both in terms of impact and process.

- Provide a wide range of family planning methods through **mobile outreach services.**
- Train and support **pharmacists and drug shop keepers** to provide a wide range of family planning methods. In addition to condoms and pills, pharmacists often play a key role in providing injectables, EC, and Cyclebeads® for SDM.
- Offer family planning services to postpartum women (up to 12 months after birth), such as screening women during routine child **immunization contacts.**

Emerging: Some initial experiences with developing interventions exist, but there is a need for more intense intervention development and research. For more information on these practices visit http://hips.k4health.org/.

For information and recommendations on the list of High Impact Practices please contact Shawn Malarcher at smalarcher@usaid.gov, Nandita Thatte at nthatte@usaid.gov, or Erika Martin at ermartin@usaid.gov.

[i] Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries, UNAIDS Inter-agency Task Team on Young People (World Health Organization: Geneva, 2006).

*Emergency Contraceptives (**EC**); Standard Days Method (**SDM**); Lactational Amenorrhea Method (**LAM**); Long Acting Permanent Methods (**LAPMs**)

Updated November 7, 2012

Annex 11 – Background Document for 2012 FP Research Donors Meeting

This document was made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. GPO-A-00-04-00019-00. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science, and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization governed by an international board of trustees.

www.popcouncil.org

Askew, Ian, and Martha Brady. 2013. "Reviewing the evidence and identifying gaps in family planning research: The unfinished agenda to meet FP2020 goals," background document for the Family Planning Research Donor Meeting, Washington, DC, 3–4 December 2012. New York: Population Council.

ACKNOWLEDGMENTS

This paper was prepared as a background document for the Family Planning Research Donor Meeting, organized by USAID, DFID, Bill & Melinda Gates Foundation, and AusAID as part of their collaboration under the Alliance for Reproductive, Maternal and Newborn Health, and in conjunction with WHO. The meeting was held in Washington, DC, on December 3–4, 2012. The authors would like to acknowledge the contributions of many. From the Population Council, we wish to thank Lauren Katzen and Nancy Termini for their stellar research assistance and painstaking efforts at extracting evidence; Gary Bologh for his excellent editing; Virginia Kallianes for her calm and steady assistance with preparing the glossary and references and with formatting; and Christina Tse and Mike Vosika for help with design and layout. We would like to thank the planning committee responsible for organizing the meeting for their valuable insights: Scott Radloff (USAID), Malcolm McNeill and Sue Kinn (UK Department for International Development), Clea Finkle (Bill & Melinda Gates Foundation), Moazzam Ali and Mario Festin (WHO) and Stanley Luchters (Burnet Institute/AusAID Women and Children's Health Knowledge Hub). We also appreciate the unwavering support of the meeting organizers: Linda Sussman (USAID,) Jill Keesbury and Molly Canty (RMNH Alliance), and Margaret Neuse (Facilitator).

Contents

Abbreviations and Acronyms

ANC Antenatal care

ART Antiretroviral therapy

CBD Community-based distribution

CCT Conditional cash transfer

CHW Community health worker

CVR Contraceptive vaginal ring

DHS Demographic and Health Survey

EC Emergency contraception

ehealth Electronic communication technology, such as computers and mobile phones, used for health services and information

FC Female condom

FP Family planning

HIV Human immunodeficiency virus

HMIS Health management information system

IUD Intrauterine device

LAM Lactational amenorrhea method

M&E Monitoring and evaluation

mhealth Mobile communication technology used in health care delivery systems

PAC Postabortion care

PBF Performance-based financing

PLWHA People living with HIV/AIDS

RCT Randomized controlled trial

RH Reproductive health

SBCC Social and behavior change communication

SDM Standard Days Method

TBA Traditional Birth Attendant

TM Total market

UNDP United Nations Development Programme

UNFPA United Nations Population Fund

WHO World Health Organization

INTRODUCTION

"The evidence is clear: Family planning improves health, reduces poverty, and empowers women" (Bongaarts et al. 2012). Voluntary high-quality family planning programs speed fertility declines, thus improving health and boosting economies. Indeed, they are among the most cost-effective health and development investments available to governments (Bongaarts et al. 2012; Cleland et al. 2006). The case for family planning has been made, yet more than 200 million women in the developing world who want to avoid pregnancy are not using a modern contraceptive method. The reasons for this are many, including lack of access to information and appropriate health services, traditional gender norms that impede women's ability to adopt contraception, community and gatekeepers' (husband, in-laws, partners) opposition, real and perceived concerns about safety and side effects, and cost, among others. Underlying socio-behavioral issues, including risk perception, ambivalence, and social costs, may also play a role in demand and use.

An Opportune Moment

After a decade of waning investment in family planning (FP), we are now witnessing a resurgence of interest and funding. This is an opportune moment to address the unfinished family planning agenda (Cleland et al. 2006). The International Family Planning Summit held in London in July 2012 witnessed unprecedented levels of financial and political commitment from national governments and the international community to achieve the goal of 120 million new users of contraceptives by 2020. This goal is to be achieved through a coordinated effort, known as FP2020, through implementing four broad objectives:

- Increase political commitment and accountability for delivery of family planning services
- Contribute to substantially increased access to family planning information, services, and supplies
- Create a healthy and sustainable market for family planning commodities
- Adapt and develop new and innovative contraceptive methods

This paper is intended to help guide discussions and considerations regarding the key evidence gaps and research investments needed to achieve the FP2020 goal and objectives. The paper focuses primarily on the social science, implementation, and operations research that will be needed to achieve the first three objectives. The contraceptive research and development (R&D) needed for the fourth objective is the subject of another initiative.

What We Know

Simply stated, we know that the most effective approach to achieving the FP2020 goal is to ensure universal access to family planning, so that all women have access to a full range of effective, acceptable, and affordable contraceptive methods appropriate to their needs and situation, made available through multiple service delivery channels in a reliable fashion. Achieving this, however, requires political will, human and economic resources, technical expertise, vision, and leadership. Context also matters. The diversity of needs, populations, and reproductive intentions of individuals and couples, along with the maturity of programming and the strength of particular national health systems, will influence the effectiveness and impact of investments in FP2020.

Research on family planning has made great strides in generating evidence about how it improves lives through reducing adverse health outcomes associated with unintended pregnancy, reducing poverty by facilitating economic development and improving women's and girls' social status. As the availability and use of FP information and services have increased over the past three decades, however, so has the need for evidence-based policy guidance, as well as evidence-based strategies for programming and financing. Moreover, the degree to which strategies and best practices proven through small-scale projects can be and have been scaled-up within national health systems is not well understood.

The design and implementation of FP services over this period has benefited from donor investments in social science, implementation, and operations research that has generated a substantial body of evidence, some of which is context-specific but much of which can be generalized across social milieu and health systems (Jacobstein et al. 2013). This paper reviews the evidence base to identify what is currently known about FP services and what evidence gaps still exist for which further investments in research will be critical for informing the design, implementation and evaluation of FP2020 initiatives.

METHODOLOGY

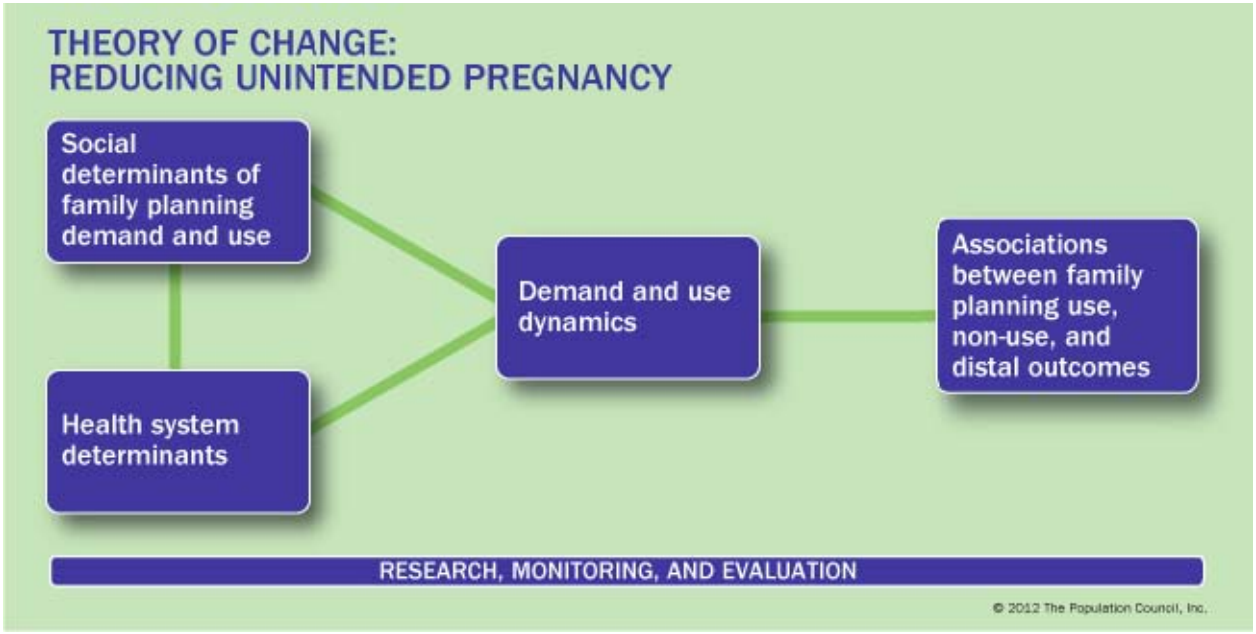
Given the scale and diversity of the evidence base, we initially identified a number of rigorous literature reviews that have been conducted on the topic and published within the past five years. Where appropriate, other key documents with relevant evidence were gleaned from reviews and informed experts (Jacobstein et al. 2013). In addition, the recent World Health Organization (WHO) prioritization exercises (Ali et al. 2012; Hindin et al. 2013)and USAID's 'High Impact Practices' (HIP) documents (K4Health 2012) were reviewed. Several systematic reviews, some following the Cochrane review methodology, were also identified. From these reviews, and drawing from expert informants and our own experience, we identified documentary sources that were considered to present research-based evidence of sufficient quality and rigor to be included. We included reviews that reported evidence generated through a range of research methods (demographic, social science, epidemiologic, policy analysis, and implementation science/operations research) and excluded evidence from biomedical, clinical trials, and other product development research. The evidence was collected and collated according to a theory of change framework.

Theory of Change Framework

Numerous frameworks exist for conceptualizing the determinants and consequences of contraceptive use dynamics. We approached this review and analysis through the lens of a theory of change comprising five critical and interrelated elements:

- Social determinants of FP demand and use
- Health system determinants
- Demand and use dynamics
- Associations between FP use, non-use, and distal outcomes
- Research, monitoring, and evaluation

Based on this theory of change, and in consultation with the expert informants, we prepared a detailed list of topics and assigned them to the appropriate elements in a Review Framework that guides the presentation of the summary of evidence below.



Evidence from the Review

Social Determinants of FP Demand and Use

Many social determinants can influence demand for and use of FP, either individually or in various combinations. In developing countries, the most influential determinants are typically: girls' and women's social status and decision-making power; level of education; marital status; economic status; age; place of residence; and experience of violence (Bongaarts et al. 2012; Cleland et al. 2006; Creanga et al. 2011; Gillespie et al. 2007; Malarcher et al. 2011; DFID 2010b; DFID 2010a; Ortayli and Malarcher 2010). In some settings, ethnicity, migrant status, and HIV status can also be key determining factors. The role of these social determinants in shaping demand for and use of FP is well documented (Cleland et al. 2006; DFID 2010b), and evidence from multiple settings and populations exists that can be used to advocate for the importance of understanding which factors are the most influential in determining demand and use in a particular setting, and, in turn, for identifying those populations that are the most underserved and have the highest unmet need.

Framing this evidence from an equity perspective is critically important so as to focus policy and programmatic attention on identifying the most disadvantaged, vulnerable, and underserved populations with unmet need (Creanga et al. 2011; Gillespie et al. 2007). Reducing inequities in access and use are central to implementing a rights-based approach to providing FP services and inherent in the goal of MDG 5B: achieving universal access to reproductive health (RH), including family planning. Inequity reduction is also central to FP2020's focus on rights and empowerment.

The extent to which social determinants interact and influence demand for, access to, and use of FP services, and consequently contribute to inequities, is highly context-and population-dependent. Situation-specific analyses should thus be undertaken to generate evidence for guiding rights-based policy/program development in all countries (Ortayli and Malarcher 2010). For example, most, but not all, Demographic and Health Surveys (DHS) include standard indicators for many of the social determinants and thus

provide an easily accessible data source (Malarcher et al. 2011; Ortayli and Malarcher 2010). Most of the evidence on social determinants comes, however, from cross-sectional surveys, such as the DHS, whereas longitudinal data could better demonstrate causality. Numerous demographic surveillance systems (DSS), which collect longitudinal data on a range of health indicators, exist in developing countries, but unfortunately very few routinely collect data on contraceptive use and fertility.

Although the DHS can provide much useful data for an overall understanding of many social determinants of unmet need and unintended pregnancy, it generally lacks sufficient data to enable a full understanding of unmet need among key populations suffering from social inequities, notably married and unmarred adolescents, marginalized ethnic populations, urban slum dwellers, and people living with HIV/AIDS (PLWHA). Because the adverse health, social, and economic outcomes of unintended pregnancies among these populations are generally more serious than among other populations (Gipson, Koenig and Hindin 2008; Malarcher et al. 2011), in-depth analyses of vulnerable populations are essential to generate evidence for rights-based policy and program development.

Although the evidence of population-level associations is fairly strong and convincing (DFID 2010b), evaluated interventions that explicitly seek to address the underlying determinants that lead to inequities in access to and use of FP are relatively scarce (DFID 2010b; DFID 2010a). This is primarily because such "structural" interventions are usually implemented with the goal of broader social change and require large-scale complex interventions that may or may not explicitly include changes in reproductive intentions and contraceptive use. However, structural interventions are emerging that are intended to have a direct impact on access to and use of FP among populations suffering from specific inequities. Examples include reaching unmarried adolescents with appropriate information and services, reducing early marriage and reaching married adolescents with supportive information and services, reducing poverty-induced barriers, and reaching PLWHA. Evidence gaps persist in how to tackle these determinants, as well as for interventions that address: i) violence reduction and contraceptive use, especially for adolescent girls; ii) unintended pregnancy among populations living in urban slums, especially adolescents; and iii) girls and women engaged in sex work.

Adolescents are a diverse group of 10-19 year olds whose capacities and needs differ by age, sex, living arrangements, area of residence, level of education, and by their marital, childbearing, and employment status. Given this heterogeneity, addressing adolescent RH needs presents complex challenges. Although some trends in adolescent health and social outcomes have improved over the past three decades—including school enrollment and retention, early marriage, and early pregnancy (WHO 2011)—disparities in many adolescent health outcomes persist by age, income, gender, region, and other socio-cultural factors.

Interventions seeking to reduce sexual risk-taking among adolescents have become increasingly common in developing countries in the past decade. These interventions have taken a variety of configurations, from conventional sex education in schools to multi-component, cross-sector efforts aimed at improving educational and economic opportunities and delaying marriage. Relatively few of these have been rigorously evaluated; and the majority of programs that have been evaluated are small in scale and implemented over a relatively brief period. There is a paucity of information concerning intervention costs, and little evidence regarding long-term behavioral effects (Speizer, Magnani and Colvin 2003).

Key determinants of adolescent pregnancy include early marriage, sexual coercion, and lack of access to and use of appropriate contraceptives. A recent systematic review (Lee-Rife et al. 2012) found little evidence concerning the effect of various non-health interventions on unintended pregnancy, and the evidence that does exist is generally weak. As a result, WHO made several research recommendations: i) assess the impact of improved educational availability on age of marriage; ii) assess the feasibility and long-term impact of economic incentives to girls and their families as a means of delaying age of marriage; iii) determine the effect of formal and non-formal education on adolescent pregnancy prevention; and iv) determine the effect of school-retention interventions (e.g., conditional or unconditional cash-transfer interventions) on delaying pregnancy. For addressing coerced sex, WHO recommends engaging men and boys to alter gender norms and normative behaviors, and highlights the need for research to assess how laws and policies to prevent coerced sex have been formulated, enforced, and monitored and to determine the effectiveness of these laws and policies in preventing coerced sex among adolescents.

Awareness of FP and Contraceptive Technologies

Raising awareness of the benefits of preventing unintended pregnancies and thereby enabling individuals and couples to plan "children by choice not chance" through using contraceptive technologies has a long history (Bongaarts et al. 2012; DFID 2010a). A substantial evidence base exists regarding the use of information, education, and communication (IEC) and social and behavior change communications (SBCC) strategies to generate demand for FP generally, and (to a lesser extent) for specific groups of contraceptive technologies (e.g., long-acting reversible methods, male methods, etc.).

Four broad categories of demand generation interventions can be considered. Evidence from quasi-experimental designs indicates that mass media campaigns can generate an immediate demand for FP services and are associated with approval of FP and greater partner communication about FP and increased contraceptive use. "Edutainment" programs through radio and TV dramas are associated with increased contact with FP providers, greater use of FP, and decreased desired family size (Bongaarts et al. 2012; Mwaikambo et al. 2011; Westoff, Koffman and Moreau 2011). Community mobilization approaches are usually implemented jointly with service delivery through community health worker (CHW) programs or social marketing programs, both of which have been found to have substantial effects on the demand for and use of FP (DFID 2010a). Evidence also supports the effectiveness of interventions that increase interpersonal communications, especially between young people, partners/couples, other family members, or social peers (DFID 2010a; Mwaikambo et al. 2011). Recent developments in mhealth for generating FP demand have stimulated much interest, and several pilot projects are currently underway, but little evidence exists because results have not yet been published (L'Engle 2012).

Because vulnerable populations are generally more isolated, poorer and less literate, they are also less likely to be exposed to many of these demand generation interventions (Ortayli and Malarcher 2010). Moreover, the relevance, or perceived relevance, of these messages may be particularly low for vulnerable populations, for example married girls and female sex workers. The extent to which vulnerable populations are reached by these types of interventions and the extent to which the interventions have an effect on such populations remain under-researched and should be highlighted in future evaluations of demand generation interventions. Social marketing organizations are often required to report on the extent to which their campaigns reach the poorest and most vulnerable populations, and such analyses should be integral to the design and evaluation of future demand generation interventions.

Reducing unmet need is the primary goal of FP2020. Focusing on reducing unmet need implicitly assumes that a demand for FP already exists and is being partially met. However, although awareness of the benefits of FP are widely known in most regions of the world (apart from West Africa), knowledge of contraceptive technologies and how to obtain them is often incomplete and inaccurate. Thus, unfounded concerns regarding side effects are widespread, contributing to personal and partner opposition to contraception (Darroch, Sedgh and Ball 2011). Strategic communication strategies (Bongaarts et al. 2012) are therefore still needed within the FP2020 framework, especially for populations without full awareness of the range of contraceptive alternatives available, how they function, and how to access them. The evidence base regarding interventions tailored to address method-related concerns is thin, however.

Health System Determinants

National health systems largely (but not solely) determine the institutional structures and processes through which FP is delivered and accessed. When considering a national health system, it is important to consider these systems from the perspective of the "total market" (TM) through which FP is made available, which includes public, commercial, not-for-profit, and faith-based sectors (Barnes et al. 2012). To organize the evidence available concerning FP delivery through a total market health system, we adopt the framework of WHO's six "building blocks" of health systems: service delivery, human resources, systems information, medicines, financing, and leadership and governance.

Service Delivery

Globally, the number and type of service delivery channels through which FP is delivered has increased dramatically over the past two decades, reflecting both expansion within the public sector and the growth of other sectors as sources of FP. To simplify the presentation of evidence, we cluster these into seven broad channels: clinic-based; integrated with other services; community-based; mobile outreach; social marketing and pharmacies; adolescent-friendly services; and other vulnerable populations.

Clinic-based. Clinic-based delivery of FP services is still the main delivery channel for married women; increasingly, this may be through non-public sector facilities as the private sector grows in many countries. How to provide clinic-based FP services is broadly understood. The evidence challenges primarily concern improving quality and choice. The key components of high-quality services are well-established, as described in the Bruce–Jain framework (Bruce 1990; Jain 2001), and substantial evidence exists that strengthening these components does impact client-provider interactions, client satisfaction, and effective and sustained method use (RamaRao and Mohanam 2003). Numerous quality improvement interventions have been developed, but relatively few have been rigorously evaluated (Mwaikambo et al. 2011; RamaRao and Mohanam 2003). A recent synthesis of the evidence (Jain 2012) yielded two broad conclusions: (a) increasing the number of methods made available to clients increases choice, which leads to more new users, reduced discontinuation through switching, and increased prevalence overall; and (b) improving providers' skills and attitudes enhances their technical competence and ability to identify and meet clients' individual needs. The evidence base for which interventions can most efficiently increase the number of methods offered, and which can most effectively improve providers' skills, particularly in counseling new clients to determine and meet their individual needs, including continued use of hormonal methods, remains limited, however (Cleland et al. 2006; Halpern et al. 2011; RamaRao and Mohanam 2003).

Evidence is also limited regarding the feasibility and effectiveness of quality assurance and monitoring mechanisms. Several have been piloted over the past two decades, but with little systematic documentation or evaluation. Key issues concerning standardized indicators, data-collection systems, and feedback and data utilization mechanisms remain under-researched. Quality monitoring and assurance feature prominently in FP2020, particularly within the Monitoring and Accountability Working Group. It is hoped that this will encourage investment in generating evidence regarding how such mechanisms can be standardized and can function effectively and efficiently.

Increasing engagement of the commercial sector in providing FP through private clinics is particularly noticeable through the burgeoning of social franchising. Recent reviews (Madhavan and Bishai 2010; Mwaikambo et al. 2011; Stephenson et al. 2004) find strong evidence that franchising does increase access to and use of FP services, moderate evidence of improved quality, and moderate evidence of increased use by the poor. The extent to which franchising addresses equity is, however, uncertain. Only one study has addressed cost-effectiveness, but it was inconclusive. Given the potential of this approach, further research is justified regarding its effect on quality of care and equity as well as its relative cost-effectiveness.

Integrating FP with other services. Increasing emphasis is being placed on integrating FP into other health services, acknowledging both that women's RH needs are often multiple and that a visit to a clinic represents a valuable and perhaps rare opportunity to address a woman's FP needs. The evidence base concerning the feasibility, acceptability, effectiveness, and cost-effectiveness of integrating FP into various maternal, infant, and child health services is extensive, yet awareness of this evidence and its routine use in programming, especially for postpartum FP services, remains remarkably limited. Recent reviews usefully summarize the evidence (Hiller, Griffith and Jenner 2007; MCHIP 2012; Vernon 2009) and provide programmatic recommendations for which models of integration with maternal, newborn, and child health services have been demonstrated to be effective and thus should be scaled-up. There appear to be few major evidence gaps. Some issues that would benefit from further evidence are: how best to link FP counseling during antenatal care (ANC) with postpartum use; how to involve male partners; whether tubal ligations can be offered safely and with informed choice following caesarean sections; whether child immunization visits are a cost-effective opportunity; and method preferences among postpartum women living with HIV (MCHIP 2012). Women at 12 months postpartum have extremely high levels of unmet need (near 65%); thus, investing in scaling up evidence-based postpartum FP strategies should be a priority for FP2020.

For almost two decades, postabortion care (PAC) has explicitly incorporated counseling and, if desired, delivery of FP. When FP is routinely offered to PAC clients, the evidence is unequivocal that clients are more likely to receive a contraceptive method than when it is not (USAID 2012c) and so is considered a proven best practice. The one study to evaluate longer-term outcomes found that exposure to postabortion FP resulted in significantly fewer abortions and unintended pregnancies during the 12-month follow-up period (Johnson et al. 2002; USAID 2012c). No study exists, however, on the impact on maternal mortality and morbidity of providing postabortion FP (Tripney et al. 2011; Tripney, Kwan and Bird In press).

In most developing countries, post-rape care is still a nascent RH service, although growing recognition of the scale and severity of sexual assault means greater investment in piloting country-specific models and preparing for scale-up. Emergency contraception (EC) is an integral component of any post-rape care model, as 5-18% of rapes result in a pregnancy. Evidence currently available is

limited to documenting the feasibility of offering EC within a comprehensive package of services (Keesbury and Thompson 2010). No evidence exists of its effectiveness in reducing pregnancy following rape.

The rationale for integrating FP with HIV services is well-established, both through offering FP within HIV services and HIV services within FP services (Wilcher, Cates and Gregson 2009). Moreover, evidence concerning the feasibility of various models of integration is sufficiently strong to support investment in piloting and scaling up (Church and Mayhew 2009; Spaulding, Brickley and Kennedy 2009). The evidence base describing which models work more effectively, efficiently, and equitably is still modest, and is characterized by generally low levels of scientific rigor. However, recent significant investments in rigorous evaluations of integrated models that measure their association with unintended pregnancies, HIV/STI incidence and stigma, as well as comparisons of outcomes between linked services with stand-alone services, will yield substantial improvements in the quantity and quality of the evidence base over the next couple of years.

Moreover, from an HIV-prevention perspective, evidence from modeling demonstrates that reducing unmet need for FP, and consequently unintended pregnancies, in a population with high HIV prevalence (with or without women knowing their status) has a significant impact on reducing perinatal HIV transmission (Reynolds et al. 2008). A recent review of the evidence by a WHO expert group found conflicting evidence regarding whether women using progestin-only injectable contraceptives may be at increased risk of HIV acquisition. The review recommended that women using progestin-only injectable contraceptives be strongly advised to also use condoms and other preventive measures (WHO 2012a).

Community-based. Community-based distribution (CBD) of FP has been an important strategy in all regions of the world for more than three decades. A vast body of documented experience, together with research-based evidence from numerous evaluations with varying levels of rigor, has demonstrated the acceptability, effectiveness (in generating demand and increasing access and use), and cost-effectiveness of CBD agents, as well as providing programmatic guidance for implementation (Mwaikambo et al. 2011; Phillips, Greene and Jackson 1999).

With the realization that providing FP through multipurpose CHWs is more efficient and better meets women's needs than through CBD agents, attention has shifted to identifying the evidence concerning CHWs as a source of FP information and services. A recent review (USAID 2012a) using evidence with varying levels of rigor showed that: (a) CHWs can meet the immediate and growing need for human resources where services are most needed; (b) CHWs can help reduce inequities in FP use and particularly for women with constrained mobility; and (c) CHWs can safely and effectively provide a wide range of methods, including pills, condoms, injectables, Standard Days Method (SDM), lactational amenorrhea method (LAM), and EC. Preliminary evidence also indicates that under appropriate conditions, CHWs can provide implants and intrauterine devices (IUDs). Further evidence is needed concerning the safety and impact of CHWs providing these long-acting methods. Evidence gaps also remain concerning the role of CHWs in meeting the needs of unmarried adolescents, recently married girls, males, and urban slum populations; the relative cost-effectiveness of CHWs compared with clinic-based and mobile outreach models; and the feasibility and effectiveness of outreach workers in other sectors (e.g., agriculture, development) as FP providers.

Mobile outreach. Provision of long-acting contraceptive methods by a mobile team of trained providers, in a modified vehicle or in a temporary facility or camp, has been a strategy used for many years but with little research-based evidence to describe performance or effectiveness. A recent review of the existing evidence (USAID 2012b) indicates that, in many settings, mobile outreach can: (a) supply between one-fifth and more than one-half of all users of particular methods; (b) outperform fixed facilities and at a lower cost; (c) reduce some inequities by reaching some underserved populations, especially those living in remote locations; and (d) reach women who have never previously used any FP. The evidence base remains limited, however, regarding issues such as women's health-seeking behaviors for complications, switching or discontinuation, client satisfaction, overall quality of service, reaching vulnerable populations living in remote locations, and the cost-effectiveness of mobile outreach.

Social marketing and pharmacies. Using commercial-marketing techniques to promote socially beneficial behaviors and make available subsidized FP commodities and services through commercial outlets is an increasingly popular service delivery model, particularly for delivering short-acting methods such as pills (including EC), condoms, SDM (cycle beads) and injectables. A recent review (Madhavan and Bishai 2010) found moderate evidence that social marketing increases access to FP products and messages, though their effect on inequities was not measured. Strong evidence was found of the cost effectiveness of social marketing, and moderate evidence that increasing price reduces use. One review (Chapman and Astatke 2003) found that the socioeconomic status of women served through social marketing tends to be lower than women purchasing commercial brands and higher than those who obtain their products from the public sector.

Although pharmacies often participate in social marketing programs, little evidence exists regarding the role that pharmacies and drug shops can play when specific interventions are introduced to strengthen their capacity to offer FP services. A recent review (Solo and Malarcher 2012) summarizes the limited evidence of their ability to safely provide many methods, and their potential to reach urban poor populations, including unmarried adolescents and males who may be stigmatized when visiting clinics. It also notes that rigorous evidence is lacking on these issues as well as on quality of care and the cost-effectiveness of the approach.

Married and unmarried adolescents. Many interventions have been developed to reduce health systems barriers for adolescents, but few have been rigorously evaluated. A recent systematic review (WHO 2011, 2012c) found little evidence, and the evidence that does exist is generally fairly weak. As a result, several research recommendations were made: (a) identify feasible and effective interventions that result in the formulation of laws and policies that reduce barriers to adolescents accessing contraceptives; (b) identify and evaluate interventions that influence community members' support for access to contraceptives among adolescents; (c) identify feasible and effective interventions to improve the availability of over-the-counter hormonal contraceptives to adolescents; (d) determine the effectiveness of interventions that provide accurate information and education about contraceptives in various settings and populations (both in-school and out-of-school); (e) identify feasible and effective interventions that involve adolescent and adult males in decisions concerning contraceptive use by partners and by themselves, including interventions that aim to transform gender norms; (f) determine the feasibility, sustainability, and impact of reducing the cost of contraceptives for adolescents.

The majority of sexually active adolescent girls in developing countries are married (Haberland 2003), yet health system-based interventions to address the FP needs of married adolescents are relatively new, and generally seek to reach and support married adolescent girls and their husbands and families with

targeted activities and services. Few rigorous evaluations have been undertaken but a number of promising practices are emerging from studies using quasi-experimental designs. Such studies feature combined community, couple, and individual SBCC strategies to build a supportive social environment, and education-and home-based supply of FP, especially during the postpartum period following the first birth (DFID 2010a).

Other vulnerable populations. The evidence base regarding the particularities of delivering FP services to urban slum dwellers, and especially to young people, is growing with recent substantial investments in urban-focused FP programs and an independent, complementary evaluation project. More evidence will be needed as the number and range of urban-focused interventions expands rapidly through FP2020; in particular, evidence of such interventions to reduce inequities within urban populations, especially young and unmarried populations. The private sector is likely to feature prominently as a source of commodities, and the electronic media, especially mobile phones, as a source of information. As urban slum populations continue to grow exponentially and with young populations, the importance of generating a rigorous evidence base to guide programming for meeting the needs of the urban youth living in poverty cannot be exaggerated.

As noted above, the evidence base for interventions that meet the FP needs of women living with HIV is growing rapidly through both research and experience. With an initial focus on integrating FP services into prevention of mother-to-child transmission (PMTCT) and ART services for HIV-positive women in high prevalence settings, there are increasing efforts to determine the client's HIV status during FP, ANC, and postpartum services so that the consultation can be tailored to meet their needs during a routine consultation rather than through stand-alone HIV services. Evidence for how this expanded service can best be done is still emerging.

Unintended pregnancy and use of contraceptives among sex workers is poorly understood. No systematic review of this sparse literature has been conducted. Such a review would be helpful because the evidence available is unclear regarding whether sex workers have higher or lower levels of unmet need than the general population. Nomadic and migratory populations, although relatively small in number, are highly vulnerable and their needs can be acute. No evidence exists concerning service delivery or models for reaching them, however.

Human Resources

Many cadres of health workers have been trained to provide FP information, counseling, and services. Task shifting and sharing are currently being promoted as a strategy for expanding access to FP through enabling larger numbers of health workers to offer a wider range of methods. A recent review of the task sharing evidence (WHO 2012b) produced recommendations for which cadre could safely and effectively provide which types of contraceptive method. This review also identified some evidence gaps that need to be addressed through rigorous research so that a determination can be made concerning whether the following cadres can provide the following contraceptives: (a) trained Lay Health Workers and Traditional Birth Attendants (TBAs) providing implants; (b) auxiliary nurses providing IUDs and vasectomy; (c) auxiliary nurse midwives providing vasectomy; and (d) nurses and midwives providing tubal ligation and vasectomy. It also recommends two situations in which cadres should provide methods although with targeted monitoring and evaluation (M&E): i) Lay Health Workers and TBAs providing injectables; and ii) auxiliary nurses and auxiliary nurse midwives providing implants. Additionally, the review recommended that, for services for which the evidence does support task

shifting or sharing without further research—namely, auxiliary nurses and auxiliary nurse-midwives providing injectables, and nurses and nurse-midwives providing implants—national programs should be provided with technical assistance to rapidly amend policies and programs to scale-up the evidence-based best practices.

As health systems expand their capacity to offer FP services, a focus on task sharing should not divert attention from broader human resource concerns that can prevent health systems from functioning at full potential (DFID 2010b). Staff shortages, their distribution and rotation, skills competency, lack of supervision, and other human resource issues, are frequently cited as barriers during implementation of new FP interventions. Localized evidence is needed to identify solutions to these problems that can be generated primarily through health systems research methods such as training audits, competency assessments, case studies, health facility assessments, and policy analysis.

A second area in which evidence is needed urgently is the role of electronic and mobile information and communication technology for training, monitoring, and supervising health workers. Despite the great interest in and potential for these technologies to improve provider competence and system efficiency, no rigorous evidence of feasibility, acceptability, effectiveness, and cost-effectiveness exists. Great care is needed, therefore, to ensure that large-scale ehealth/mhealth interventions are not rolled out without sufficient evidence to determine how their introduction will impact the health system.

Systems Information

Effective and efficient delivery of FP services requires the production, analysis, and communication of data regarding the performance of service delivery sites and providers, and the relation between use of FP services and achievement of reproductive intentions through prevention of unintended pregnancy. Performance monitoring will be critical if the FP2020 goals are to be achieved. The collection, processing and use of performance-related data is usually organized through the design and implementation of an M&E strategy. M&E strategies are informed primarily through experiential rather than research-based evidence and usually conceptualized according to logical frameworks based on a "theory of change." At the heart of most M&E strategies for FP service delivery is a health management information system (HMIS) that records and reports the delivery of FP services.

Most national HMISs are notoriously weak at monitoring FP performance. Incorporating data from the non-public sector into an HMIS has proved difficult. Because HMISs also do not usually track client characteristics, monitoring whether inequities are being reduced will be difficult without changes. Because they also do not regularly monitor quality of care, sufficient investments will be needed to strengthen and amend national HMISs and link them with the evolving global framework being developed by the FP2020 Performance Monitoring and Accountability Working Group. Moreover, if an accountability mechanism is to be established and function so that it can routinely track that service delivery is rights-based, it will need to be linked directly with the national HMIS.

Although the overall goal of FP2020, 120 million new users, can be tracked through a strengthened HMIS, the population-level impacts of the various interventions implemented to meet this goal will also need to be measured through data generated through representatively sampled surveys. Historically, the DHS mechanism has provided these data, but with the increased focus on unmet need, unintended pregnancy, and equitable access—all measures that require population-level samples—there is likely to

be a need for increased investment in surveys, including in the human resources to undertake them, analyze the findings, and support the uptake of this evidence by stakeholders and decision-makers.

Paper-based HMISs are increasingly being replaced by electronic systems, handheld devices for data collection and transmission, and computerized analyses are informing budgeting and planning decisions. Despite their rapid increase, rigorously tested and validated electronic HMISs that can be used with ease by program and clinic managers are still a minority. Substantial investment in computerization of national HMISs and in building human resource capacity to use them effectively should be a priority as FP2020 rolls out at the country level.

Commodities

Maximizing global access to FP commodities in accordance with quality assurance requirements at affordable and sustainable prices, or "market shaping," is one of the objectives of FP2020. Problems with FP commodity production, pricing, forecasting procurement needs, efficient supply logistics, and quality assurance have all been identified as key barriers that restrict access and choice for women wishing to use FP, thereby contributing to unmet need. To plan for and implement a market-shaping strategy that will reduce these barriers to develop a more efficient, effective, and equitable market for FP commodities will require substantially more evidence than is currently available. For example, the FP2020 Market Dynamics Working Group is expected to improve processes and tools for demand forecasting, coordinated procurement, harnessing innovative financing, strengthening supply chains, and testing innovative products. All of these processes and tools will require valid, regular data, some of which can be generated through an HMIS, but most will need to be documented and analyzed through new procedures and mechanisms.

In particular, validated TM approaches will be needed to assess the characteristics of existing and likely future markets, and to define the comparative advantage of commercial, social marketing, non-governmental organization (NGO), and public sector actors in terms of their competence and value for money in delivering a range of products or services to different market segments, including the poorest. Rigorous methods for defining, measuring, and monitoring method mix, both in terms of demand and supply, will be essential for maximizing choice. Evidence to support the bridging from product development to market introduction is lacking. Conceptual frameworks and critical pathways exist, but with limited validation and demonstration of utility across the spectrum of methods.

Some specific evidence gaps exist for the provision of individual contraceptive commodities:

- Condoms: **Male condom** use is increasing rapidly among unmarried people, especially in Africa. Evidence is needed regarding how to sustain its use after marriage, especially as a dual protection strategy. Evidence concerning programming for **female condoms** (FC) is increasing slowly; until recently there has been limited interest in FC as a family planning method per se among potential users and providers. Provider and policy bias has inhibited investment in research and programming, although that has begun to change with the recent development of newer models of female condoms coming on the market.
- Contraceptive vaginal rings (CVR): Extensive research is needed regarding how best to introduce and mainstream both progesterone-only and other CVRs. For the latter, market forecasting for developing countries and evidence are needed to inform strategies for affordable production, procurement, and sales.

- Emergency Contraception (EC): Although evidence-based guidance concerning the introduction and mainstreaming of EC products does exist (Hossain and et al. 2009), the UN Commission on Life-Saving Commodities for Women and Children has included EC (together with implants and FCs) in its list of over-looked commodities. Earmarked investments will become available to expand the evidence base regarding the supply of this commodity.
- Injectables: This is the most rapidly increasing contraceptive commodity being used in Africa. The implications of this rapid increase in access and use need better understanding, especially in countries with high HIV prevalence for which concerns remain about its possible association with HIV acquisition. Conversely, use of injectables in South Asia is relatively limited, and more evidence is needed to determine whether there is greater potential demand and if so, how this could best be met.
- Implants: Evidence concerning implants is fairly complete, with the main gap being the extent to which provision of this method can be task shifted to lower-level cadres to increase access, especially in rural areas. Evidence concerning their use by adolescents is limited.
- IUD/intrauterine system: The evidence regarding reasons for non-use is generally quite good. The main evidence gap is the extent to which method provision can be task shifted to lower-level cadres to increase access, especially in rural areas.
- LAM: Evidence is still needed regarding how best to facilitate the transition from LAM to an effective contraceptive technology after breastfeeding.
- Oral contraceptive pills: No further evidence seems to be needed at this point in time.
- SDM: Evidence suggests that demand exists for SDM and that this can increase as availability and awareness increase. The method is most popular among women not currently using an effective method, thus providing programs a strategy to reach underserved couples; how best to do this needs informing through locally obtained evidence (Lundgren 2012).
- Tubal ligation: Options for easier procedures are currently being explored and evidence is needed to determine the extent to which lower cadres can task share its provision.
- Vasectomy: Evidence is needed concerning the reasons for non-use and to identify innovative and effective ways to communicate messages, especially in Africa.
- What is next? Emerging contraceptive and multipurpose prevention technologies (MPTs): A diverse set of research endeavors will be needed as new technologies enter into clinical trials and pre-introduction studies.

Financing

Increased effectiveness and efficiency in health systems functioning is intimately tied to the way in which systems are financed. Most public sector and NGO health programs pay for the inputs needed to produce FP services and not for their performance outputs or outcomes (i.e., whether FP services are actually delivered or whether the population's RH improves). Paying for performance (P4P), result-based financing (RBF), output-based aid (OBA), performance-based financing (PBF) performance-based incentives (PBI), and other similar terms describe interventions that finance a health system through paying for the outcomes delivered. Over the past decade, many models have been and continue to be developed and tested using this principle, and indeed some major donors are also configuring their service delivery tenders so that payment is performance-based.

As described by a recent Cochrane review, the evidence base for PBF is presently too weak to draw general conclusions. PBF is not a uniform intervention; its impact depends on the interaction of several

variables, including the design of the intervention (e.g., who receives payments, the magnitude of the incentives, the targets and how they are measured), the amount of additional funding, other ancillary components such as technical support, and contextual factors including the organizational context in which it is implemented (Witter et al. 2012). For maternal health, an "evidence summit" convened in mid-2012 provided the focus for collating and synthesizing the evidence concerning the full range of financing mechanisms being piloted. The evidence summarized at that meeting is currently being prepared for distribution and should be available by early 2013.

For FP specifically, several PBF mechanisms are being tried (Eichler et al. 2010): donors incorporating PBF in the way they structure payment to countries by conditioning aid on evidence of health results; national governments transferring funds to sub-national levels of government based partly on attainment of health or coverage targets; donors paying NGOs for results that include FP; rewarding health facilities for quality counseling and availability and use of modern FP methods; reducing financial barriers to accessing FP by selling to poor women vouchers for FP services at subsidized rates from accredited providers; and conditional cash transfer (CCT) programs providing income support to poor families if they meet health and education conditions that include participating in health education talks about FP and some evidence of increased FP use (Mwaikambo et al. 2011). Given the high level of interest in PBF, further investment in research concerning these various PBF mechanisms is critical. In particular, concerns regarding the potential for coercion when incentives are used with FP providers need to be carefully addressed in any research (Eichler et al. 2010). In addition, the effect of PBF programming on equity also needs to addressed, because the evidence available appears mixed (Hotchkiss 2011; Ravindram and Fonn 2011). Moreover, the relative cost-effectiveness of alternative PBF models is an important policy issue for which there is no firm evidence.

Many national governments have made substantial commitments to FP2020. It is likely, therefore, that traditional "input-based" financing for FP services through allocations from the countries' finance ministries is likely to continue to be the predominant model in the public sector. Evidence is needed, therefore, regarding how existing governmental financing mechanisms function and can be improved—for example, through country-specific and meta analyses of national health accounts and other resource tracking methods.

The influence of price on the acceptability and use of different contraceptive methods is not clear. Definitive evidence regarding the price elasticity of contraceptive demand is still scarce, and much evidence tends to come from observational studies from the 1980s and 1990s. Most evidence indicates that contraceptive pricing is actually quite inelastic (Cleland et al. 2006), although income seems to be a factor in determining elasticity, implying that the poorest are more likely to be affected by user fees (DFID 2010a). More up-to-date rigorously designed studies are needed concerning the impact of user fees or out-of-pocket payments on contraceptive use and RH and potential equity impacts (DFID 2010a).

Leadership and Governance

The importance of political commitment as a determinant of demand for and use of FP cannot be overstated. Indeed, increasing such commitment is one of FP2020's four objectives. Trends in global and national support for FP are associated with trends in demand for and use of FP (Cleland et al. 2006; DFID 2010b). The stall in fertility decline in sub-Saharan Africa can be attributed in large part to ambiguous national will and reduced global commitment to FP throughout the 1990s and early 2000s

(Bongaarts et al. 2012; Cleland et al. 2006), and recent rapid increases in FP use in several African countries can be attributed to increased political will (Murunga et al. 2012; USAID Africa Bureau 2012). Evidence supports the role of political commitment for increasing awareness of and demand for FP, as well as enhancing investments in and effective implementation of service delivery strategies to reduce unmet need (Jacobstein et al. 2013; Lee et al. 1998). Following the political and financial commitments made at the London FP Summit in July 2012, substantial investments will be made in advocacy efforts over the next few years to capitalize on these commitments. However, little evidence currently exists to guide investments in advocacy, to ensure that they are effective in increasing access, reducing unmet need, and addressing inequities. In addition to evaluations of recent and on-going advocacy initiatives (Murunga et al. 2012; USAID Africa Bureau 2012), prospective research is needed to evaluate the feasibility, implementation process, and effectiveness of forthcoming advocacy projects.

To ensure that these commitments translate into investments in a rights-based approach to reducing unmet need, FP2020 will be supporting mechanisms that hold governments, donors, and other organizations making and implementing the commitments accountable to the intended beneficiaries. Within the FP2020 architecture, both the Rights and Empowerment and Performance Monitoring and Accountability Working Groups will be responsible for ensuring accountability. They will require rigorous evidence to guide them in empowering communities, especially the most marginalized, to voice their needs and demand their entitlements, engage in decision-making to design and implement service delivery; and monitor potential rights abuses concerning FP provision. Accountability mechanisms do exist for FP, but evidence of their feasibility and effectiveness is limited primarily to case studies (Bongaarts et al. 2012; DFID 2010b; DFID 2010a). In anticipation of a rapid increase in accountability mechanisms, operations research to develop, test, and evaluate accountability interventions should be an urgent priority.

Demand and Use Dynamics

A thorough and context-specific understanding of the demand and use dynamics for FP is critical for planning to expand access to and reduce unmet need for FP through FP2020. Moreover, to ensure that all responses are rights-based and will contribute to universal access through reducing inequities, all analyses must disaggregate population-level data by the relevant social determinants for each country. The DHS provides substantial datasets from which many analyses of demand and use dynamics have been, and can be, undertaken. Given the scale of investment and the need to target interventions strategically for diverse populations, undertaking additional population-specific DHS-like surveys will probably be necessary to determine the specifics of such dynamics, especially for particularly vulnerable and poorly-documented populations.

In determining why many women with a demand for FP have an unmet need, understanding the reasons for non-use is an essential starting point. Unfortunately, the evidence base for understanding the reasons for non-use is still limited, due in part to an over-reliance on the evidence generated through the "reasons for non-use" questions used in the DHS. While useful if carefully interpreted, there is an urgent need for additional standardized measures that are able to describe the ambivalence women often feel concerning contraceptive use, their perceptions of various risks associated with use or non-use, and that can capture changes over time. Moreover, more nuanced and insightful interpretations of the responses given and their implications for investments in programming are needed. For example, in most developing countries, lack of access or high cost are no longer the primary reasons for non-use – infrequent sex and fear of side effects are the most commonly cited –

(Darroch et al. 2011), possibly because most investments in FP programming over the past two decades have been oriented towards reducing these barriers, and with apparent success. Future investment should be determined by the key reasons, disaggregated by population groups, within each country.

Recent evidence highlights the importance of and reasons for discontinuation, switching, and failure as factors determining unintended pregnancy and achievement of reproductive intentions (Ali, Cleland and Shah 2012). Indeed, one-third of unintended pregnancies occur among women who are using FP (i.e., have a met need). Better addressing the needs of women already using FP may be as effective a means of reducing unintended pregnancy as focusing on new users (Jain 1989). High rates of discontinuation (on average, around 40% at 12 months) stress the need to both ensure access to longer-acting effective methods, as well as improve service quality, particularly counseling, so that women can make an informed choice and are forewarned about side-effects and reassured about health concerns. Timely and informed method-switching needs to be better recognized to avoid unintended pregnancies, abortion, and unwanted or mistimed births. A lack of longitudinal data, especially prospectively collected, hinders better understanding of these important use dynamics.

One weakness of the DHS is that it does not adequately sample for adolescents and other non-married women, women living in vulnerable situations (e.g., sex workers, women living with HIV) and men. Although varying by country, these populations can suffer a significant proportion of the unmet need. Thus, more evidence is essential to understand contraceptive demand and use dynamics among these populations, either through strengthening the DHS or undertaking further population-specific surveys. For example, several countries have recently commissioned surveys of young people.

Determining whether a woman is using a method that is appropriate for her needs at a particular point in her life cycle, and whether there may be other, more suitable methods that are not available to her, is an important element of use dynamics that influences choice. It can also affect the likelihood of unintended pregnancy if she is using a less effective method because more effective options are not available, accessible, affordable, or acceptable. And it can potentially affect the cost of using and of providing contraceptives. Longer-acting methods generally cost less per couple year of protection (cost is amortized over longer term), than short-acting methods, and so a lack of access to such methods can increase costs to the woman and to the program. Information regarding the appropriateness of a method for a woman's reproductive intentions is critical for any market-shaping initiatives; thus, investments in generating such evidence would be extremely helpful.

Associations between FP Use, Non-Use, and Distal Outcomes

A central goal of family planning is to enable women to space and limit their children according to their own needs and desires. Family planning provides the means through which a woman's right to have children by choice and not by chance can be actualized. In addition, FP has important social, economic, environmental, and population implications. The associations between FP use and fertility, maternal, infant, and child health, population dynamics, economic development, poverty reduction, and food security are well-established after decades of research (Bongaarts et al. 2012; Bongaarts and Sinding 2011). This evidence is used primarily to advocate for political and financial commitment, which has proved essential in refocusing global and national attention on the adverse outcomes associated with unintended pregnancy and unwanted fertility. This evidence is also used for development planning by countries with emerging economies, as the integral role of population health and dynamics in poverty reduction and a country's economic and social growth is increasingly grasped by politicians and economists.

Going forward, a continued investment in the generation and interpretation of demographic evidence remains critically important, especially in countries where the fertility transition is not yet complete and where important fluctuations in these relationships must be monitored. Moreover, in countries that could potentially benefit from a "demographic dividend" – when the working age population is increasing faster than the dependent population, leading to rapid economic growth (Cleland 2012) – country-specific analyses that inform policymakers and politicians of how this dividend can be achieved would be important advocacy interventions and should be supported. A recent review of the likelihood of a demographic dividend in Africa cautions against expecting the same scale of dividend as those witnessed in East and South Asia unless the institutional setting is favorable, the economy is able to generate employment and provide education and health care for the increasing labor force, and household savings can lead to productive investments (Cleland 2012). Without these associated factors, rapidly increasing numbers of unemployed, poorly educated young people can lead to discontent and strife.

As the number of women in the reproductive age group increases because of population growth, so does the number of women needing contraceptive services and commodities. Thus for many developing countries seeking to increase access to FP, an important outcome is that the number of commodities required will increase dramatically due to the combination of increasing contraceptive prevalence and increasing population size; for example, between 2008 and 2012, an additional 42 million women were using contraceptives, half of which was due to population growth (Singh and Darroch 2012).

More recently, research on the associations between FP use, population growth (especially in urban populations and those living on coastal and desert fringes), the environment, and climate has become increasingly prominent and will continue to do so (Jiang and Hardee 2011). Although links between global climate patterns and a woman's right and means of having children by choice and not by chance may seem too distant to many, evidence from such analyses will become increasingly important for policy discussions and investment choices, especially in countries suffering from environmental degradation and problems meeting the food, water, and sanitation needs of their populations.

Using Research, Monitoring, and Evaluation for Guidance Development

The scientific evidence that informed this review draws from data collected through numerous methodologies and from a variety of sources. Broadly speaking, these can be categorized into: a) Research studies using social science methods to collect and analyze quantitative or qualitative data using designs that seek to maximize the validity and reliability of the findings (including, for example, the DHS); b) Formal evaluations of the feasibility, acceptability, cost, and effectiveness of service delivery and system strengthening interventions that seek to increase access to and use of FP; c) HMISs that routinely monitor systems performance in delivering FP information and services.

Much of the focus in this review has been on research to improve health systems. The past decade has seen a burgeoning of research strategies, approaches and methods being applied to generate evidence to influence decisions around health systems strengthening; indeed, global conferences on health systems research held in 2010 and 2012 attest to the sheer scale of research being undertaken. An unfortunate consequence has been the plethora of definitions and terms that have been developed and applied to this research, resulting in confusion and misunderstandings, not least among research donors and researchers themselves. A review and framing of the key domains (operational, implementation, health

systems) that comprise research to improve health systems (Remme et al. 2010) provides a useful starting point from which research donors and researchers can understand and agree upon definitions and categories of research for framing and organizing future research investments.

Evidence for informing strategic investments to increase access to FP derives primarily from formal evaluations of intervention feasibility and effectiveness, although those responsible for making such investment decisions are increasingly seeking evidence of an intervention's impact on quality of care, on universal access and equity, and on its sustainability. Evidence of effectiveness is usually considered to be of highest quality, and so can provide the strongest recommendations for action, if it is derived from a randomized controlled trial (RCT). As this review found, RCTs are rarely undertaken in FP research for numerous reasons: they may be too costly; they may not be ethically or practically feasible; or they may produce evidence that is not programmatically useful. While recognizing the theoretical strength of these "probability" designs, the role of "plausibility" designs in generating evidence that is of acceptable quality to decision-makers and can be used to make strong recommendations is gaining acceptance (Bosch-Capblanch and Team 2011; Victora, Habicht and Bryce 2004). Such designs are often quasi-experimental and use multiple methods and sources to generate data that provides a plausible, rather than statistically probable, attribution of effect to the intervention being evaluated.

Evidence Gaps: Areas for Research Investment
Approaches to Determining Inequities and Identifying Needs of Underserved and Vulnerable Populations
Methodologies to Prospectively Evaluate Structural Interventions to Reduce Inequities and Vulnerability
Interventions to Meet the Needs of Unmarried and Married Adolescents
Interventions to Improve and Sustain the Quality of FP Services
Strategies for Scaling up Effective Models of Integrated Services
Strategies for Reaching Rural Communities
Strategies for Reaching Urban Poor Populations
Techniques for Defining and Shaping Contraceptive Markets to Improve Availability and Access
Innovative Financing Mechanisms to Expand Access and Increase Affordability
Strategies for Advocacy and Accountability
Understanding the Dynamics of Contraceptive Decision-Making and Use

Building Capacity and Improving Methods to Generate and Use Evidence on FP

Recommendations for expanding access to FP that derive from research-based evidence are frequently framed as service delivery 'guidelines' or systems strengthening 'guidance', defined in a WHO-commissioned handbook as "the systematically developed body of knowledge, integrating research evidence and descriptions of the types of other considerations needed to inform decision making about appropriate health system arrangements in specific settings" (Bosch-Capblanch 2011); The handbook proposes a rigorous and systematic process for reviewing and using research-based evidence for health systems guidance and policymaking (Bosch-Capblanch et al. 2012; Lavis et al. 2012; Lewin et al. 2012).

What qualifies as high quality "evidence" and what is a "best" or "proven" implementation practice remains open to debate, however. Other approaches to reviewing and synthesizing evidence and formulating guidance have accepted evidence from non-RTC designs and more experiential evidence, for example DFID's series of "evidence reviews" on Reproductive, Maternal and Newborn Health, and USAID's "High Impact Practices in Family Planning (HIPs)". Lack of agreement on the criteria for evidence quality and its use in the formulation of policy and programmatic recommendations, especially at the global level, will inhibit FP2020's ability to introduce and expand effective interventions for reducing unmet need; achieving such consensus is an urgent priority.

Research Gaps

This review shows that a substantial body of evidence concerning the determinants, outcomes and dynamics of contraceptive use and unmet need has been, and continues to be, generated through a range of research and evaluation activities. Prior investments over several decades in research and evaluation, including building capacity to produce and use research-based evidence, has yielded an impressive body of knowledge that has guided the development and expansion of FP information and services in many developing countries.

The commitments made at the London FP Summit, and the establishment of the FP2020 initiative to implement these, require that many developing countries will need to rapidly and efficiently increase the scale and intensity of existing FP delivery systems, while simultaneously expanding the number and diversity of public and non-public sector markets through which FP can be accessed by those needing FP services. The evidence base to guide how best to do this is, however, lacking in several key areas, as described above. The following evidence gaps warrant consideration for immediate investment in research and in building research capacity.

Approaches to Determining Inequities and Identifying Needs of Underserved and Vulnerable Populations

Although the social determinants of FP demand and use are well understood, how these function in specific national and sub-national contexts must to be clearly mapped if countries are to implement rights-based approaches to reducing unmet need. For many countries, population-level surveys, in addition to or as a component of a regular DHS, that are designed to more precisely determine inequities in access to and use of FP are needed urgently to inform programming, policy and, importantly, budgetary allocations and investments within a country's FP2020 plan. Using these surveys as a baseline, they should be repeated regularly to detect and monitor whether reductions in inequities are occurring and whether underserved and vulnerable populations are being reached.

Such research should proactively engage those often excluded in routine surveys, such as married and unmarried girls and boys, sex workers, migrants, and indigenous and slum populations. In-depth analyses should also be conducted to determine the specific needs of vulnerable and underserved populations and to identify targeted interventions that would increase their access and empower them to hold the health system accountable. This evidence would also provide countries the opportunity to provide "voice" to its vulnerable groups so that they can actively engage in FP programming.

Methodologies to Prospectively Evaluate Structural Interventions to Reduce Inequities and Vulnerability

The importance of structural determinants in limiting access and use of FP is well-understood; much more evidence is needed, however, of the feasibility and effectiveness of interventions that can reduce the inequities and vulnerabilities that they cause. Evidence of the effectiveness of interventions that reduce early marriage, reduce unmarried girls' exposure to unwanted and coerced sex, and empower women to meet their reproductive intentions is largely non-existent. Evidence is also needed concerning "gendered" interventions that enable more positive and balanced interactions by girls and women with their partners, families, and communities. Prospective, rigorously designed impact evaluations of multi-faceted structural interventions are needed. Although requiring substantial investments of time and funding, they would generate evidence that would not only increase FP use but also improve social relations, gender dynamics, and women's and girls' rights more widely.

Interventions to Meet the Needs of Unmarried and Married Adolescents

Adolescent girls and boys, both married and unmarried, form substantial proportions of those with unmet need; moreover, they are often among the most vulnerable and underserved of populations and their needs for appropriate sexuality education are often as great as their need for contraceptives. However, despite the evidence generated through many and varied initiatives over the past two decades, context-specific research is critical if countries are to better understand the needs, preferences and circumstances of the many and extremely varied groups of adolescents that exist in all societies. The diversity of "adolescence" cannot be overemphasized, and so combinations of social science and operations research are needed to first diagnose the varied needs of different adolescent groups and to then test and scale-up sustainable strategies that are appropriate for addressing the educational, informational and service needs of the different adolescents. Moreover, national HMISs urgently need to be strengthened so as to collect, analyze, and use data disaggregated by age and other critical determinants of adolescents' FP needs.

Interventions to Improve and Sustain the Quality of FP Services

FP2020 recognizes and endorses all individuals' right to the highest quality of care; moreover, existing evidence indicates that poor-quality counseling and delivery are universal barriers to initiation and sustained use of FP. More evidence is needed to identify feasible and acceptable interventions that enable and require providers to respond to their clients' individual needs. Evidence is also needed of their effectiveness and sustainability in both attracting new FP users and in reducing discontinuation, as well as their ability to ensure that the distinct needs of vulnerable and underserved populations are appropriately met. Investment in context-specific operations and implementation research around quality improvement interventions would enable health systems to address the many method-and program-related factors that are the most commonly cited reasons for non-use of contraception among women with an unmet need. A key research investment would be the

strengthening of quality assurance and monitoring mechanisms to ensure that such improvements are standardized, routinized, and sustained.

Strategies for Scaling up Effective Models of Integrated Services

Integrating FP within other health services is an important strategy for FP2020; integrated services can be more accessible, acceptable, affordable and less stigmatized, and there may be greater efficiencies in service delivery. Evidence of the feasibility, acceptability and effectiveness of various models of FP integration with antenatal, delivery, postpartum and postabortion care, and with HIV services, is well-established. Evidence of how to adapt, scale-up, and institutionalize these models within a national health system is lacking, however, in part because there is little experience of offering integrated services at scale. Prospective implementation research is needed that systematically documents strategies for scaling up various proven models through describing the systems-level organizational modifications (e.g. in commodity supplies, provider training and supervision, M&E, etc.), policy adjustments, budgetary reallocations, and the costs and cost-savings involved when expanding an integrated model proven through a small-scale pilot study.

Strategies for Reaching Rural Communities

Many developing countries are still characterized by largely rural, often remote, populations. Evidence supports the effectiveness of CHW programs in expanding access to FP among these populations and so expansion of such programs is likely to feature significantly in many national FP2020 initiatives. Countries would benefit, however, from investments in operations and implementation research that would enable them to fine-tune this proven best practice to their national contexts and to rapidly roll-out coverage to better reach underserved and vulnerable populations. CHWs can also be important strategies for reaching populations living in urban informal or 'slum' settlements. Greater investment in policy analyses and health systems research would guide countries in incorporating community-level services into the formal health system, especially countries seeking to adapt national models that have been proven effective by NGOs or faith-based organizations (FBOs).

Existing evidence also supports investment in expansion of a second proven strategy for reaching rural communities, that is, mobile outreach services, which can be an essential source of long-acting reversible and permanent contraception, thereby complementing the delivery of short-acting methods that characterizes most CHW programs. However, investment in operations and implementation research would help countries to rapidly adapt this strategy in both public and non-public programs.

Strategies for Reaching Urban Poor Populations

Rapid urbanization is leading to burgeoning populations of urban poor that are often more disadvantaged and have poorer reproductive and maternal health than the rural poor. Despite geographical proximity to a wide range of outlets, access to affordable and appropriate services is often constrained. Evidence-based strategies for reaching the rapidly growing urban poor will be critical for FP2020, given the scale of growth in these populations and the increasing share the urban poor will contribute to unmet need. Private sector pharmacies, drug sellers, and commercial retail outlets—either independently or within a social marketing program—have tremendous potential to complement public (and private) facilities in urban areas, but evidence of feasibility, affordability, quality of care, and effectiveness in engaging with the private sector to reach the urban poor are lacking. A "total market" approach, including a range of research activities to assess and analyze the situation and opportunities, would be particularly appropriate when planning and developing strategies to reach the full spectrum of slum dwellers.

Techniques for Defining and Shaping Contraceptive Markets to Improve Availability and Access

Market shaping will feature prominently in FP2020 and is a process that requires much more evidence of contraceptive demand and use dynamics and of commodity market dynamics than is currently available – or than can be generated with existing research methods. Developments in research methods are needed urgently, by drawing initially from the experiences of organizations and donors undertaking market shaping in other health fields (e.g. HIV, malaria) and adapting these techniques to contraceptive market development approaches. Investments in building the capacity of FP researchers to understand and apply these methods, and of health system planners to understand and use

the data generated from market shaping analyses, are needed immediately if this key element of FP2020 is to be successful.

Innovative Financing Mechanisms to Expand Access and Increase Affordability

The impressive commitments of financial and other resources for FP2020 can only be successful if the systems in which they are invested function efficiently and ensure that a full range of affordable contraceptive options are available to as wide a population as possible. PBF is emerging as a potential complement to conventional input-based public-sector financing for health systems generally, but little evidence exists concerning PBF of FP services. Investment in operations and implementation research to evaluate and compare the cost, effectiveness and equity effects of various PBF models in the public and non-public sectors with conventional input-based financing models is essential and urgently needed. As most national health systems will continue to finance FP services through input-based financing, however, (at least during the lifetime of FP2020), research is also needed to better understand these financing mechanisms and to identify interventions to improve their functioning and efficiency.

As contraceptive markets continue to diversify, the price of contraceptive commodities, both to governments and to users, will become an increasingly important factor. Further evidence is needed, which can be researched with existing methods, about users' willingness and ability to pay, and about the role of method pricing in determining access for vulnerable and marginalized populations as well as the method mix available, especially in public sector programs.

Strategies for Advocacy and Accountability

Two major and interrelated thrusts of FP2020, for which clear conceptualizations are lacking and there is little research-based evidence of what is effective, are interventions for advocacy (to ensure that commitments are actually made and invested appropriately) and for accountability (to empower communities to engage meaningfully in FP2020-supported initiatives and to institutionalize this engagement). Given the centrality to the objectives of FP2020 of both advocacy and accountability, investments in developing an evidence base for both types of interventions should be an urgent priority. Case studies of existing experiences, operations research that develops and tests various interventions, and rigorous M&E mechanisms to document their implementation and assess their impact would be helpful in building this evidence base.

Understanding the Dynamics of Contraceptive Decision-Making and Use

To reduce unmet need effectively, a national program first needs to fully understand the reasons why women, girls, and their partners do or do not use contraception when they are at risk of an unintended pregnancy, and how these reasons vary among different population groups. Country-specific social science research is needed to analyze these reasons and their determining factors so as to identify which delivery strategies, financing mechanisms, demand generation strategies or commodity mix options would best address the various barriers to use, disaggregated by key population groups. Moreover, methodological developments are needed to better measure and explain socio-behavioral determinants of demand and use, including risk perception, ambivalence, and fear, both for the women and their partners. This research is particularly needed in settings and for populations marked by low literacy rates, poverty, and low contraceptive prevalence.

Recent evidence reinforces the major contribution to unmet need and unintended pregnancy of discontinuation and method failure or inconsistent/incorrect use of contraceptives. Context-specific social science and acceptability research are needed to inform programs of the reasons for method discontinuation or failure so that interventions can be developed and tested through operations research to reduce the causative factors. Such evidence can also inform market shaping (to identify appropriate method mixes for particular populations) and product development (to guide new product designs).

Building Capacity and Improving Methods to Generate and Use Evidence on FP

The human resources needed to undertake the research that will address these evidence gaps remains highly concentrated in northern countries and organizations; a substantial and immediate investment in building southern-based research capacity is critical if evidence generation is to be institutionalized and sustained in the countries that need the evidence. Moreover, some evidence gaps will need new or adapted measures and research methods, which will require investment in their development, validation, and testing in a variety of contexts. Additionally, despite the heavy reliance on national HMISs for data to evaluate FP services, virtually all HMISs in developing countries generate data of dubious validity; investment is urgently needed to strengthen HMISs in most developing countries, especially through computerization, as well as the capacity of program managers to extract and use the data reported.

While increasing emphasis on evidence-informed decision-making by donors and national health systems is welcomed and strongly endorsed, the capacity of decision-makers, in both developing and developed countries, to interpret and use research-based evidence is mixed. In particular, there is much confusion and a lack of agreement about procedures for collating and synthesizing evidence from various sources, including research, for formulating recommendations for programming. For guidance in “best practices” to be recommended, there needs to be greater consensus among decision-makers, especially in donor and policymaking organizations, on what constitutes high-quality evidence and which types of evidence provide the greatest degree of confidence for making strong recommendations. Uncertainty over the credibility of evidence not generated through RCTs and the role of experiential evidence are just two of the factors confusing the role of evidence in programmatic recommendations.

Looking Ahead

Research shows that through high-quality voluntary FP programs, governments can reduce fertility and generate substantial improvements in health, wealth, human rights, and education. Family planning programs for the 21st century will require thoughtful design—engaging both public and private sectors—to meet the growing need for safe and effective FP services. Moreover, the combination of substantial commitments to FP2020 from national governments and a wide range of development partners presents a major challenge in coordinating efforts by multiple actors with different expectations and ways of functioning.

A new generation of women and men will be entering their reproductive years during FP2020; they represent future global markets, future parents, and future FP users. Efforts to provide timely, accurate, and culturally appropriate information can contribute to the RH of many. The challenges ahead for FP programs will be to increase overall access while reducing inequities in individuals’ ability to use a method of their choice, particularly inequities due to poverty, gender, age, and marital status. This

requires investments in research that not only informs health systems strengthening but also empowers girls and women to make and act upon their own best decisions about pregnancy and childbearing. These challenges need to be addressed in the context of constantly increasing population sizes in most developing countries, necessitating additional investments just to sustain existing levels of need.

We must seize the moment and "capitalize on the growing momentum to establish family planning programs as accepted, expected, and routine elements of national health care systems worldwide" (Bongaarts et al. 2012).

Glossary of Terms and Definitions

Contraceptive prevalence
The percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49.
(http://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/)

Market development approaches (MDAs) to reproductive health are initiatives that work toward enhanced financial sustainability, improved access and expanded choice. The term "market development approach" encompasses a very broad set of approaches to health care delivery, but by definition involves the commercial sector.

Market shaping
Market shaping (in this context) is defined as supporting the efficient procurement of quality commodities while ensuring sustainable supply at affordable prices to eligible countries.
(http://www.gavialliance.org/library/gavi-documents/white-papers/market-shaping--strategic-considerations-for-a-healthy-vaccine-marketplace

Market segmentation
Market segmentation is the process of dividing the total market into smaller subsets (segments) that have similar characteristics, needs, or behaviors. Market segmentation analysis looks at current patterns of demand and use for RH commodities and the characteristics of users—socioeconomic, sociocultural, and behavioral—in order to find better and more efficient ways to meet existing demand or generate increased demand.
(http://deliver.jsi.com/dhome/topics/policy/csinitiatives/marketsegmentation

Market segmentation strategies are used by businesses to divide their customers into distinct groups based on different factors, such as income, and to target their products accordingly. In FP, market segmentation is used to divide the FP market into groups based on choice of method and provider and to match clients with sources based on need and ability to pay.
http://www.fhi.org/en/RH/Pubs/booksReports/fpfinancing/brief3.htm

Population momentum
The tendency for population growth to continue beyond the time that replacement-level fertility has been achieved because of the relatively high concentration of people in the childbearing years.
(http://www.prb.org/Educators/Resources/Glossary.aspx)

Social determinants
The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries. (http://www.who.int/social_determinants/en/)

Inter-related social and economic factors that influence health. Social determinants of health include, but are not limited to: socioeconomic status, discrimination, housing, physical environment, food security,

child development, culture, social support, healthcare services, transportation, working conditions, and democratic participation.

Structural interventions
Structural interventions refer to public health interventions that promote health by altering the structural context within which health is produced and reproduced. Structural interventions differ from many public health interventions in that they locate, often implicitly, the cause of public health problems in contextual or environmental factors that influence risk behavior, or other determinants of infection or morbidity, rather than in characteristics of individuals who engage in risk behaviors. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1473169/)

Interventions designed to remove barriers and incorporate facilitators of an individual's HIV prevention (health-seeking, disease prevention) behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid (disease, poor health) exposure to HIV. (http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/glossary.htm)

Structural approaches include social, economic, and political interventions that can improve public health outcomes by increasing the willingness and ability of individuals to practice prevention. (http://www.aidstarone.com/focus_areas/prevention/pkb/structural_interventions/overview_structural_approaches_hiv_prevention)

Total fertility rate
The number of children who would be born per woman (or per 1,000 women) if she/they were to pass through the childbearing years bearing children according to a current schedule of age-specific fertility rates. The TFR is the most widely used fertility measure in program impact evaluations for two main reasons: (1) it is unaffected by differences or changes in age-sex composition, and (2) it provides an easily understandable measure of hypothetical completed fertility. (http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fertility/total-fertility-rate)

The average number of live births a woman would have by age 50 if she were subject, throughout her life, to the age-specific fertility rates observed in a given year. Its calculation assumes that there is no mortality. (http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/demographics/total_fertility_rate.pdf)

Total market approach
Having the public and nonprofit sectors provide subsidized services for needy consumers while maintaining sustainable commercial provision for consumers who are able to pay is often referred to as a "total market" or "whole market" approach. (http://www.rhsupplies.org/fileadmin/user_upload/MDA_Documents/Total_Market_Initiatives_for_Reproductive_Health.pdf)

DFID defines a TMA as a process to "assess the characteristics of existing and likely future markets, and to define the comparative advantage of commercial, social marketing, non-governmental organization, and public sector actors in terms of competence and value for money in delivering a range of products or services to different market segments, including the poorest. It can enable closer and more structured linkages with commercial, public and non-governmental organizational sectors and aid

the gradual shifting of consumers with sufficient purchasing power out of the public sector." (http://shopsproject.org/sites/default/files/resources/5010_file_Total_Market_Approach_honeymanp3.pdf

Unmet need
The percent with an unmet need for family planning is the number of women with unmet need for family planning expressed as a percentage of women of reproductive age who are married or in a union. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child. (http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/index.html)

Youth bulge
A high proportion of 15-to-29 year olds relative to the adult population. (http://blogs.worldbank.org/developmenttalk/youth-bulge-a-demographic-dividend-or-a-demographic-bomb-in-developing-countries)

The youth bulge is a common phenomenon in many developing countries, and in particular, in the least developed countries. It is often due to a stage of development where a country achieves success in reducing infant mortality but mothers still have a high fertility rate. The result is that a large share of the population is comprised of children and young adults, and today's children are tomorrow's young adults. (http://blogs.worldbank.org/developmenttalk/youth-bulge-a-demographic-dividendor-a-demographic-bomb-in-developing-countries)

REFERENCES

Ali, M., et al. 2012. "Reducing unmet need for family planning: Results of a global research priority setting exercise," presented at Family Planning Research Donor Meeting, Washington, DC, 3–4 December 2012.

Ali, M.M., J. Cleland, and I.H. Shah. 2012. *Causes and Consequences Of Contraceptive Discontinuation: Evidence from 60 Demographic and Health Surveys*. Geneva: World Health Organization.

Barnes, J., J. Vail, and D. Crosby. 2012. *Total Market Initiatives for Reproductive Health*. Bethesda, MD: Abt Associates.

Bongaarts, J., J. Cleland, J.W. Townsend, J.T. Bertrand, and M.D. Gupta. 2012. *Family Planning Programs for the 21st Century. Rationale and Design*. New York: The Population Council, Inc.

Bongaarts, J., and S. Sinding. 2011. "Population policy in transition in the developing world." *Science* 333(6042):574–576.

Bosch-Capblanch, X. 2011. *Handbook for Supporting the Development of Health System Guidance*. Basel, Switzerland: Swiss Centre for International Health.

Bosch-Capblanch, X., J. Lavis, S. Lewin, R. Atun, and J. Røttingen. 2012. "Guidance for evidence-informed decisions about health systems: Rationale for and challenges of guidance development." *PLoS Med* 9:e1001185.

Bosch-Capblanch, X., and Project Team. 2011. *Handbook for Developing Health Systems Guidance: Supporting Informed Judgments for Health Systems Policies*. Basel: Swiss Tropical and Public Health Institute.

Bruce, J. 1990. "Fundamental elements of the quality of care: A simple framework." *Studies in Family Planning* 21(2):61–91.

Chapman, S., and H. Astatke. 2003. *Review of DFID Approach to Social Marketing. Annex 5: Effectiveness, Efficiency and Equity of Social Marketing and Appendix to Annex 5: The Social Marketing Evidence Base.* London, UK: DFID Health Systems Resource Centre.

Church, K., and S. Mayhew. 2009. "Integration of STI and HIV prevention, care, and treatment into family planning services: A review of the literature." *Studies in Family Planning* 40(3):171–186.

Cleland, J. 2012. *Will Africa Benefit from a Demographic Dividend?* Oxford, UK: Oxford Policy Management.

Cleland, J., S. Bernstein, A. Ezeh, A. Faundes, A. Glasier, and J. Innis. 2006. "Family planning: The unfinished agenda." *The Lancet* 368(9549):1810–1827.

Creanga, A.A., D. Gillespie, S. Karklinsa, and A.O. Tsui. 2011. "Low use of contraception among poor women in Africa: An equity issue." *Bull World Health Organ* 89:258–266.

Darroch, J., G. Sedgh, and H. Ball. 2011. *Contraceptive Technologies: Responding to Women's Needs*. New York: Guttmacher Institute.

DFID. 2010a. *Improving Reproductive, Maternal and Newborn Health: Burden, Determinants and Health Systems. Evidence Overview*. Working Paper (Version 1.0). London, UK: DFID.

DFID. 2010b. *Improving Reproductive, Maternal and Newborn Health: Reducing Unintended Pregnancies. Evidence Overview*. Working Paper (Version 1.0). London, UK: DFID.

Eichler, R., B. Seligman, A. Beith, and J. Wright. 2010. *Performance-Based Incentives: Ensuring Voluntarism in Family Planning Initiatives*. Bethesda: Health Systems 20/20 Project, Abt Associates Inc.

Gillespie, D., S. Ahmed, A. Tsui, and S. Radloff. 2007. "Unwanted fertility among the poor: an inequity?" *Bulletin of the World Health Organization* 85:100–107.

Gipson, J., M. Koenig, and M. Hindin. 2008. "The effects of unintended pregnancy on infant, child, and parental health: A review of the literature." *Studies in Family Planning* 39(1):18–38.

Haberland, N. 2003. "The neglected majority: Married adolescents," in *Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming; Background Document for UNFPA Workshop, May 1-3 2002*. New York: Population Council.

Halpern, V., L. Lopez, D. Grimes, and M. Gallo. 2011. "Strategies to improve adherence and acceptability of hormonal methods of contraception." *Cochrane Database of Systematic Reviews 2011* (4):CD004317.

Hiller, J., E. Griffith, and F. Jenner. 2007. "Education for contraceptive use by women after childbirth." *Cochrane Database of Systematic Reviews 2002* (3):CD001863.

Hindin, M.J., C.S. Christiansen, and B.J. Ferguson. 2013. "Setting research priorities for adolescent sexual and reproductive health in low- and middle-income countries." *Bulletin of the World Health Organization* 91:10–18 (Article ID: BLT.12.107565).

Hossain, S.M.I., et al. 2009. *ECP Handbook: Introducing and Mainstreaming the Provision of Emergency Contraceptive Pills in Developing Countries*. Washington, DC: FRONTIERS, Population Council.

Hotchkiss, D. 2011 "Effect of an expansion in private sector provision of contraceptive supplies on horizontal inequity in modern contraceptive use: Evidence from Africa and Asia." *International Journal for Equity in Health* 10(1):33.

Jacobstein, R., C. Curtis, J. Spieler, and S. Radoff. 2013. "Meeting the need for modern contraception: Effective solutions to a pressing global challenge." *International Journal of Gynecology and Obstetrics*. http://dx.doi.org/10.1016/j.ijgo.2013.02.005.

Lee, K., L. Lush, G. Walt, and J. Cleland. 1998. "Family planning policies and programmes in eight low-income countries: A comparative policy analysis." *Social Science and Medicine* 47:949-959.

Jain, A. 1989. "Fertility reduction and the quality of family planning services." *Studies in Family Planning* 20(1):1–16.

Jain, A. 2001. "Family planning programs: Quality of care," in *The International Encyclopedia of the Social and Behavioral Sciences*, edited by N.J. Smelser and P.B. Baltes. Amsterdam: Elsevier.

Jain, A. 2012. "Quality of care," prepared for USAID/UNFPA-sponsored meeting on "High Impact Practices in Family Planning," 9 July 2012, New York.

Jiang, L., and K. Hardee. 2011. "How do recent population trends matter to climate change?" *Population Research and Policy Review* 30:287–312.

Johnson, R., S. Ndhlovu, S. Farr, and T. Chipato. 2002. "Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception." *Studies in Family Planning* 33:195–202.

Keesbury, J., and J. Thompson. 2010. *A Step-by-Step Guide to Strengthening Sexual Violence Services in Public Health Facilities: Lessons and Tools from Sexual Violence Services in Africa*. Lusaka: Population Council.

K4Health. 2012. http://hips.k4health.org/. Accessed February 27, 2013.

L'Engle, K. 2013. "Evaluating feasibility, reach and potential impact of a text message family planning information service in Tanzania." *Contraception* 87(2):251–256.

Lavis, J., J. Røttingen, X. Bosch-Capblanch, R. Atun, and F. El-Jardali. 2012. "Guidance for evidence-informed policies about health systems: linking guidance development to policy development." *PLoS Med* 9:e1001187.

Lee, K., L. Lush, G. Walt, and J. Cleland. 1998. "Family planning policies and programmes in eight low-income countries: A comparative policy analysis." *Social Science and Medicine* 47:949–959.

Lee-Rife, S., A. Malhotra, A. Warner, and A.M. Glinski. 2012. "What works to prevent child marriage: A review of the evidence." *Studies in Family Planning* 43(4):287–303.

Lewin, S., X. Bosch-Capblanch, S. Oliver, E. Akl, and G. Vist. 2012. "Guidance for evidence informed decisions about health systems: Assessing how much confidence to place in health systems evidence." *PLoS Med* 9:e1001187.

Lundgren, R. 2012. "Assessing the effect of introducing a new method into family planning programs in India, Peru, and Rwanda." *Reproductive Health* 9(17).

Madhavan, S., and D. Bishai. 2010. *Private Sector Engagement in Sexual and Reproductive Health and Maternal and Neonatal Health A Review of the Evidence.* Baltimore: Department of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public Health.

Malarcher, S., O. Meirik, E. Lebetkin, I. Shah, J. Spieler, and J. Stanback. 2011. "Provision of DMPA by community health workers: What the evidence shows." *Contraception* 83:495-503.

MCHIP. 2012. *Synthesis of Postpartum Family Planning Program Literature.* Washington, D.C.: Maternal and Child Health Integrated Program (MCHIP).

Murunga, V., N. Musila, R. Oronje, and E. Zulu. 2012. *Africa on the Move! The Role of Political Will and Commitment in Increasing Access to Family Planning in Africa.* Washington, DC: The Wilson Center.

Mwaikambo, L., I.S. Speizer, A. Schurmann, G. Morgan, and F. Fikree. 2011. "What works in family planning interventions: A systematic review." *Studies in Family Planning* 42(2):67–82.

Ortayli, N., and S. Malarcher. 2010. "Equity analysis: Identifying who benefits from family planning programs." *Studies in Family Planning* 41(2):101–108.

Phillips, J., W. Greene, and E. Jackson. 1999. *Lessons from Community-based Distribution of Family Planning in Africa.* New York: Population Council.

RamaRao, S., and R. Mohanam. 2003. "The quality of family planning programs: Concepts, measurements, interventions, and effects." *Studies in Family Planning* 34(4):227–248.

Ravindram, S., and S. Fonn. 2011. "Are social franchises contributing to universal access to reproductive health services in low-income countries?" *Reproductive Health Matters* 19(38):85–101.

Remme, J., T. Adam, F. Becerra-Posada, C. D'Arcangues, M. Devlin, et al. 2010. "Defining research to improve health systems." *PLoS Med* 7(11): e1001000.

Reynolds, H., B. Janowitz, R. Wilcher, and W. Cates. 2008. "Contraception to prevent HIV-positive births: Current contribution and potential cost-savings in PEPFAR countries." *Sexually Transmitted Infection* 84 (Suppl II):ii49-ii53.

Singh, S., and J. Darroch. 2012. *Adding it up: Costs and Benefits of Contraceptive Services-Estimates for 2012.* New York: Guttmacher Institute and United Nations Population Fund.

Spaulding, A., D. Brickley, and C. Kennedy. 2009. "Linking family planning with HIV/AIDS interventions: A systematic review of the evidence." *AIDS* 23 (Suppl 1):S79–S88.

Speizer, I., R. Magnani, and C. Colvin. 2003. "The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence." *Journal of Adolescent Health* 33(5):324–348.

Stephenson, R., A.O. Tsui, S. Sulzbach, P. Bardsley, G. Bekele, T. Giday, R. Ahmed, G. Gopalkrishnan, and B. Feyesitan. 2004. "Franchising reproductive health services." *Health Services Research* 39(6, part 2):2053–2080.

Tripney, J., K.S. Bird, I. Kwan, and J. Kavanagh. 2011. *The Impact of Post-abortion Care Family Planning Counselling and Services in Low-income Countries: A Systematic Review of the Evidence*. London, UK: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, 90 pp.

Tripney, J., I. Kwan, and K.S. Bird. 2013. "Postabortion family planning counseling and services for women in low-income countries: A systematic review." *Contraception* 87(1):17–25.

USAID. Unpublished-a. *Drug Shops and Pharmacies: Important Sources for Family Planning Commodities and Information*. High Impact Practices in Family Planning (HIPs) brief. Washington, DC: USAID.

USAID. Unpublished-b. *Mobile Outreach Services: Expanding Access to Long-acting and Permanent Methods*. High Impact Practices in Family Planning (HIPs) brief. Washington, DC: USAID.

USAID. 2012a. *Community Health Workers: Bringing Family Planning Services to Where People Live and Work*. High Impact Practices in Family Planning (HIPs) brief. Washington, DC: USAID.

USAID. 2012b. *Postabortion Family Planning: Strengthening the Family Planning Component of Postabortion Care*. High Impact Practices in Family Planning (HIPs) brief. Washington, DC: USAID.

USAID Africa Bureau. 2012. *Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs*. Washington, DC: USAID.

Vernon, R. 2009. "Meeting the family planning needs of postpartum women." *Studies in Family Planning* 40(3):235–245.

Victora, C., J. Habicht, and J. Bryce. 2004. "Evidence-based public health: Moving beyond randomized trials." *Am J Public Health* 3:400–405.

Westoff, C.F., D.A. Koffman, and C. Moreau. 2011. "The impact of television and radio on reproductive behavior and on HIV/AIDS knowledge and behavior." Calverton, Maryland: ICF International.

WHO. 2011. *Guidelines on Preventing Early Pregnancy and Poor Reproductive Health Outcomes among Adolescents in Developing Countries*. Geneva, Switzerland: WHO.

WHO. 2012a. *Hormonal Contraception and HIV: Technical Statement*. Geneva, Switzerland: WHO.

WHO. 2012b. *Recommendations for Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting*. Geneva, Switzerland: WHO.

WHO. 2012c. *From Evidence to Policy: Expand Access to Family Planning -Improve Contraceptive Services for Adolescents*. Geneva, Switzerland: WHO.

Wilcher, R., W. Cates, and S. Gregson. 2009. "Family planning and HIV: Strange bedfellows no longer." *AIDS* 23(Suppl I):S1–6.

Witter, S., A. Fretheim, F. Kessy, and A. Lindahl. 2012. "Paying for performance to improve the delivery of health interventions in low-and middle-income countries." *Cochrane Database of Systematic Reviews* (2):CD007899.