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GH/PRH Priorities for 2014-2020

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Introduction

International family planning is an impressive story of global evolution in political will, policy change, appreciation for human rights, social norms and behavior change. Modern contraceptive prevalence has more than quadrupled to 46% (55% including China) since the 1960s, and actual family size has declined from more than six children per woman to three (2.6, including China), on average. Change that took centuries in Western Europe and the US has transpired in just one or two generations in Asia and Latin America and is unfolding increasingly rapidly in much of Africa. For five decades, USAID has played an intellectual and technical leadership role in this transformation.

Even so, challenges remain. Family planning receded from the global radar screen in the years following the 1994 Cairo Conference on Population and Development as the broader concept of reproductive health took center stage and attention and resources shifted to fighting the HIV/AIDS epidemic. Millennium Development Goal (MDG) 5b, universal access to reproductive health (which includes access to voluntary family planning), has seen the least progress over the 15-year MDG timeframe. More than 220 million women in developing countries want to postpone or stop childbearing but are not using a modern method of contraception and actual family size still exceeds desired family size in many countries. Key subpopulations —adolescent girls and boys, the poor, newly married couples, post-partum women, and men—do not have equitable access to the FP/RH services they want and deserve. Unequal gender norms continue to disadvantage women and girls in multiple health and non-health arenas. Public sector supply systems are struggling to meet the needs of their populations for high-quality information, services, and products. Long acting and permanent methods of contraception (LAPM) are not as available, affordable, accessible, or acceptable as short acting methods despite the fact that desire to limit childbearing exceeds desire for spacing everywhere except West and Central Africa.

Various partnerships in recent years have helped to revitalize attention to FP/RH. The Ouagadougou Partnership, established by USAID, Government of France, the Bill & Melinda Gates Foundation (BMGF), and Hewlett Foundation in 2011, focuses on jump-starting FP/RH in Francophone West Africa. The Alliance for Reproductive, Maternal, and Newborn Health, founded in 2012 by USAID, the U.K. Department for International Development, BMGF, and Australian Department of Foreign Affairs and Trade, created a forum for these four donors to jointly prioritize accelerated action towards achievement of MDG 5. The 2012 London Summit on Family Planning brought welcome global visibility to family planning, setting a goal of enabling 120 million additional women and girls in the world's 69 poorest countries to access and use contraception by 2020 and launching the global movement known as Family Planning 2020 (FP2020). More than 30 of the 69 countries have made commitments to address the policy, financing, delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies; and donors, foundations, and private entities have pledged an additional US$2.6 billion in funding. USAID remains the largest bilateral donor of international FP/RH assistance, has a

leadership role in the FP2020 governance structure, and is a key implementing partner of the FP2020 agenda.

With this history and renewed momentum as background, USAID's Office of Population and Reproductive Health held an Office-wide retreat in September 2013. Our primary purpose was to identify priorities for the use of core FP/RH funds over the 2014-2020 period. This an opportune time to look forward and position the Office for continued leadership:

- The 2015-2030 Sustainable Development Goals (SDG) are taking shape, providing a unique opportunity for the Office to demonstrate global leadership in influencing how FP/RH is included and progress is measured.
- Rights and equity are key themes in the SDGs and have particular salience for FP/RH. The Office can contribute its experience in promoting voluntarism, informed consent, and program quality, as well as its pioneering work on gender equity to the global dialogue and to country-level programming.
- A majority of the countries that have made pledges to FP2020 are USAID FP/RH priority or Ouagadougou Partnership countries yet progress towards the FP2020 goals has been slower than expected. A clearer focus by the Office on method choice, supply chains, family planning workforce, behavior change communication, a total market approach, and country support by Office staff can help accelerate progress.
- The Lancet Commission on Investing in Health identified three key components of a road map to achieving a convergence in health status between developing and developed countries: mobilizing financing, targeting financing towards the most cost-effective interventions, and increasing investment in research and development. Building on its history of strong support for improving the policy environment, the Office can help foster commitment for increased domestic resource allocation to family planning (a Lancet Commission best buy) in partner countries; and the Office will continue its leadership in contraceptive research, development, and introduction.

Our thinking since the retreat has benefitted from input at a PRH Partners' Meeting in early 2014 and additional elaboration of five focus areas by small working groups. This document identifies priorities, and how and where we will work. These parameters will guide decisions about the allocation of GH/PRH core funds and the core-funded activities of our implementing partners. We hope the document will be useful to USAID field missions and AID/W offices, donors, foundations, and other public and private sector entities that may be interested in partnering and/or investing with us to advance this work.

GH/PRH Priorities for 2014-2020

1. Continued Commitment to Fundamental Principles and Guiding Rationales

Our commitment to long-standing fundamental principles and guiding rationales remains unchanged.

Our work will continue to be guided by the principles of voluntarism and informed choice that have been the foundation of USAID's population (now family planning and

reproductive health) program since its inception in 1965. Decisions about whether, when, and how many children to have are personal and private. Individuals and couples have the right to make and act on those decisions freely and for themselves, without coercion and with accurate and full information about the benefits and side effects of available contraceptive methods, as well as all legal pregnancy options. Additional principles of equity and rights are also fundamental to the Agency's FP/RH program. The principle of equity requires that the ability to make and act on these fertility decisions be available to all, regardless of circumstances such as geography, income, or HIV status, among others. The rights principle extends beyond the right of individuals and couples to choose the number, timing, and spacing of their children to the responsibility of duty bearers to protect, respect, and fulfill that right. *Over the 2104-2020 period, the Office will continue to fund and support activities that ensure voluntarism and informed consent in FP/RH programming and promote equity in access to FP/RH services. We will also seek opportunities to demonstrate the value-added of a rights-based framework for family planning, helping to refine the framework as needed.*

USAID's FP/RH program is guided by three inter-related rationales: 1) Individuals and couples have a right to choose the number, timing, and spacing of their children (discussed above); 2) FP/RH programs improve women's and children's health; and 3) FP/RH programs benefit economic development, natural resource sustainability, and state stability through their effects on population size and age structure. Although each of these rationales has enjoyed support at different times or among particular stakeholder groups, all are relevant to both FP/RH and the broader development agenda. For example, FP/RH programming as an economic development intervention makes recognized contributions to achieving USAID's mission of "partnering to end extreme poverty and to promote resilient, democratic societies while advancing our security and prosperity." As a health intervention, it contributes to the Agency's health goals of ending preventable child and maternal deaths and achieving an AIDS-free generation. *Over the 2014-2020 period, the Office will categorize its work according to the Agency mission and health goals. The Office will continue to fund and support activities that promote achievement of the demographic dividend, with attention to equity; link family planning and population dynamics to resilience, environmental sustainability, and state stability; further demonstrate through research and implementation the linkages between healthy timing and spacing of pregnancy and improved maternal and child health; and improve access to high-quality information, services, and appropriate contraceptive methods for people living with HIV and AIDS.*

2. Provide Global Leadership on a FP Indicator and Benchmark for the SDGs

Over the 2014-2020 period, GH/PRH's efforts will contribute to the FP2020 goal of enabling 120 million additional women and girls to use contraceptive information, services, and supplies, without coercion or discrimination, by 2020. At the same time, we seek to ensure that FP/RH continues to be recognized as an indispensible component of development programming well into the future. To that end, GH/PRH supports the inclusion of universal access to reproductive health as a target for the SDGs. We define access as encompassing availability, affordability, accessibility, acceptability, and quality of information, services, and products, as well as agency to seek and use the FP/RH services of one's choice. GH/PRH also believes the concept of voluntarism must be central to a family

planning indicator under this broader reproductive health target. To this end, GH/PRH has proposed "met demand for family planning" as the indicator and "75% of the demand for family planning met by modern contraceptive use in every country" as the 2030 SDG benchmark. *Over the 2014-2020 period, the Office will support additional analysis of the implications of this benchmark for country programs, including expansion of the denominator to include all women, disaggregation of the benchmark by age groups and wealth quintile, and implications for programming strategies and investments. GH/PRH will also undertake further analysis of the relationship between the FP2020 goal and the 2030 FP benchmark.*

3. Advance Five Focus Areas

A significant outcome of the retreat was the decision to identify five focus areas[1] for the Office's work for the 2014-2020 period. These five areas represent both a focus on ensuring that the fundamentals of strong FP/RH programming are solid and advancing new approaches. The five focus areas are:

1. Method Choice: Method choice exists when client-centered information, counseling, and services enable women, youth, men, and couples to decide and freely choose a contraceptive method that best meets their reproductive desires and lifestyle, while balancing other considerations important to method adoption, use, and change.
2. Social and Behavior Change Communication: Social and behavior change communication is most effective when it is theory-driven, interactive, and uses a range of communication channels and approaches to shape not only demand and FP use, but also client-provider communication, couples' communication, and engagement of community leaders and other influencers.
3. Supply Chains: Supply chains are functioning well when contraceptives and related FP/RH supplies are available to clients, when and where they need them, in good quality and at affordable cost.
4. Family Planning Workforce: A well-performing FP workforce is one that works in ways that are responsive, fair and efficient to achieve the best FP outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
5. Total Market Approach: A total market approach is implemented when the comparative advantages and complementary roles of all sectors of the FP/RH market are considered and supported in order to foster long-term, sustainable delivery of FP/RH information, products and services to all market segments or population groups who want to use them.

Each of the five areas is further elaborated in the appendix to this document. Each focus area brief provides a definition of the focus area, a vision for 2020 and 2030, priorities for programming with PRH core funds, and linkages to the other focus areas. GH/PRH

[1] For the past decade, the Office has had six technical priorities—FP/HIV integration, FP/MCH integration, contraceptive security, long-acting and permanent methods, community-based access, poverty/equity—and four cross-cutting priorities—youth, gender, population-environment, and repositioning family planning. As a result of the 2013 retreat, some of these areas are being folded into one of the five focus areas (e.g., Method Choice encompasses LARC/PMs; Total Market Approach and FP workforce encompass different aspects of community-based access) while others will be pursued as components of the principles (e.g., attention to gender and poverty/equity as component of rights) or as integral to the Agency mission (poverty/equity, population-environment) or health goals (FP/MCH, FP/HIV), or centered within our geographic focus (repositioning family planning).

recognizes that these five focus areas do not encompass the full range of FP/RH programming needed at the country level nor the full range supported by USAID missions. However, we believe that prioritizing them will greatly further the Office's strategic objective of "advancing and supporting voluntary family planning and reproductive health programs worldwide" and assist Missions in achieving their specific FP/RH program objectives. *Over the 2014-2020 period, GH/PRH will support these focus areas with additional attention, technical underpinning, and resources.*

4. Maintain Attention to Evidence and a Supportive Environment

These focus areas do not define the totality of the Office's portfolio. Success in the five focus areas will require attention to FP/RH program components that are traditional strengths in the GH/PRH portfolio. These strengths include improving the enabling policy environment, attention to gender norms, biomedical and implementation science research, and strong data collection, monitoring and evaluation. *Over the 2014-2020 period, the Office portfolio will continue to include activities that advance and support these components, while also ensuring that they evolve to meet new needs (e.g., mobilizing domestic resources for FP/RH).*

5. Focus on Underserved Populations, Particularly Youth

Youth ages 10-24 account for more than 30% of the population in many developing countries, and their reproductive health knowledge and access to information and services is generally worse than that of married women of reproductive age. Their access to education, health services, and jobs, and the decisions they make in these areas, will affect the world's progress for decades to come. It is impossible to think about future FP/RH programming without considering the needs of youth.

However, youth are not a homogenous population. Nor are they the only key population. Married youth are often underserved by FP programs, as social norms to prove their fecundity are strong. Keeping girls in school is a proven intervention to delay age at marriage but often exposes them to gender-based violence and unintended pregnancy. Post-partum mothers and post-abortion clients are key audiences for messages about healthy birth spacing. Rural and peri-urban populations often have to travel long distances to access FP/RH services or find them too expensive. *The Office will prioritize youth and other underserved populations over the 2014-2020 period. Effectively reaching underserved populations will require both demand-side interventions (e.g., tailored messaging for youth, awareness-raising among key influencers) as well as supply-side programming (e.g., training for service providers in LAPM, expanding provision of fertility-awareness based methods and vasectomy, changes in policies, effective market segmentation).*

How GH/PRH Will Work

The Office will continue to organize its work according to the three intermediate results of our strategic framework: 1) global leadership demonstrated in FP/RH policy, advocacy, and services; 2) knowledge generated, organized, and disseminated in response to program needs; and 3) support provided to the field to implement effective and sustainable FP/RH programs. *Over the 2014-2020 period, the Office will increase our emphasis on, and capacity to undertake and successfully nurture, donor and public-private partnerships.*

Where GH/PRH Will Work

The 24 priority countries for USAID's FP/RH program are identical to those for EPCMD activities, with the exception of the exclusion of Indonesia (which has graduated from USAID FP/RH assistance), and the inclusion of the Philippines (which has strong MCH indicators and poor FP/RH indicators). In addition, as a founding partner in the Ouagadougou Partnership, USAID is increasing attention to FP/RH programming in Francophone West Africa (Benin, Burkina Faso, Cote d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo). *Over the 2014-2020 period, the Office will continue to prioritize these 31 countries[2] in its allocation of core resources and its program design, as well as advocate for additional bilateral resource allocation to West African countries.*

Beginning in the early 2000s, USAID has pursued a strategic approach to graduating countries that have developed strong and sustainable FP/RH programs. This approach has permitted the allocation of additional resources to priority high-need countries, largely in sub-Saharan Africa and South Asia, even in the face of relatively stagnant budgets. Budget increases that came with President Obama's Global Health Initiative have enabled additional increases in country allocations. *Over the 2014-2020 period, the Office will revisit the graduation strategy and identify the next set of countries that is approaching graduation thresholds.*

[2] Senegal and Mali are included in both the 24 priority countries and the Ouagadougou Partnership countries.

Appendix

1) Method Choice

VISION: In support of the goals for reaching 120 million additional family planning users by 2020, meeting 75 percent of demand for family planning by 2030, ending preventable child and maternal deaths, and achieving an AIDS-free generation:
By 2020 more women, youth, men and couples in USAID's 24 priority countries and the Ouagadougou Partnership countries who wish to prevent pregnancy are using their preferred method of family planning (FP).
By 2030, a broad range of contraceptive methods is available to meet the varying needs of women, youth, men and couples who wish to prevent pregnancy.

DEFINITION: Client-centered information, counseling and services enables more women, youth, men, and couples to decide and freely choose a contraceptive method that best meets their reproductive desires and lifestyle, while balancing other considerations important to choice, correct use, or switching methods,

PRIORITIES for 2014 - 2020:

1. **Connect specific population groups with appropriate methods by expanding the range of existing methods available.** Some contraceptive methods may be specific to certain populations, such as permanent methods (PMs) for limiters and the Lactational Amenorrhea Method (LAM) for postpartum women, while other methods remain underutilized by or inaccessible to certain populations, such as long-acting reversible contraceptives (LARCs) for youth and postabortion women, and vasectomy for men. Thus, specific sub-populations to reach include:
   - Youth: expand access to methods beyond pills and injectables, including LARCs, emergency contraception (EC), male and female condoms, LAM for young breastfeeding mothers, and the Standard days Method (SDM) to raise awareness about reproductive health (RH), menstrual cycles and pregnancy risk.
   - Limiters: ensure that LARCs and PMs are available and affordable; remove access barriers.
   - Postpartum: Promote LAM; offer IUD, tubal ligation and vasectomy for immediate PP use; for breastfeeding women offer progestin-only methods after six weeks (MEC review may change the timing for immediate postpartum use) and combined hormonal methods after six months. Counsel non-breastfeeding women to begin use of ANY method within 30-45 days after birth.
   - Postabortion: expand access to all FP methods, including EC, LARCs and PMs.
   - Men: encourage participation with partner in FP counseling and use of SDM, condoms, and vasectomy.
   - Lowest quintiles: remove cost barriers to all FP methods and services.

2. **Introduce or scale up access to under-utilized methods** (e.g., implants, IUDs, tubal ligation, vasectomy, emergency contraception, injectables, LAM, SDM) to expand

method choice for poor and underserved communities and sub-population groups (e.g., youth, poor, peri-urban, postpartum, postabortion, limiters, men, PLHIV)

- Implement evidence-based and effective **service delivery approaches** that include both supply and demand components and reach underserved communities and population groups, such as:
  - mobile outreach, community-based distribution (CBD) of injectables, social marketing, social franchising, postpartum and postabortion FP integrated with MNCH/N services, FP integration with HIV services, task shifting, youth-friendly services, male clinics, event days, vouchers, mobile technology, etc.
- Identify and implement activities for key points of intersection with the other four focus areas and policies to enhance method choice, such as:
  - Social and Behavior Change Communication (SBCC): Promote "Positive Positioning" of FP that addresses the beneficial aspects of FP and of each contraceptive method. Refocus counseling to be rights-based and client-centered, starting with clients' needs, desires, knowledge, and requests, and helping her/him decide on a method that can be correctly and consistently used, or to switch to another method in order to achieve their reproductive desires and fit with their lifestyle.
  - Product Availability (PA): Strengthen the role of service providers and pharmacy managers in logistics management information system (LMIS), stock management and forecasting; strengthen last-mile distribution and first-mile LMIS reporting to avert stockouts.
  - Family Planning Workforce (FPW): Address provider bias regarding specific methods or client characteristics; ensure skill base to provide quality counseling to male and female clients as well as couples to enable all clients to make free and informed decisions about whether and when to have children, what method to use, and how to correctly use it. Ensure provider competence to provide quality clinical services for methods requiring injection, insertion, removal, or surgery.
  - Total Market Approach (TMA): Offer a range of quality information, counseling and services to obtain methods through public, NGO, commercial, and lay and private (not for profit) providers/ outlets, as appropriate to the population and the method.
  - Policies: Promote operational policies that enhance access to method choice (e.g., to support task shifting, reduce price to consumers, enable service integration, improve quality and informed choice, remove age, parity and other medical barriers, expand private sector sales and provision, etc.)

3. Support missions and bilateral projects to expand method choice

- Support missions and their bilateral projects to implement and document High Impact Practices (HIPs) and other evidence-based/effective practices (EB/EPs) for introduction and scale up of methods and choice, and to evaluate the impact of expanding method choice and access, including to specific populations.
- Support missions to build method choice, access, and specific sub-populations into new designs as well as their PMP and reporting.

- Provide periodic data-based updates (e.g., met/unmet need among specific sub-populations, procurement orders); coordinate on mission needs (e.g., policy, service delivery capacity, BCC, etc.) to respond to shifts in fertility intentions, method choice and access, etc.

4. Introduce new methods/technologies

- Introduce and document the effectiveness of information, counseling, service delivery, demand creation and system strengthening approaches for expanding access to new methods/technologies and/or population groups, including introduction of:
  - new technologies (e.g., Sayana Press, Implanon NXT)
  - women-initiated methods (e.g., SILCS diaphragm, vaginal rings, women's condom)
- Understand and support women's agency related to female-initiated and controlled methods.

5. Demonstrate global Leadership

- Communicate the vision, definition and priorities of method choice to internal and external stakeholders [coordinate w/ Knowledge Sharing, Country Support, Partnerships, and SBCC].
  - Provide direction to PRH projects and communities of practice (CoP) to: expand method choice for specific methods and population groups; improve the quality of counseling for method choice; ensure norms support clients' decision making.
  - Implement staff updates in PRH, (and with HIDN, OHA, OCS, HSS, regional bureaus and Missions) including technical information and programming considerations for each method.
- Collaborate with global partners, manufacturers, Missions and projects on:
  - Specific methods and technologies, such as the Implants Access Program, Sayana Press, LNG-IUS, expanding access to permanent methods, PPIUD inserter, etc.
  - Advocacy for financial resources to scale up information, counseling, quality, service delivery, and the development of new contraceptives and technologies.
- Collaborate with WHO on key issues of global impact, such as Medical Eligibility Criteria (MEC); Task Shifting; HC/HIV safety and drug interactions; materials for program managers, providers, clients, trainers; prequalification of contraceptives and technologies, research priorities, etc.

6. Strengthen Measurement, Monitoring, Research and Data Utilization

- Conduct research to better understand method choice as it relates to patterns of use, switching; client interest, concerns and preferences by age, wealth, parity, residence, lifestyle. Develop, test and implement indicators to measure method choice. Incorporate into DHS analyses, special studies, Mission PMPs/PPRs.
- Commission HIP Briefs, DHS secondary analyses, journal articles and papers around issues related to method mix, method choice, fertility intentions, method switching, etc.

- Test alternative approaches to facilitating client's decision making and method choice that are client-centered, based on reproductive desires, fit with the client's lifestyle, provide comparative information on effectiveness and side effects, and enable the client to use the method correctly and consistently, or switch to another method if desired.
- Monitor, analyze, and support advocacy and policy formulation based on results of studies in emerging areas, such as ARV/HC interactions.
- Monitor DMPA and implants orders and pipelines as sentinel indicators, and engage countries to assess / align with their service delivery capacity for scale up.
- Continue biomedical research to:
    - develop multipurpose prevention technologies (MPTs) that provide simultaneous protection from unintended pregnancy and STIs, including HIV;
    - fill gaps in the existing method mix (e.g., highly effective methods that last for one-to-two-years);
    - refine existing methods to make them more acceptable, affordable and easier to provide and to use (e.g., biodegradable implants, non-surgical sterilization).

Social and Behavior Change Communication (SBCC)

Vision:
PRH envisions a future in which women and girls, as well as men and boys, possess the knowledge, skills and motivation to practice positive reproductive health-related behaviors, including:

- Open discussion of sexual health and reproductive health, desired fertility, and contraception,
- Healthy timing and spacing of pregnancies,
- Voluntary adoption of family planning, with attention to changing needs across the lifespan, and
- Correct and consistent use of contraception.

By 2020, USAID-supported behavior change activities in priority countries will consistently reflect proven practices in coordination, design, implementation, and evaluation for SBCC,[3] and will measurably contribute to increased contraceptive utilization among priority populations.

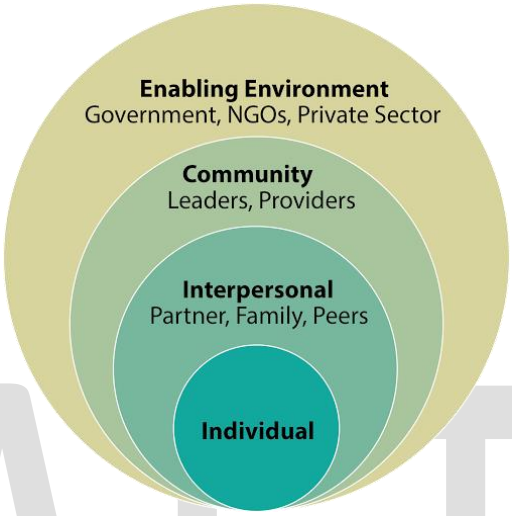
By 2030, partner governments and local organizations will possess the technical and operational capacity to coordinate, design, implement, monitor, and evaluate effective SBCC programs. Locally-led behavior change programs will employ proven practices, including close alignment with health services and attention to social and normative factors, to increase and sustain correct utilization of contraception. Finally, there will exist sustainable country-level or regional mechanisms for SBCC training and professional development, including academic programs, specialized training organizations, and communities of practice, as well as fora for knowledge management and learning, such as online platforms, databases, or materials libraries.

Definition: **SBCC is the use of communication strategies—mass media, "new" and social media, community-level activities, and interpersonal communication (IPC)—to influence individual and collective behaviors pertaining to health.** High-quality SBCC is an essential element of health programming, as it shapes not only demand, but also client-provider communication, couples' communication, and engagement of community leaders and other influencers. SBCC is closely related to advocacy (which seeks to influence the behavior of leaders) and social marketing (which includes demand creation for socially marketed products and services), and should ideally be aligned with both at the country level through partner coordination and shared planning processes.

Many implementers situate SBCC in a socio-ecological framework, which recognizes that determinants of health and health behavior exist on multiple levels and extend beyond the individual. Specifically, socio-ecological models acknowledge the influence of interpersonal

[3] As defined in *High Impact Practices in Family Planning: Health Communication,* available at https://www.fphighimpactpractices.org/resources/health-communication-enabling-voluntary-and-informed-decision-making.

relationships, community structures, and cultural norms and values on individual choices and behaviors.



Research shows that **theory-driven**, **interactive** communication that follows a **proven design and implementation process** [4] can increase knowledge, shift attitudes and norms, and produce changes in a wide range of behaviors. In the context of family planning programs, well-designed and -implemented SBCC can increase **acceptability**, **quality of care**, and **agency** by:

- Creating informed and voluntary demand for family planning products and services.
- Ensuring individuals can use contraceptives correctly and appropriately.
- Helping healthcare providers and clients interact with each other in a respectful and non-judgmental manner.
- Changing non-clinical behaviors that contribute to sexual health, such as age of sexual debut, number of sexual partners, alcohol/substance abuse, and gender-based violence.
- Shifting norms that influence individual and collective behavior, including those pertaining to desired family size and birth spacing; women's decision-making, couples' communication; men's roles and responsibilities in family planning; and young people's sexuality and sexual health.

Priority Audiences:

SBCC has been shown to influence uptake of family planning services among women with unmet need. It is also unique in its ability to address norms and behaviors that exist outside the health system, and to reach those who may not access clinic-based health services. For this reason, priority audiences for reproductive health SBCC include young people (including very young adolescents; unmarried and married adolescents; and young parents); men (as both users and supporters of family planning); and socially marginalized groups.

In addition to these primary, or "direct," audiences, SBCC should be leveraged to improve knowledge, attitudes, and behaviors among influencing audiences, including healthcare providers, parents, and community leaders.

[4] Proven approaches for design and implementation of SBCC programming include JHU-CCP's P-Process, FHI360's C-Cycle, PSI's DELTA, and other processes that encompass systematic review of data; identification of audiences, messages, and channels; pretesting of creative outputs; implementation; and evaluation.

Cultivating Global Leadership in Social and Behavior Change

To achieve its goals in FP/RH behavior change, USAID must support its staff and partners in developing, evaluating, and refining targeted, innovative approaches to behavior change. PRH will continue to emphasize innovation in the behavior change work it supports, through:

- Review of trends across the behavior change and communication fields;
- Evaluation of emerging practices; and
- Support for activities that encourage engagement of new partners and ways of thinking.

GH/PRH and Missions will cultivate a culture of learning and collaboration that emphasizes exchange between USAID and other donors active in development communication (including UNICEF, UNFPA, the Bill and Melinda Gates Foundation, and the World Bank); and among SBCC implementers and other behavior change professionals. Engaging private sector communication and behavior change professionals such as commercial marketers, journalists, and social media specialists in the US and abroad will remain a priority.

PRH Priorities

SBCC has long been an area of investment for PRH. Practices supported by the Office have been documented through a High Impact Practices (HIP) Brief on Health Communication, and mainstreamed via trainings and courses targeting USAID staff and partners.

Despite this longstanding commitment, USAID-supported SBCC – like family planning communication more broadly - continues to face serious challenges. SBCC for family planning is often overly clinical in both messaging and mode of delivery, and ineffective in reaching the populations most in need of information and motivation. It can also lack the visibility or quality of design to effectively and sustainably change behaviors. There is an urgent need for large-scale, high-quality social and behavior change campaigns that promote dialogue around reproductive health, women's empowerment, desired fertility, and male engagement, in the interest of increasing voluntary and correct use of contraception.

PRH's SBCC team has identified four priority areas in behavior change programming for health: 1) expansion of the evidence base; 2) consistent application of proven practices; 3) in-country capacity strengthening; and 4) continued innovation in research, design, and production. Within these broad categories, there are a number of important needs that should be addressed.

Expansion of the evidence base through research and measurement:

The literature around SBCC for family planning, while extensive, is dated, with few major studies conducted in the last decade. As a result, much of the existing research does not accurately reflect the current state of SBCC practice, including use of multi-channel interventions or information communication technology (ICTs) and social media. There is an urgent need to update this evidence base with new research, particularly rigorous studies that approximate randomization or allow for longitudinal analysis. Studies measuring social and normative change are particularly scant, as are evaluations of

community-level SBCC programming and interpersonal communication (IPC) delivered at scale. USAID should prioritize research and evaluation in these areas.

USAID Missions are increasingly approaching social and behavior change through integrated platforms that address a range of health areas, and/or sectors beyond health. Evaluating the impact of such integrated programs – and the effect of integration upon reproductive health-related behavior change specifically, will be essential in the coming years in order to define and apply best practices.

Application of best practices:
Better practices in SBCC for family planning are well understood, but not consistently applied. SBCC is most likely to produce behavioral impact when it:

- Uses research to segment and profile audiences;
- Uses research to identify key drivers of behavior among specific audiences, and addresses these drivers through messaging and activity design;
- Addresses the social context, including gender norms and dynamics;
- Communicates harmonized messages across a variety of channels;
- Promotes audience engagement and participation;
- Is closely aligned with supply-side interventions, including service delivery and social marketing. [5]

USAID Missions should ensure that SBCC, social marketing, and service delivery partners clearly reflect these practices (and others outlined in the Health Communication HIP brief) in their communication activities. PRH will provide technical assistance to Missions and their bilateral partners to ensure that best practices are mainstreamed in country activities, with attention to scale and sustainability.

Capacity strengthening:
To ensure the long-term sustainability of current social and behavior change efforts, developing the capacity of both partner governments and local implementers is critical. Over the last decade, many bilateral and central SBCC projects have begun to incorporate capacity strengthening as well as direct design and implementation in their work. These experiences have demonstrated that SBCC capacity strengthening must utilize a range of learning approaches to enhance the ability of individuals, institutions, and systems, with attention to both technical and operational functions. Despite increasing USAID emphasis on capacity strengthening, there are few robust studies exploring the process or impact of capacity strengthening interventions for SBCC; additional research in this area will help ensure that implementers use the most effective approaches and interventions for their needs and context.

[5] Noar SM, Palmgreen P, Chabot M, Dobransky N, Zimmerman RS. A 10-Year Systematic Review of HIV/AIDS Mass Communication Campaigns: Have We Made Progress? Journal of Health Communication 2009; 14(1):15-43.

Innovation:
SBCC has not systematically incorporated or addressed advances in other behavioral disciplines, including commercial marketing and advertising, behavioral economics, social psychology, applied anthropology, and human-centered design. Integrating practices from these fields into SBCC research, implementation, and evaluation has the potential to improve the impact of SBCC interventions, particularly around intractable social and behavior change challenges and hard-to-reach audiences. Innovative behavior change approaches offer an opportunity to revitalize plateauing family planning programs and stimulate latent demand.

Supply Chains

I. 2020 Vision

PRH priority countries possess the capacities to design, implement, and sustain high-performing supply chain systems for family planning and reproductive health services.

II. 2030 Vision

The long-term availability of affordable and quality family planning and reproductive health supplies to clients is ensured.

III. Definition

This c area is dedicated to improving the long-term availability of affordable, quality-assured contraceptives and related family planning/reproductive health (FP/RH) supplies for clients -- when products are available to clients, when and where they need them, in good quality and at affordable cost. PRH provides commodity procurement and technical leadership to improve product availability through improved supply chain systems from manufacturers to service delivery points, specifically improving *global supply*, *country supply chain systems*, and *enabling environments*.

The supply chains focus area works in concert with other focus areas to support PRH's principles by:

- making available through PRH's global supply operation the full range of products needed for informed choice;
- strengthening both public and private sector country supply chain systems, with a focus on last mile distribution to ensure that contraceptives are available to even the most marginalized, hard-to-reach, or disadvantaged clients; and
- supporting policy and regulatory environments that ensure the availability of a full range of products through healthy markets, including the introduction of new products that expand contraceptive options for clients.

IV. Priorities to 2020

While other priorities are described below, data visibility and monitoring and evaluation are the single largest area of PRH investment under this focus area. For example:

- having a management information system and the business intelligence capabilities to support day-to-day transactions and to monitor performance and support higher-level strategic decision-making for PRH's global supply operation;
- strengthening in-country logistics management information systems, particularly to improve last mile visibility;

- working with global partners for data standardization and interoperability across donor and country systems;
- improving data collection and analytical methods to support the design and assessment of supply chain alternatives; and
- monitoring enabling environments through the Contraceptive Security Indicators and Contraceptive Security Index.

Reproductive health commodity security, once an area dominated by a few players, is now a global movement joined by many actors. PRH's leadership for product availability is increasingly exercised through partnerships, both formal and informal. Key global partnerships with product availability as their primary raison d'être are the Reproductive Health Supplies Coalition, People that Deliver, and U.N. Commission on Life-Saving Commodities. Within USAID, PRH is expanding its coordination and collaboration with other health programs (HIV/AIDS, malaria, maternal and child health) as they too increase their support for product availability through the same supply chain systems. And, there are an expanding number of inter-agency partnerships focused on specific tasks, such as with UNFPA, World Bank, and Gates Foundation.

a) Global supply

Availability to the client begins with quality-assured, affordable products entering supply chain systems. PRH supports a "best in class" global supply operation that provides a consistent supply of contraceptives and other FP/RH products for USAID-supported programs. PRH collaborates with partners to ensure uninterrupted supply to country programs, and provides technical leadership to secure full product pipelines for the future by developing and implementing tools and approaches to reduce unpredictability/volatility and vulnerability in the global market. To support healthier global markets for FP/RH products, PRH focuses on

- improved global demand forecasting and coordinated supply planning;
- enabling existing and new quality-assured suppliers to enter markets;
- harmonization of country regulatory environments (e.g., product registration);
- better use of data and multi-agency fora to engage industry and align supply and demand;
- improved visibility into country markets and understanding of future trends; and
- support for new product introduction.

b) Country supply chain systems

Improving country supply chain systems to ensure that FP/RH products are then available to clients requires attention to myriad supply chain functions, from product registration, forecasting, and procurement, to last mile distribution. Three strategic routes to strengthening these functions are:

- *Strategic design of supply chain systems*: supporting supply chain systems to use industry best practices for improved performance, risk management, efficiency, and sustainability. Network optimization, segmentation, integration, outsourcing, supply chain costing.

- *Data visibility*: enabling end-to-end, real time data visibility that drives supply chain system decision-making. Automation of information systems, data standardization, systems interoperability, improving the "first mile" of data from service delivery points.

- *Human resources*: supporting cost-effective human resource strategies for supply chain systems. Professionalization of the supply chain work force, recruitment and retention, incentives and supervision.

c) Enabling environments

Whether for global supply or country supply chain systems, improvements in supply chain systems require more than technical solutions. They also require *commitment, leadership, and engaged stakeholders in the public and private sectors*; *adequate, predictable, and sustainable financing for products and supply systems*; and *good governance and supportive policies*. Illustrative areas of attention are:

- *Commitment, leadership & engaged stakeholders*: providing and using quality data for advocacy and decision making; strengthening organizational leadership and supporting champions; engaging civil society as stakeholders.

- *Financing*: building capacities to gather, analyze and interpret financing requirements and revenue sources across the public and private sectors, and to coordinate stakeholders to implement strategies that ensure effective allocation and utilization of resources so that products are available to all.

Governance & supportive policies: promoting supportive policy and regulatory environments (product selection and registration, essential medicines lists, etc.); improving transparency in decision-making and financial and supply chain systems; strengthening government-led coordination with active participation of relevant actors.

Family Planning Workforce

VISION: In support of the goals for reaching 120 million new family planning users by 2020, meeting 75 percent of contraceptive need by 2030, ending preventable child and maternal deaths, and achieving an AIDS-free generation:

By 2020 the public and private sector FP workforce in PRH priority countries will be strengthened, expanded and in place to support and implement the priority interventions of the other PRH focus areas in order to increase access to high quality FP products, information and services that are gender sensitive and age and developmentally appropriate.

By 2030 there will be adequate numbers of well-prepared family planning providers positioned within both the public and private sectors, so as to ensure access to high quality FP products, information and services by women and men of all ages who want them. As part of the larger health workforce, they will be supported by human resource systems that embody strong human resource management (HRM) practices, thereby enhancing the sustainability of the strengthened FP workforce.

Definition

In large part, the workforce for family planning is the same workforce that provides maternal and child, HIV, malaria, tuberculosis, and other health services. The WHO has defined a "well-performing health workforce" as "one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive)."[6] For family planning, this means:

- adequate numbers of the appropriate mix of workers necessary to ensure access to and the delivery of services (e.g., doctors, nurses, midwives, pharmacists, CHWs, etc.; public and private sector; lay and professional cadres; paid and unpaid workers; male and female workers; managers; supply chain workers; pharmacists, drug shop keepers, non-formal providers),
- with up-to-date knowledge and skills across the full spectrum of FP methods and services (as appropriate), and interpersonal communications skills to reach a wide range of clients,
- positioned within communities and facilities to ensure full access to a variety of FP methods,
- in a well-equipped, supportive and equitable work environment that promotes productivity, respects the dignity of all clients, and encourages retention in the workforce.

[6] 2007, World Health Organization, Everybody's Business: Strengthening health systems to improve health outcomes: WHO's framework for action.

Workforce Priorities 2014-2020

1. **Increase access to high quality FP services by expanding the number of FP workers/providers available**
   With an estimated shortage of 7.2 million healthcare workers worldwide, including the priority countries for EPCMD, FP2020 and AFG, increasing the number of current and future FP workers is a priority. Key interventions to achieve this include:
   - Task sharing/new cadres: Re-thinking the characteristics of workers needed to provide essential FP services and how they can be most effectively used will create a larger pool of service providers who can be deployed to serve the populations most in need, at the point of need. PRH will promote and support task sharing at all levels of workers, addressing not only safety issues, but also the needed regulatory framework (scopes of practice, training, licensure/certification requirements, supervision patterns, and appropriate compensation).
   - Dedicated FP workers: While there is recognition that dedicated FP workers are needed in a variety of service delivery settings or approaches, there is no standard definition of who they are or how they function most effectively. PRH will support the use of dedicated FP workers, while documenting the approaches used (static, mobile, etc.) and their effect within the implementation context (fully dedicated, only at indicated times, etc.).
   - Pharmacists, shop keepers and other providers outside the formal healthcare system: Many users routinely access FP methods outside the formal healthcare system. PRH will identify approaches for incorporating these sources into the service delivery system, while addressing issues of quality and safety.
   - Supply chain management workforce: There is an urgent need for a competent, recognized, and empowered health supply chain workforce. USAID is a partner in the global People that Deliver Initiative which is addressing this need, and PRH will continue efforts to apply global learning at the country level for testing and implementation.

2. **Address the quality/competency of FP workers through education and training**
   To maintain competency, workers require a continuum of learning throughout their career.
   - Pre-service Education: Both public and private educational institutions are essential to fill the healthcare system's workforce needs. To ensure all graduates complete their basic preparation with the needed knowledge and skills to provide FP services that are gender sensitive and age and developmentally appropriate, PRH will support institutions to develop up-to-date FP/RH curricula, as well as strengthen delivery of that curricula. Curricular content will ensure the development of clinically and socially competent providers who are also equipped with essential leadership, management and governance skills. To maintain standards in both public and private schools, PRH will support quality assurance mechanisms, including accreditation systems, needed to ensure that FP/RH content and teaching is consistently of high quality.

- In-service Training (IST)/Continuous Professional Development (CPD): PRH will support both the institutionalization of in-service training programs that complement, reinforce and expand on the FP/RH content of pre-service education; and the role of professional and regulatory bodies in developing and implementing CPD programs that include FP. The need to develop a cadre of health managers will be addressed through a well-designed IST/CPD program.

3. **Collaborate on wider efforts to improve the work environment (when feasible)**
FP providers are part of the larger health workforce and as such are affected by the quality of the systems for managing the workforce writ large. Human resource management is the integrated use of data, policy and practice to plan for necessary staff, recruit, hire, deploy, develop and support health workers. It includes, but is not limited to: transparent recruitment and deployment practices; performance based evaluation; supportive supervision; established career advancement pathways; appropriate incentive packages for enhanced productivity and retention; and policies and practices that ensure equitable treatment of all staff regardless of gender or sex. While some aspects of HRM – ensuring adequate supervision for task sharing of injectables to CHWs, for example – can and should be implemented for a specific set of workers, opportunities to work with other areas of health, donors and stakeholders to make more systemic improvements that will also address FP needs – providing incentives to improve the retention of workers in underserved areas, for example – are encouraged. When HRM interventions are implemented with a FP focus only, attention is needed to avoid creating inequities or other disruptions in the system as a whole. PRH will partner with other donors and stakeholders to ensure improved governance of and accountability by the workforce, including any special considerations necessary for FP.

4. **Demonstrate global leadership**
Coordinate, collaborate and/or partner with global FP/RH and HRH partners, including WHO, UNFPA, Global Health Workforce Alliance (GHWA), World Bank, Global Fund, ICN, ICM, FIGO, World Medical Association, DFID, NORAD, academia, governments, private sector organizations, foundations, USG agencies, and Implementing Partners, on:
   - continued development, dissemination, utilization and evaluation of the *Training Resource Package for Family Planning (TRP)*, ensuring its application for pre-service education and in-service training.
   - continued application, piloting and updating of the *WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*.
   - implementation and documentation of the *WHO Task Shifting: Global Recommendations and Guidelines*
   - inclusion of FP/RH service delivery issues in the global HRH dialogue while bringing wider HRH learning back to the FP community.
   - broader workforce interventions to improve the health system overall.

Expand the knowledge and evidence base through documentation, research and measurement

- Document and disseminate experiences with task sharing, dedicated workers, pharmacists/drug shop owners, and other innovative workforce approaches and their impact on FP uptake and use. Focus on the environment needed for successful implementation and scale up, including the regulatory framework.
- Case studies/secondary analysis of workforce models and the performance of FP programs in CPR stagnant and CPR improved countries.
- Document the effect of improved leadership and management on the performance of FP programs, including at the facility level.
- Using FP services as an entry point, measure/quantify the impact of workforce interventions on service delivery and health outcomes.
- Develop approaches to reduce provider FP biases related to gender, age and socio-economic status, and to improve provider interpersonal communication skills; evaluate impact of client autonomy and informed decision-making, satisfaction with services, update and continuation of FP, and adherence to method use.
- Secondary analysis of DHS and SPA data to further clarify the relationships among facility readiness, health worker factors, quality of service delivery and health outcomes.

5. Support the field in addressing FP workforce issues

- Support missions and their bilateral projects to implement and document evidence-based/effective practices (EB/EPs) for implementation of innovative workforce interventions to increase the quality and quantity of the FP workforce, and to evaluate the impact of these innovations at the facility and national levels on the workforce, service delivery and health outcomes
- Support missions to build workforce considerations and interventions into new designs as well as their PMP and reporting

Points of intersection with other focus areas:

This focus area supports and is supported by the other focus areas. For example, this focus area:

- Addresses method access and SBCC by: creating awareness of age and gender issues in the service delivery setting, within cultures, and between partners that influence reproductive decision-making; developing communication and counseling skills that respect and promote the rights and autonomy of all FP clients, of all ages; preparing providers to serve youth in a non-judgmental and positive manner; and addressing provider bias regarding specific methods or client characteristics.
- Further improves method access by increasing the number of workers available to provide high quality FP services, at sites most accessible to users; and ensuring provider competency to provide quality clinical services.
- Supports Total Market Approach by addressing workforce needs and interventions for both public and private sectors, as well as non-formal providers.
- Supports supply chain systems by supporting the development of dedicated supply chain management workforce.

Total Market Approach

Vision

A fully rational and efficiently segmented market where youth, women, men and couples have access to a full range of family planning products and services.

By 2020, USAID supported priority countries possess the capacities to design, implement, and sustain high-performing family planning programs that include all sectors for information, product and service delivery in a rational, efficient, and equitable way.

By 2030 all sectors (public, non-profit, informal, commercial), will provide a full range of FP products and services with donor/government/subsidized products being efficiently targeted to those consumers with the greatest economic, geographic, and/or other barriers to access.

Definition

The Total Market Approach (TMA) considers and supports the comparative advantages and complementary roles of all sectors of the FP market in order to foster long term, sustainable delivery of FP information, products and services to all market segments, or population groups who want to use contraceptives. PRH defines the FP market as those actors providing the supply of FP information, products and services and can include any constellation of public and private, nonprofit and for profit sectors depending on the context.

The public and private sectors have different and complementary incentives and roles with regard to participating in the FP market. The role of the public sector generally includes a focus on improving equity and access, often with an aim to serve the poorest. Private sector may serve those with some ability and willingness to pay, or provide FP products and services in areas where and when government systems do not reach. These roles and comparative advantages differ by country context, and are influenced by factors such as maturity of health systems, demand for and use of family planning products, and broader economic development.

Both the public and private sectors need to be taken into consideration when designing and implementing a total market approach for long-term, sustained demand for and supply of FP information, products and services. Governments are key to providing stewardship for the development and implementation of a total market plan, establishing and implementing policy, coordinating different actors, facilitating participation of non-governmental actors and overseeing the execution of the plan. A total market approach for family planning strives to create efficiency and sustainability in the health system such that, for example, public support of FP efforts does not undermine- but instead fosters- the long term potential of private sector incentives and provision of high quality FP products and services. At the product level, TMA informs pricing and marketing of FP products to ensure that the range of products are positioned appropriately to address FP needs and expand overall access to family planning, and to avoid having products and stakeholders competing against each other.

TMA is a valuable tool to monitor and ensure a healthy FP market and ensure complementarity across the FP actors in countries where Missions manage subsidized FP social marketing portfolios, and in countries where multiple donors support social marketing, donated FP commodities or commercial products. For FP services, when gaps to access exist in the public sector to a range of quality FP methods, a TMA can help to identify and engage those actors that can add complementarity, by helping to improve access to a range of FP products and services

Using a TMA approach, PRH provides technical leadership and programming to increase equity and access to family planning information, products and services to improve market segmentation and optimal use of the NGO (including faith-based), informal, (including non-formal providers and health volunteers), commercial (including private providers, pharmacies, manufacturers and drug shops), and the public sector. USAID also works to organize the fractionalized private sector to ensure family planning quality and to engage with the MOH as the steward of the health system.

Cultivating Global Leadership in TMA

Common family planning program challenges can be understood and addressed through TMA. Stock-outs of contraceptives are all too frequent, and services providing a full choice of methods may be limited. Vulnerable populations, such as youth and rural communities, may have limited access to services and products. Financial subsidies may not be reaching those most in need, such as the poorest populations. Financial subsidies may be reaching those who are willing and able to pay for family planning, and thus subsidies are not being directed at those who need them most and being used with those who may be more appropriately served elsewhere.

Depending on the extent of the family planning program and the diversity of the different sectors (public, non-profit and commercial), total market interventions will vary. Where there is little commercial activity, programming may focus on general coordination of donor-supported efforts, demand generation and advocacy and policy development to encourage access (including economic) to a wide range of methods and through the non-profit sector. As programs diversify and mature, key issues are to target subsidies to low-income consumers and transition consumers with ability to pay to the non-profit and commercial sector.

USAID supports well-designed and implemented TMA that can help support and strengthen existing family planning information, products and services.

PRH Priorities

Expansion of the knowledge and evidence base through documentation, research and measurement:

- Develop a joint TMA workplan with UNFPA that will create a compendium of TMA tools and a guide to their use.
- Organize a TMA working group with UNFPA and CA partners to further share knowledge and best practices.

- Document and test the effects of TMA planning and implementation on the FP market and use.
- Build an understanding in PRH and Missions of the private sector including social marketing, social franchising, and the pharmaceutical market with respect to reproductive health and emerging markets through the development of e-learning courses and training sessions. (Social franchising, social marketing, TMA for products, TMA for services and private sector training sessions for new health officers.)
- Increase evidence-based research to capture learnings, to analyze impact, and to develop best practice models for future market planning purposes.
- Collect routine IMS or 3rd party partner market data (regular total market data by country from IMS or a third-party, such as commercial and nonprofit sector partners) to better understand the commercial market and its relationship to public and non-profit sectors of the FP market for specific products.

Application of best practice

- Increase the number of USAID Missions that develop a strategy to provide information, products and services through a total market approach.
- Encourage Missions to subsidize mobile outreach to ensure access to LARCs and PMs for poor, rural and/or marginalized, youth and underserved populations and to implement demand side activities to address economic access issues.
- Ensure social marketing projects target products and subsidies to specific target segments and that they ensure projects are designed with the end in mind, i.e. collect baseline market data and monitor overall market growth.
- Ensure countries incorporate new product introductions using rational, data-based methodologies.
- Conduct willingness to pay studies with those groups involved in FP product and service provision to ensure that services and products are appropriately priced to reach consumer segments.
- Support commercial products (manufacturers' models) with lower price points including both large Pharma and generics manufacturers' products subsidizing marketing and communications for a limited amount of time to build volume of sales.

Capacity building

- Strengthen MOH leadership and USAID Mission staff support for committees that represent the public sector, NGO sector, and the commercial sector to plan and implement a total market approach.
- Work with other donors when there are several social marketing products and services in a country to ensure that there is a total market approach.
- Continue education and dialogue with MOH to understand the potential role of the private (NGO and commercial) sector to contribute to health outcomes including meeting unmet demand for FP and to perform a stewardship function including regulating, financing and overseeing private sector information, product and service provision including quality.

- Pair social franchising and NGO voluntary FP service delivery with financing such as vouchers for the poor and youth to ensure economic access to a full range of family planning services including LARCS and PMs.
- Test and implement demand side (e.g. vouchers) or supply side (e.g. insurance) for voluntary family planning to reduce financial barriers to access and to maximize use of available resources.
- Collaborate with other PRH Office focus area priority teams on Method Access/Method Choice around financial barrier reduction activities to ensure sustained access to arrange of methods.

Points of intersection with other focus areas

This focus area supports and is supported by the other focus areas. For example, this focus area:

- ensures there is method choice by supporting a broad choice of family planning methods including products and services through commercial, social marketing, social franchising, networks, mobile outreach, private providers, and community based distribution;
- supports supply chain systems by working with international NGOs including Social Marketing Organizations and other International Family Planning NGOs and commercial distributors for social marketing and commercial products;
- works to ensure that product and service availability keep pace with demand generation efforts and includes demand side activities in social marketing, social franchising, community-based distribution and mobile outreach; and
- supports human resource strategies in the health sector through task sharing.