FANTA III

FOOD AND NUTRITION TECHNICAL ASSISTANCE

USAID

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Desk Review of Programs Integrating Family Planning with Food Security and Nutrition

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Abbreviations and Acronyms

AIN-C	*Atención Integral a la Niñez en la Comunidad* (Integrated Community Child Health)
BCC	behavior change communication
C-IMCI	community-integrated management of childhood illnesses
COMACO	Community Markets for Conservation Program
CSHGP	Child Survival and Health Grants Program
ENA	Essential Nutrition Actions
FANTA	Food and Nutrition Technical Assistance III Project
LAM	lactational amenorrhea method
MCHIP	Maternal and Child Health Integrated Program
MCHN	maternal and child health and nutrition
MIYCN-FP	maternal, infant, and young child nutrition and family planning
MNCH	maternal, newborn, and child health
NGO	nongovernmental organization
PD/Hearth	positive deviance/hearth
PHE	population, health, and environment
PRH	USAID Office of Population and Reproductive Health
PROGRESS	Program Research for Strengthening Services
SBCC	social and behavior change communication
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

An important intervention that is often overlooked in nutrition and food security programming, but has been prioritized in the U.S. Agency for International Development (USAID) Multi-Sectoral Nutrition Strategy 2014–2025, is family planning and reproductive health services. To date there has been limited documentation on integrating family planning with food security and nutrition programming. In an effort to fill the evidence gap in this area, the Food and Nutrition Technical Assistance III Project (FANTA) conducted a desk review to take stock of and better understand *how* food security and nutrition programs are integrating family planning. This review is the first systematic effort the authors are aware of to examine the grey and published literature focusing specifically on nutrition, food security, and family planning integration across both health sector and multisectoral programs.

Based on learnings from 102 primarily USAID-funded programs operating between 2003 and 2013, this report provides a rich set of program examples, including three case studies, to illustrate the various ways programs are integrating family planning with nutrition and food security interventions. A synthesis of potential promising programmatic practices and recommendations for USAID is also provided.

A program was considered integrated if food security and/or nutrition and family planning interventions were delivered either (a) at the same contact/entry point or (b) by the same provider. Programs were categorized as offering one of three types of family planning integration models based on the type of family planning interventions offered across all the nutrition and/or food security points of contact within the program: (Model 1) family planning education, (Model 2) family planning education and counseling, and (Model 3) family planning education, counseling, and commodity provision, with all three models including referrals to family planning services. Close to two-thirds of the programs implemented Model 3.

Findings from the review show that family planning and nutrition or food security interventions are primarily built into program design from the onset as part of a larger health package, especially maternal, newborn, and child health, integrated management of childhood illness, or food security and livelihood packages. Examples are provided of nutrition and family planning integration in health sector programs as well as nutrition, food security, and family planning integration in multisectoral programs. Examples are also provided on the wide range of community- and facility-based platforms and providers that are used for integrated service delivery.

The findings also revealed potential promising practices for integration. These practices include: building on existing platforms, targeting the 1,000-day window from a mother's pregnancy up until the child is 2 years of age, conducting home visits, ensuring multiple contacts, and engaging men. To further strengthen integration, the review recommends that USAID: define family planning and nutrition integration and family planning and food security integration, including success for this type of integration; harmonize reporting requirements; ensure adequate funding and time for implementation of integrated programs; fund rigorous research focused on testing effectiveness of integration models; develop guidance for and provide technical assistance to programs integrating family planning with nutrition or food security interventions; and promote dialogue and cross-learning across health and multisectoral programs.

1 Introduction

The U.S. Agency for International Development's (USAID's) Multi-Sectoral Nutrition Strategy 2014–2025, launched in May 2014, aims to reduce chronic malnutrition, as measured by stunting, by 20 percent over 5 years. At the foundation of the strategy is the growing body of evidence emphasizing that the actions taken to address the immediate determinants of malnutrition through nutrition-specific interventions primarily delivered in the health sector can be further enhanced by tackling the underlying and systemic causes of malnutrition through nutrition-sensitive interventions implemented across other sectors (Bhutta et al. 2013; Ruel et al. 2013; World Bank 2013). In response, one area that has benefited from increased efforts and investments is agriculture-nutrition linkages (Webb and Kennedy 2014; Hoberg et al. 2013; Food and Agriculture Organization of the United Nations 2013). Another important nutrition-sensitive intervention that is often overlooked in nutrition and food security programming, but has been prioritized in the USAID nutrition strategy, is family planning and reproductive health services.

Integrating maternal, newborn, and child health (MNCH), including nutrition and family planning services has long been recognized and promoted as a key strategy to reduce global maternal and child mortality and to successfully meet the Millennium Development Goals (Brickley et al. 2011; Partnership for Maternal, Newborn and Child Health 2011; Ringheim et al. 2011; Singh et al. 2009; Ekman et al. 2008). Since the early 1990s, there has also been an increase in integrated approaches that address the linkages between population, health, and environment (PHE), and there have been efforts recently to raise awareness of the importance of taking into account population factors when addressing food security in the face of climate change (DeSouza 2009; Moreland and Smith 2012; Potts et al. 2013). Despite these links, to date there has been limited peer reviewed literature and a dearth of programmatic documentation on integrating family planning with food security and nutrition programming (Alvesson and Mulder-Sibanda 2013; Brickley et al. 2011; Maternal and Child Health Integrated Program [MCHIP] 2010; Ringheim 2012; USAID 2011; Yourkavitch 2012). To optimize the effectiveness of food security and nutrition programs, and escalate the U.S. Government's global commitments in this area, there is both a need to understand how best to operationalize program links with family planning and a need to raise awareness about the importance of family planning for improved food security and nutrition outcomes.

In an effort to fill the evidence gap in this area, USAID's Office of Population and Reproductive Health (PRH) funded the Food and Nutrition Technical Assistance III Project (FANTA) to conduct a desk review to: (1) identify, review, and synthesize programmatic experiences and (2) document lessons learned and promising practices in integrating family planning with nutrition and food security programming. As a companion to this review, PRH funded the Health Policy Project to conduct a review on the empirical evidence on the linkages between family planning and nutrition (Naik and Smith 2015) and family planning and food security (Smith and Smith 2015).

The findings in this report are organized based on the review objectives. After the methods are discussed, section 3 includes how nutrition and food security programs are integrating family planning with a focus on sector-related service delivery findings, models of integration, platforms, contact points, and providers used for integrated service delivery. Section 4 discusses limitations in the documentation available for these programs, section 5 highlights potential promising practices for programming, and section 6 provides recommendations for USAID. Appendix 1 includes case studies on three programs: the Ramba Kibondo (Live Long Child) Child Survival Program in Burundi; Sak Plen REP/Full Sack Resiliency Enhancement Program in Haiti; and the Community Markets for Conservation (COMACO) program in Zambia. The case studies provide detailed information on how programs used various platforms and providers to implement integrated services, facilitators and barriers to integration, and lessons learned.

2 Methods

This report presents findings from an extensive document review of grey and published literature to investigate integration strategies that have been used by programs. Examples of data sources include program documents such as evaluation, annual, final, and research reports; technical briefs; PowerPoint presentations; and videos. Multiple methods were used to obtain program documents including coordinating with USAID staff and relevant technical support projects; direct requests to program staff; and searches on organization and/or program websites, Google, and the USAID's Development Experience Clearinghouse website. In addition, telephone interviews were conducted with program staff in the development of three case studies included in this review (see Appendix 1).

Operational Definitions. This review focused on programs that work toward improving food security and/or nutrition outcomes and the integration of family planning into these programs. Given the limited information on this type of integration, the aim was to capture examples of integration strategies from a wide range of relevant programs. Therefore, a broad operational definition for what constituted a "food security and/or nutrition program" was adopted (see Box 1). A program was considered integrated if food security and/or nutrition and family planning interventions were delivered either (a) at the same contact/entry point, such as through a facility or community service or (b) by the same provider, such as a nurse or community health worker.[1] Location of integrated interventions was also considered, mostly as a function of the first two criteria, in order to better understand if integration was happening predominantly at the facility or community level. For the purpose of this review, family planning interventions could include education, counseling, provision of contraceptive commodities, or referral to these services.[2]

Box 1. Operational Definitions

Food security and/or nutrition program: Development (non-emergency) program implemented over a 10-year period (2003–2013) that measures at least one food security and/or nutrition outcome as part of its program monitoring and evaluation activities (see Appendix 2 for a list of outcomes).

Family planning interventions: Include education, counseling, provision of contraceptive commodities, or referral to these services.

Integrated programming: Program in which food security and/or nutrition and family planning interventions are delivered either (a) at the same contact/entry point or (b) by the same provider.

Universe of Programs. The review focused primarily on USAID-funded programs implemented over a 10-year period (2003–2013).[3] Three primary methods were used to identify relevant programs to include in the review. First, the review targeted several funding streams supporting the implementation of food security, nutrition, and family planning programs across USAID Bureaus and Offices. These included Child Survival and Health Grants Program (CSHGP), the Office of Food for Peace's Title II development food assistance programs (referred to in this review as Title II), the private voluntary organization/nongovernmental organization Flexible Fund grant program (referred to as the Flexible Fund), Feed the Future programs, and PHE programs with a focus on programs that promoted sustainable practices (in agriculture, fishing, and natural resource management) and livelihoods. In

[1] There is no universal definition of integration of services—it can mean different things to different people depending on the context (Atun et al. 2010; Global Health Initiative 2012; World Health Organization [WHO] 2008).
[2] Programs focusing on providing only condoms without family planning education or counseling were not considered to meet the definition of having a family planning intervention since condoms alone can be used for prevention of HIV and other sexually transmitted infections, which is not a focus of this review.
[3] Programs active in 2003 or 2013 were included in the review. For example, a program that ran from 1999–2003 or 2011–2015 (an ongoing program) was included, since program implementation fell within the 10-year period of interest to this review.

addition, the review also targeted other health sector bilateral and globally-funded child survival, MNCH, nutrition, and family planning programs. Secondly, in an effort to capture both USAID and non-USAID-funded programs not included in the targeted funding streams, FANTA disseminated a "call for programs" that was broadly disseminated electronically through several development community of practice listservs including Agrilinks; Agriculture-Nutrition; CORE Group; Food Security and Nutrition Network; Maternal, Infant and Young Child Nutrition and Family Planning (MIYCN-FP); Post-partum family planning; and PHE Policy and Practice. The announcement included a link to a brief online survey through which individuals could make recommendations for programs to include in the review. Finally, to capture relevant programs through the published literature, two electronic databases—Popline and Global Health—were systematically searched using all possible combinations of nutrition, food security, and family planning terms. Appendix 2 provides additional information on these methods.

Screening. Using the methods discussed, 518 programs were identified for initial consideration for inclusion in the review. Each program was screened to determine if it met primary inclusion criteria and if it did, it was then screened for integration criteria (see Table 1). The screening was conducted by a team of 12 trained screeners using a 51-item screening tool. The screening process resulted in 102 programs being included in the review. Additional details, including a flowchart summarizing the screening process is provided in Appendix 2. Detailed information on the programs included in the review, including a summary of data sources that were available for each, is provided in Appendix 5.

Table 1. Review Inclusion Criteria

Primary Inclusion Criteria	Integration Inclusion Criteria
• Development (non-emergency) program AND • Implemented within 2003–2013 time period AND • Measures one or more food security and/or nutrition outcomes AND • Includes a family planning component (education, counseling, contraceptive/commodity provision, referral) AND • Availability of program documents (in English)	• Food security/nutrition and family planning interventions delivered: o At same contact/entry point OR o By same provider

Data Extraction, Management, and Analysis. A centralized Microsoft Excel database was used to manage information on all programs that were screened. The 102 programs that met the review criteria were systematically coded in Excel and Word by four reviewers using a data extraction tool and a codebook FANTA developed. Information extracted and coded during analysis included program descriptors (e.g., if the program had a family planning objective); the integration context (e.g., timing of family planning and whether it was integrated only within the health sector or across sectors); entry points used for integration; types of providers delivering integrated interventions; type of family planning interventions offered at the nutrition or food security point of contact; integration barriers and facilitators; the type of nutrition, food security, and family planning outcomes measured; and if the family planning components included strategies to involve men, youth, or religious leaders. Data cleaning and analysis were conducted using Excel and SPSS. The analysis on the information extracted related to barriers and facilitators was conducted using the qualitative software package NVivo.

Case Studies. To further illustrate integration models and strategies, three programs were selected as case studies. The criteria for case study selection included:

- Recently completed (2012–2013) program to enable interviews to be carried out with appropriate program staff and facilitate institutional memory concerning the design and implementation of the program
- Programs with a model that included a family planning referral or commodity provision component (i.e., not just family planning education)
- Availability of quantitative data for nutrition/food security and family planning program indicators from an annual program report, midterm report, or final evaluation
- Representation of contact point and provider-driven strategies
- Representation of USAID funding streams and geographic diversity

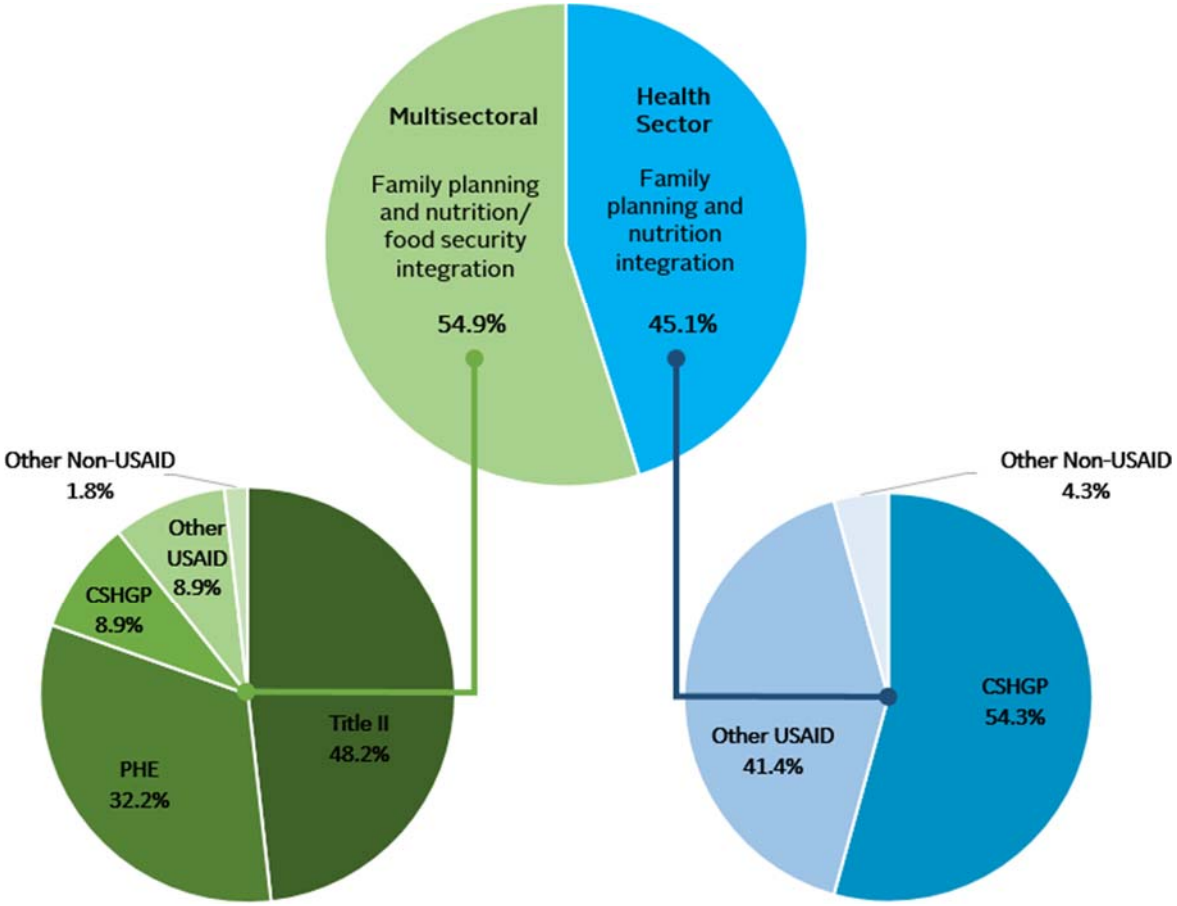
3 How Nutrition and Food Security Programs are Integrating Family Planning

3.1 Sector Related Service Delivery Findings

Family planning integration occurs in both health sector and multisectoral programs

Family planning integration was found in health sector programs (45.1 percent), implementing only health activities, as well as in multisectoral programs (54.9 percent) that included agriculture, environment, fisheries, or livelihood activities in addition to health activities. While nutrition and family planning integration occurred in both health and multisectoral programs, family planning and food security integration occurred only within multisectoral programs (see Figure 1).

Figure 1. Programs Integrating Family Planning by Sector and Funding Stream



Over half of the health sector programs were CSHGPs (54.3 percent); the rest included other USAID global and mission-funded health sector programs and two non-USAID health programs. Close to half of the multisectoral programs were Title II programs (48.2 percent), about a third were PHE (32.1 percent), less than 10 percent were CSHGPs that also included economic development activities, and the rest were other global or mission-funded USAID programs and one non-USAID program. Overall, half (49 percent) of the programs were in Africa, a quarter (24.5 percent) in Asia, a fifth (20.6 percent) in Latin America and the Caribbean, and a limited number in the Middle East (3.9 percent) and in Europe/Eurasia (2 percent). Of the 102 programs included in the review, 16 programs received additional funding for family planning through a Flexible Fund grant (10 CSHGP, 2 Title II, 2 PHE, and 2 other USAID). About a

third (37.3 percent) of the programs included a family planning referral component and 60 percent included family planning as an objective or intermediate result within the program.[4]

Some programs included the following as part of the family planning interventions: a youth component in 22 programs (21.6 percent), 15 of which were multisectoral programs; a male engagement or gender component in 39 programs (38.2 percent), which included 22 health sector and 17 multisectoral programs; and 16 programs (15.7 percent) worked with religious leaders, 13 of which were health sector programs.

Family planning, nutrition, and food security interventions are delivered as a part of larger integrated packages

The programs included in the review offered family planning, nutrition, and food security interventions as part of larger integrated health packages or multisectoral agriculture, conservation, livelihoods, and health packages (see Box 2 for illustrative examples of integrated packages). Nutrition and family planning were usually part of an MNCH or integrated management of childhood illness package. This review revealed that family planning is very rarely added to or integrated into nutrition or food security programs that are already underway, but instead both interventions are included from the outset in program design as part of a larger integrated package. Only about 10 percent of the programs included in the review added family planning after program implementation began, usually as a result of receiving additional funds to address family planning. Teasing out the nutrition or food security and family planning components from integrated packages that were intended to be delivered as a package is challenging and is also a limitation to being able to understand the nuances of nutrition, food security and family planning integration.

Box 2. Examples of Integrated Packages

- Project HOPE's CSHGP in Kyrgyzstan focused on maternal and newborn care (30 percent of program's efforts); nutrition (25 percent); child spacing, control of diarrheal diseases, pneumonia case management, and sexually transmitted diseases (10 percent each); and immunization (5 percent).
- The Environment and Health Program in Madagascar focused on 10 themes: smaller families, child health, disease prevention, women's health, children's nutrition, women's nutrition, food security, natural resource management, gender, and livelihoods.

Family planning is integrated largely with other health interventions in multisectoral nutrition and food security programs

Although more than half of the programs included in the review were multisectoral, within these multisectoral programs, family planning was integrated only within the health activities in close to half of the programs (43 percent). This suggests that there is room for more family planning integration across non-health sector interventions within multisectoral nutrition and food security programs.

A typical example of family planning only being promoted within health sector interventions in multisectoral programs is the Food and Livelihood Security in Pita and Telimele Title II program in Guinea. This program worked toward two strategic objectives: one related to increasing food access through agriculture and livelihood activities, and the second to improve health and nutritional practices. As a part of the second strategic objective, family planning was incorporated into nutritional rehabilitation workshops for caregivers and mothers of malnourished children. These workshops took

[4] Although all programs selected for the review included a family planning component, this analysis looked at if family planning was specifically included as part of a strategic objective or intermediate result.

place over a 12-day period once or twice a year. During these workshops education was provided on various topics including breastfeeding; frequency, quality, density, and utilization of food; food groups; micronutrients; hygiene; child growth monitoring; malaria prevention; immunizations; diarrhea; prenatal care; postnatal care; family planning; and HIV awareness. However, there was no evidence of integration of family planning within any agriculture and livelihood activities within this program.

A common strategy used by the few Title II programs that integrated family planning across sectors were through care groups[5] or mother's and father's clubs which delivered health education on a broad range of topics including nutrition and family planning, but also education on topics related to agriculture and livelihoods, such as messages on vegetable home gardening or access to microcredit activities. In some cases the care group leaders and community health workers who led the care groups were also equipped to conduct family planning counseling and/or served as community-based distributors of contraceptives. Other strategies used by these programs included delivering nutrition and family planning education on various topics at food distribution sites and via radio programs; and delivering food security and family planning education at adult functional literacy sessions for farmers that focused on strategies to improve farming practices and other relevant skills.

Multisectoral programs that routinely integrated family planning across sectors were primarily the PHE programs, which by nature seek to integrate family planning and reproductive health into the environment sector. One example is the World Wildlife Fund's Successful Communities from Ridge to Reef program in Kenya. This program integrated family planning and reproductive health messages into its existing Conservation Education and Awareness Program, which targeted youth groups, local school curriculums, community meetings, and sermons at mosques. The program also promoted family planning and nutrition services through antenatal care services provided through clinics, community-group meetings, and mobile clinics. Another example is the Healthy Families Healthy Forest program in Madagascar. This PHE program focused on improving health (including nutrition and family planning) and hygiene outcomes and on promoting environmental protection using forest committees as the entry point. Forest committee members and community health workers were trained to serve as PHE field agents and used several information, education, and communication approaches, including theater groups featuring folklore specialists and marionettes, to deliver information on family planning, immunization, improved rice production, vegetable gardening, diversified diets, and reforestation; and to refer clients to local health centers to obtain services.

> "The main objective of the integrated population, health, and environment approach to conservation and health is to improve access to family planning and related health services while simultaneously helping communities manage their natural resources, with the goals of both improving people's health and livelihood and conserving wildlife and other biological resources" (Hahn et al. 2011).

3.2 Models of Integration

The level of family planning services delivered at the nutrition or food security point of contact varied across programs. Even within a program, multiple strategies were often employed, each delivering a different level of family planning. For example, a program might have implemented nutrition and family planning education through a care group while also providing family planning counseling, commodity distribution, growth monitoring and promotion, and vitamin A distribution through nurses via mobile clinics.

[5] A care group is typically a group of community-based volunteers that regularly meet together with program staff for training and supportive supervision. The volunteers are then responsible for regularly meeting with 10-15 families to share what they learned and facilitate behavior change at the household level.

This review found that, in general, programs can be categorized as offering one of three types of integration models based on the type of family planning intervention(s) delivered across all the nutrition and/or food security points of contact within the program: (1) family planning education, (2) family planning education and counseling, and (3) family planning education, counseling, and commodity provision. All three models could include referrals to family planning services.

An overview of the programs that met the review criteria is presented in Table 2 by integration model. Close to two-thirds of the 102 programs (63.7 percent) were delivering some element of family planning education, counseling, and commodity provision at the points of contact with nutrition and/or food security interventions (Model 3). The rest of the programs were almost equally distributed as providing only family planning education (18.6 percent, Model 1) or family planning education and counseling (17.6 percent, Model 2). Although Model 3 was most common across both health and multisectoral programs, the least common model implemented by health sector programs was Model 1 while the least common model for multisectoral programs was Model 2. Referral for family planning services were found across all three models. A brief overview and examples of each Model are provided next, and additional analysis on the models by funding stream, regions, and countries can be found in Appendix 3.

Table 2. Matrix of Programs by Family Planning Integration Models

Programs	Total	Family Planning Integration Models*					
		Model 1: Education		Model 2: Education and Counseling		Model 3: Education Counseling and Commodity Services	
	N	N	%	N	%	N	%
All	102	19	18.6	18	17.7	65	63.7
Health Sector	46	3	6.5	11	23.9	32	69.6
Multisectoral	56	16	28.6	7	12.5	33	58.9

* All three family planning intervention categories may include referral to family planning services.

Model 1: Family planning education. While family planning education, including behavior change communication (BCC), was the most common family planning intervention integrated with nutrition and food security interventions across all programs reviewed, only 19 of 102 programs provided only family planning education. Two of these programs also including a family planning referral component. This model was implemented primarily by multisectoral programs (16 of the 19 programs, 13 of which were Title II programs). The family planning, nutrition, and/or food security messages were usually a part of the program's broader BCC or social and behavior change communication (SBCC) strategy and delivered primarily during community group meetings or home visits and sometimes through health education meetings held at a health facility. The following are examples of how Model 1 programs integrated family planning with nutrition and food security.

- In a Save the Children Title II program in Haiti, the SBCC campaign focused on seven key health messages related to nutrition, hygiene and sanitation, water treatment, and family planning. The messages were rotated monthly during the year across all program activities.
- In Guatemala, the Title II Rural Development Program used radio to educate communities on all aspects of food security and health through 20-minute long educational radio programs and shorter public service announcements to reinforce messages, which were aired on the Voice of the Country radio program. The socio-dramas focused on topics such as infant health and nutrition, maternal health, birth spacing, and identification of danger signs during pregnancy.

- In Azerbaijan, Mercy Corps' CSHGP Building Partnerships, Saving Lives employed an approach called "mentors and mobilizers" to empower communities to take responsibility for their own health and that of their children. A team of 18 trained professionals, all local men 26–48 years of age with university degrees in medicine, economics, law, engineering, and the arts, were employed to provide health education. Education topics included breastfeeding, child spacing, danger signs of pregnancy, and home management of pneumonia and diarrhea. The mentors and mobilizers would travel to remote villages in teams of two where the mentor (medical doctor) focused on coaching and providing refresher training to local health care professionals, and the mobilizer worked with village health councils, community health educators, and community members.
- In a CSHGP in Yemen, the program trained facility health workers and community midwives to deliver health education on the technical areas the program promoted, including in contraception and nutrition. The program also trained traditional birth attendants on breastfeeding and family planning. Community midwives and health workers were trained on promoting breastfeeding, importance of family planning, weighing mothers and babies using growth charts, how to diagnose mothers with anemia, conducted cooking demonstrations in the health facilities and all three providers distributed vitamin A to lactating women within 6–8 weeks after delivery and iron folate tablets to pregnant women. Concern Worldwide's CSHGP in Bangladesh used a similar model involving traditional birth attendants and volunteers.

Model 2: Family planning education and counseling. This model, which was implemented by 18 of the 102 programs, includes programs delivering family planning education and counseling at the nutrition and/or food security points of contact. Programs were categorized as providing family planning counseling if documents used the specific term "counseling" to describe the family planning intervention and/or if the documents went beyond describing the intervention as "education" or "providing messages" to suggest that information on specific family planning methods was being promoted by the program. Eleven of these programs were health sector programs and the remaining seven were multisectoral. Six of the eighteen programs implementing family planning and counseling included family planning referrals. The following are examples of how Model 2 programs integrated family planning with nutrition and food security.

- In Adventist Development and Relief Agency's CSHGP in Guinea, community health volunteer teams, including community health workers and traditional birth attendants, delivered family planning and nutrition interventions. The traditional birth attendants maintained the pregnancy/birth registers, promoted immediate and exclusive breastfeeding, and provided birth spacing counseling, including referrals to community-based distributors and health centers for family planning commodities. The traditional birth attendants also provided referrals for other services such as antenatal care (including iron-folate supplementation), malaria prophylaxis, and postpartum follow-up, such as immediate vitamin A supplementation.
- In Jordan, the LINKAGES program supported the Ministry of Health to strengthen the capacity of primary health care staff to integrate breastfeeding counseling, lactation management, and lactational amenorrhea method (LAM) into all maternal and child health centers. The 5-day training included counseling on LAM criteria and the need to transition to other methods such as oral contraceptives, intrauterine devices, condoms, or withdrawal once the criteria were no longer met. In addition, breastfeeding and LAM were also promoted through television and radio spots, posters, clinic-based brochures, and desk flipcharts.
- As part of the program's broader BCC strategy, health agents in the Haitian Health Foundation's CSHGP promoted messages on breastfeeding and natural family planning methods, including the

standard days method and LAM, through home visits, community-based groups including mother's and father's clubs and mobile theater troupes, and community health fairs.

- In Myanmar, the Department for International Development (UK)-funded Joint-Initiative on Maternal, Newborn and Child Health trained basic health staff to deliver essential health services through outreach visits targeting hard to reach areas. During these visits, auxiliary midwives and community health workers delivered services such as antenatal and postnatal care, health education, immunizations, malnutrition screening for mothers and children, promotion of exclusive breastfeeding, and birth spacing counseling.

Model 3: Family planning education, counseling, and commodity provision. Close to two-thirds of the programs (65 of the 102) were delivering some element of family planning education, counseling, and commodity provision across the various nutrition and/or food security interventions within the program. Programs implementing this model were evenly split between health sector (32) and multisectoral (33) programs. Close to half of these programs (46.2 percent) included a family planning referral which might seem odd for programs that had a commodity provision component. However, this is mainly because many of the community-based providers were able to provide certain family planning methods (such as pills and condoms), but referred to the health center for other long-acting permanent methods. The following are examples of how Model 3 programs integrated family planning with nutrition and food security. (The case studies in Appendix 1 provide additional examples of Model 3.)

- In the BASICS-II newborn and child survival program in Nepal, female community health volunteers were involved with providing communities with infant feeding and maternal nutrition messages, participating in vitamin A distribution campaigns, providing family planning counseling, and distributing contraceptives.
- The Enhancing Food Security through Poverty Alleviation Title II program in Uganda trained health extension workers and community health assistants to deliver messages on optimal maternal and child health and nutrition practices including the importance of family planning through education talks held at growth monitoring and promotion and supplemental feeding sessions and mother's group events. With support from a Flexible Fund grant, the program trained government-recognized community reproductive health workers to provide family planning counseling and distribute condoms, birth control pills, and Depo-Provera in addition to training them in community-based integrated management of childhood illnesses, including nutrition.
- In the Albania Child Survival Program, activities focused on formation, training, and support of a village health team made up of a village nurse midwife, a village health educator, and in some cases a leader mother. The team promoted activities on four activities—monthly growth monitoring, home visits, health education sessions with mothers of young children, and family planning focus groups. The nurse midwives were authorized to provide family planning counseling and commodities. The program was also successful in incorporating the standard days method into the Ministry of Health's family planning curriculum and method mix. This model of a team approach was employed by many programs, including the ISCOM CSHGP in Guinea in the form of a village health committee. Traditional birth attendants were trained in nutrition and distributed vitamin A in the community, and community health agents conducted family planning counseling and commodity provision in addition to nutrition activities such as monthly growth monitoring sessions, nutrition talks, and cooking demonstrations. Other members of the village health committee included an HIV/AIDS peer educator.

- In the World Neighbors Terai Program in Nepal, the leaders of self-help groups received training in family planning education and counseling. The program also helped establish NGO paramedical clinics, staffed by an auxiliary nurse midwife and/or a certified medical assistant, who provided services at the clinic and through outreach activities to communities where the self-help groups were located. Services included prenatal care, including nutrition for pregnant and lactating women; postnatal care including immediate breastfeeding, vitamin A, and iron-folate distribution; and family planning counseling and service provision. Trained traditional birth attendants also provided community-based counseling in nutrition and family planning and referrals for family planning and maternal health services.

3.3 Platforms, Contact Points, and Providers for Integrated Service Delivery

A range of platforms, lifecycle contact points, and providers were used for integrated service delivery across the three models both at the community and health facility levels. Platforms and providers were not unique to a specific integration model. For example, in some programs a platform was used to integrate only family planning education (Model 1) and the same platform was used by other programs to implement family planning education, counseling, and commodity provision (Model 3). Examples of how programs integrated family planning using various platforms, contact points, and providers are provided next. Note that programs typically used more than one type of platform or provider and examples are not inclusive of the full range of the programs' interventions. The three case studies in Appendix 1 provide more detailed information on how programs implementing Model 3 used several of the platforms and providers described next to implement integrated services.

Platforms

Some programs used routine service delivery platforms such as mobile clinics and rally posts to deliver integrated services. Other programs added family planning into platforms such as nutrition weeks, farmer field days, or nutrition rehabilitation sessions. Examples are provided next to illustrate how different programs implemented integrated services through different platforms.

Nutrition weeks. Abt Associates' Assistance Technique Nationale Plus program, used national nutrition weeks, held once every 6 months, to target immediate postpartum women and mothers with children under 5 years of age with services such as deworming, screening for malnutrition, vitamin A, and immediate postpartum family planning counseling. Messages included exclusive breastfeeding, return to fertility, and the advantages of child spacing. During the family planning counseling session at the nutrition week, women were given a plastic ticket (see image) to serve as their referral to the health center where they could access the family planning services. The ticket was used by the program to track family planning referrals from the national nutrition week. Similarly, the Santénet program in Madagascar supported bi-annual Mother-Child Health Weeks, during which time the Ministry's health facilities offered services such as growth monitoring, vitamin A supplementation for children 6–59 months and recently delivered women, prenatal consultations, and family planning counseling and service provision. In the

Ticket used by the Assistance Technique Nationale Plus program in Mali to track family planning referrals from the national nutrition week.

Source: Nichols 2013

Strides for Family Health program in Uganda, family planning and reproductive health education was promoted during nutrition fairs.

Farmer field days. In Kenya, the Program Research for Strengthening Services (PROGRESS) program collaborated with Land O' Lakes-supported dairy cooperatives to sponsor health camps as part of 1-day farmer field days. These attracted large numbers of dairy cooperative households and employees where exhibitors marketed products and taught attendees about improved agricultural practices. Family planning education, counseling, and services (such as distribution/provision of oral contraceptives, injectables, and condoms) were provided by trained health providers/clinicians who also provided referrals to the health center for clients choosing long-acting family planning methods.

Rally posts. Community members accessed health services at rally posts usually at a designated place and time once a month. This platform was used by both Title II and CSHGPs, especially in Haiti. Mercy Corps' Title II Maternal and Infant Community Food Diversification Program (known by its Spanish acronym, PROCOMIDA) is an example from Guatemala that implemented services through convergence centers, which are rally posts located in small rural villages. In this program rally posts were used to integrate only family planning education. The program trained both institutional and community-based health teams on key BCC messages promoted by the program, including growth monitoring and promotion, breastfeeding, child spacing, vaccinations, homemade rehydration solution, and how to detect high risk pregnancies and malnourished children. The program trained institutional health teams, a medical team consisting of an ambulatory doctor or nurse and an institutional facilitator who provided basic health services at the convergence center, on BCC messages every 3 months. The community-based health teams were made up of a community facilitator, a community health worker, a trained midwife, and nutrition educators. The community health team staff, specifically the community health worker and the midwife were responsible for making home visits to remind women to go to the convergence centers and were responsible for promoting the BCC messages. The program also trained fieldworkers to deliver BCC sessions monthly on child nutrition, women's nutrition, and health, including family planning, at the convergence centers before the beneficiaries collected their food rations. Following the BCC sessions and food distribution, the fieldworkers also provided recipe demonstrations utilizing the program rations.

In other programs, such as the FOCAS Child Survival Program and three Title II programs in Haiti, services offered at rally posts included growth monitoring and promotion, immunization, deworming, distribution of vitamin A and contraceptives, and health education sessions on various topics including family planning and nutrition. The rally posts were managed by program-trained community health volunteers and community health workers from the Ministry of Health.

Mobile clinics. Under the Extending Services Delivery Associate Award in Burundi, integrated mobile teams delivered a basic package of services including screening for malnutrition, nutrition counseling, family planning counseling, and provision of pills, condoms, and injectables. For clients requesting methods such as implants, intrauterine devices, and permanent methods, referrals were made. The team was made up of a minimum of six members drawn from the district in which the mobile team was created and included a Ministry of Health doctor, nurse, midwife, and community health worker as well as Maman Lumieres (community nutrition volunteers).

Family planning action sessions. Two PHE programs in the Philippines—Save the Children's People and Environment Co-Existence Development and the World Wildlife Fund's Successful Communities from Ridge to Reef—implemented integrated family planning education and counseling using "family planning action sessions" developed by Save the Children, as the entry point to discuss population, family planning, and marine conservation linkages. At these family planning action learning sessions, trained facilitators brought 10–12 couples together to learn about contraceptive methods and population-

environment linkages, used "action cards" to document family planning decisions made by the couples, and made referrals to community-based distributors and health facilities to obtain the method of choice.

Positive Deviance (PD)/Hearth sessions.[6] In the Title II Guinea Food Security Initiative, community health agents who distributed micronutrients (vitamin A and iron-folate) also provided family planning counseling and provided oral contraceptive pills, condoms, and spermicides as part of Positive Deviance (PD)/Hearth or nutrition rehabilitation sessions. The health agents and traditional birth attendants conducted home visits for women participating in PD/Hearth sessions during which time husbands were also sensitized on family planning and immediate care seeking of sick children. A similar approach was used in Guinea for the Title II Food and Livelihood Security in Pita and Telimele program discussed previously. In the Extending Service Delivery Program in Burundi, Maman Lumieres who facilitated the PD/Hearth sessions were trained to provide healthy timing and spacing counseling and referrals, and as discussed earlier, they also participated in integrated mobile teams.

Community/social mobilization techniques. The Environment Health Project and the Madagascar Green Healthy Communities programs in Madagascar, implemented an integrated social mobilization strategy, called "champion communes," to raise awareness of PHE links. As part of the strategy, communities set health and environment goals and targets across the various themes the program focused on, monitored these targets, and celebrated successes. A similar approach was adopted by the Child Survival XVII program in Cambodia through the "Child Friendly Village" initiative where a committee was formed comprising key village leaders, a traditional birth attendant, a village-level volunteer, and a staff member from the health center. Based on community priorities, this committee would set village-wide targets for indicators across the maternal and child health spectrum including modern contraceptive use and exclusive breastfeeding, and villages that met their targets were declared a Child Friendly Village during Village Health Days.

Lifecycle Contact Points

The use of specific lifecycle contact points such as during antenatal care, birth and discharge, postpartum care, or childhood was a strategy employed by all types of integration models. However, this was more commonly found among programs implementing Model 2 and Model 3 as compared to programs implementing only family planning education (Model 1), which tended to more broadly target pregnant women and children under 5 years of age. Programs either targeted a specific lifecycle point, such as antenatal care, postnatal care, or birth and discharge, or more often adopted a continuum of care approach that targeted several or all lifecycle contact points by implementing approaches such as essential nutrition actions or timed and targeted counseling.

Antenatal and postpartum. With support through a Flexible Fund grant, Project Hope's CSHGP in Uzbekistan used patronage nurses trained in breastfeeding, maternal nutrition, and family planning (including LAM) to reach women during antenatal and postpartum care home visits. The program established counseling centers called New Parents' Schools at primary health care facilities where obstetricians-gynecologists and midwives provided education and counseling to expectant parents on pregnancy, breastfeeding, family planning, use of mother home cards, and newborn care. Fathers were specifically targeted at these centers using a "family responsibility" approach. The program also used International Breastfeeding Week to promote breastfeeding and LAM through various materials including posters, leaflets, and TV spots.

[6] PD/Hearth refers to a meeting of a group of five to six parents of malnourished children in a group member's home for a 2-week period where they discuss and learn about infant feeding practices from women who have well-nourished children in the community.

The MaiMwana program (funded by Saving Newborn Lives, UK Department for International Development, and Wellcome Trust) worked in the areas of community-based health promotion and health service strengthening in Mchingi District in Malawi through women's groups and volunteer peer counseling. The program's infant care counseling intervention trained female volunteers identified by local communities in counseling on breastfeeding, key newborn and child care practices, prevention of mother-to-child transmission of HIV and family planning. The peer counselors identified pregnant women and made five home visits during and after pregnancy. These five visits took place in the third trimester of pregnancy, in the first week following birth, and then at 1, 3, and 5 months after birth.

Birth and discharge. Under the Extending Services Delivery Scaling up Best Practice initiative in Yemen, a set of best practices (early and exclusive breastfeeding, kangaroo mother care, vitamin A supplementation, and postpartum family planning, including promotion of healthy timing and spacing and LAM) were promoted by trained health professionals in the obstetrics-gynecology wards and nurseries of hospitals. The program established a room specifically to allow for counseling and to supply women with contraceptives pre-discharge. The program also implemented a quality improvement (Improvement Collaborative) approach. At the community level, the program trained male and female religious leaders to be family planning champions and to support the community in health education efforts (including on benefits of breastfeeding and family planning from an Islamic perspective) through sermons, teachings, and community events.

Africare's CSHGP in Liberia used maternity waiting homes it helped establish as the contact point for integration of family planning with nutrition and food security during antenatal care, birth and discharge, and the immediate postpartum period. Certified midwives and trained traditional midwives run the homes and interact with pregnant women during their stay at the maternity waiting home on adopting healthy lifestyles, early and exclusive breastfeeding, immunizations, family planning counseling, and income-generation activities. In addition, community health volunteers were also trained to provide family planning and nutrition-related messages primarily through group education activities.

Postpartum. In the integrated postpartum care program for midwives in Cambodia, midwives provided a package of interventions including breastfeeding and birth spacing counseling, targeting mothers and newborns through three contact points: at the first postnatal contact (within 24 hours of birth), at the 6-week postnatal care visit, and at all other postnatal contacts. The ACCESS-FP and FRONTIERS programs implemented a postnatal care and family planning package in Kenya through four focused consultations provided by trained staff in one hospital and four health facilities including staff from antenatal care, the maternity unit, the labor/delivery ward, prevention of mother-to-child transmission of HIV services, and the health center in-charges (see Table 3 for timing and content of services).

Table 3. FRONTIERS/ACCESS-FP Program in Kenya: Timing and Content of the Postnatal Care-Family Planning Package of Care

Timing of Assessment or Visit	Services for the Mother	Services for the Baby
Assessment 1: Pre-discharge (or within 48 hours if delivered at home)	• Focused physical exam • Counseling on early breastfeeding and LAM • Healthy timing and spacing of pregnancies • Maternal danger signs and management of complications • HIV and syphilis tests as indicated • Refer to Comprehensive Care Centers for HIV follow up as indicated • Appointment for next visit	• Early breastfeeding • Essential newborn care • Newborn physical exam • Newborn danger signs and management of complications • Nevirapine as indicated • Appointment for next visit
Assessment 2: 2 weeks at maternal and child health clinic	• Physical check • Maternal danger signs and management of complications • Early breastfeeding counseling • Healthy timing and spacing of pregnancy messages • Return to sexual activity • Return to fertility • LAM and family planning counseling and services • Appointment for next visit	• Essential baby care • Baby danger signs and management of complications • Immunization • Early breastfeeding • Physical exam • Appointment for next visit
Assessment 3: 6 weeks at maternal and child health clinic	• Focused physical exam • Maternal danger signs and management of complications • LAM users—supportive counseling including transition • Healthy timing and spacing of pregnancy messages • Return to fertility and sexual activity • Family planning counseling and services (refer women for methods not available at health centers) • Dual method use • Return visit	• Essential baby care • Danger signs and management of illnesses • Immunization • Physical exam • Early breastfeeding • Cotrimoxazole at 4 week as indicated • Appointment for next visit
Assessment 4: 4–6 month check-up at maternal and child health clinic	• Focused physical exam • Transition counseling for LAM users • Healthy timing and spacing of pregnancy messages • Family planning counseling and services (refer women for methods not available at health centers) • Referrals for Comprehensive Care Centers as indicated	• Immunization as indicated • Physical exam • Support weaning and continued breastfeeding • Vitamin A supplement • Return visit for well-baby and immunization at 9 months

Source: Mwangi et al. 2008

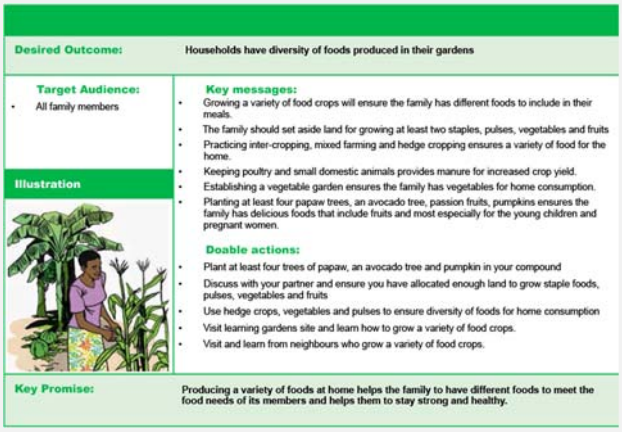
Essential Nutrition Actions (ENA). The ENA framework is an integrated package of seven priority nutrition actions: exclusive breastfeeding for 6 months, adequate complementary feeding starting at 6 months with continued breastfeeding for 2 years, nutritional care of sick and malnourished children, adequate intake of vitamin A for women and children, adequate intake of iron for women and children, optimal nutrition for women, and adequate intake of iodine by all members of the household (WHO 2013a; CORE Group 2011). The priority nutrition messages are intended to be promoted at six contact points across the lifecycle (antenatal care, delivery and immediately postpartum, postnatal and family planning, immunization, growth monitoring/well child, and sick child visits). The following examples show the implementation of ENA in three programs that were delivering the three family planning integration models.

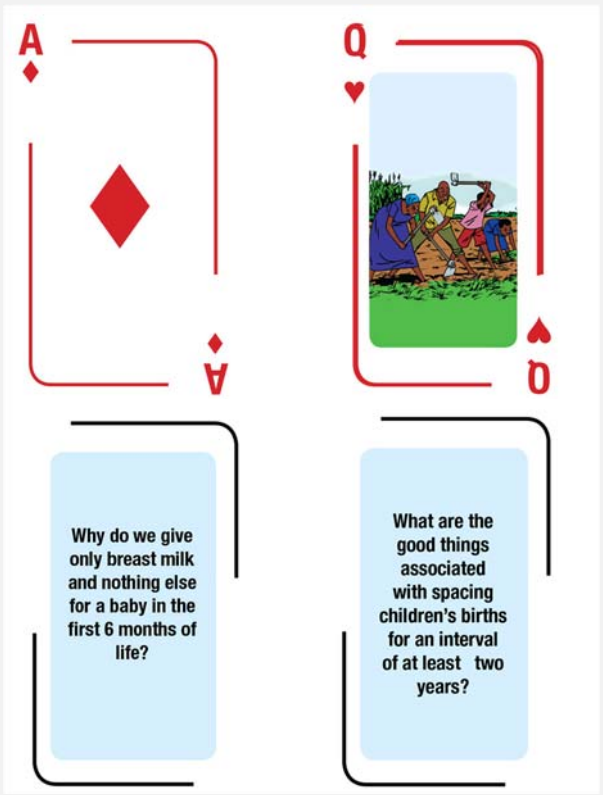
- **Model 1:** The ongoing Feed the Future-funded Community Connectors program in Uganda promotes a Family Life Model in which family welfare is supported by three basic pillars: health, food, and wealth. The program trains community health workers, known as community knowledge

workers, on BCC messages on ENA, spaced pregnancies, improved hygiene and sanitation, and diet diversification. The community knowledge workers provide the messages on ENA and child spacing at child health days, field days, and through youth groups, and also provide referrals for family planning services. They utilize a BCC message booklet developed by the program, which includes child spacing messages (see Box 3). BCC messages are also incorporated into games such as playing cards and "snakes and ladders" for use by youth groups to facilitate discussion around various topics including income generation, financial services, teen pregnancy, child and maternal nutrition, child spacing, and agricultural practices.

- **Model 2:** The ENA approach was also leveraged by programs implementing integrated family planning education and counseling, especially to promote LAM and/or the standard days method. For example, USAID's LINKAGES program in Madagascar and Ethiopia integrated LAM and the transition of LAM to other family planning methods into ENA training for facility and community-based health workers.
- **Model 3:** In the ongoing Suaahara program, female community health volunteers, a new cadre of community volunteers (*poshan aama* or "nutrition mothers"), and health center staff are being trained in an "ENA+ package." In addition to the seven standard priority nutrition actions, the package also includes: promotion of child spacing and family planning; dangers of smoking to the health of mother and baby; treatment and safe storage of drinking water; handwashing with soap or ash at critical times (after defecation or handling feces and before preparing food, feeding children, and eating); safe disposal of feces; proper storage and handling of food to prevent contamination; and community construction and use of affordable latrines. The program raises awareness of healthy timing and spacing of pregnancy and offers a range of family planning methods across various intervention points. For example, community providers counsel mothers and families about nutrition, healthy timing and spacing of pregnancy, and hygiene during home visits, mother's group meetings, monthly growth monitoring events, and village model farms (demonstration sites to learn about poultry production and home gardening). Health center

Box 3. Community Connector BCC Message Booklet and Cards



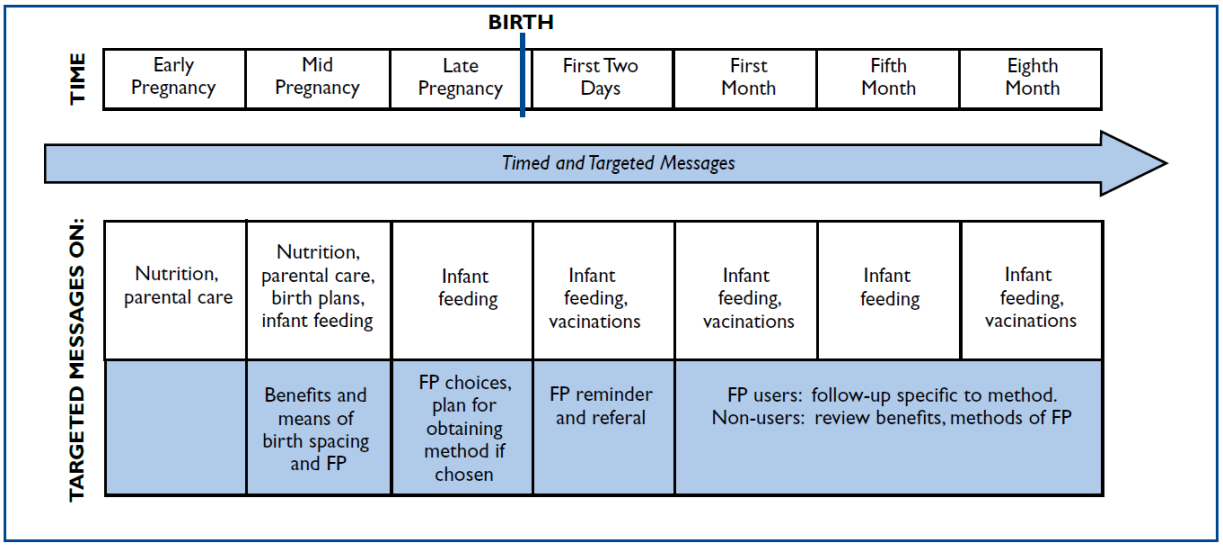


Source: USAID/Community Connector 2013

staff target women who come for postpartum visits to deliver integrated nutrition and family planning services, including LAM.

Timed and targeted approach. Another example of the lifecycle or continuum of care approach, was found in World Vision's child survival Pragati program in Uttar Pradesh, India. In this approach, key messages were bundled, timed, and targeted to reach families through a series of seven scheduled visits by community health workers—three during pregnancy, one after childbirth, and three during infancy (see Figure 2). During the home visits, the trained community volunteers delivered the targeted message related to nutrition, birth spacing and family planning, and immunization; followed up on previous messages; and documented any changes in behavior or services used. World Vision developed a toolkit for implementing this strategy which includes: a counseling plan, three color-coded registers (pregnancy, infant, and family planning) and protocols for the use of these registers, a standardized supervision checklist, manuals for community-level providers, and manuals for training and supervision.

Figure 2. Pragati Program Schedule of Targeted Messages Delivered During Seven Home Visits



Source: Toth 2008

Providers

Similar to the range of platforms used across the programs, the review also found a range of providers involved in delivering integrated nutrition, food security, and family planning services. As is evident from many of the program examples discussed in this report, the majority of programs trained both community- and facility-based providers. Examples are provided next to illustrate how different programs integrated family planning with nutrition and food security through different providers.

Community-level providers. Community-level providers were critical to most program integration strategies. Most often, the family planning education component (Model 1) was delivered through the various platforms described previously by community health workers and/or community volunteers. Community health workers and volunteers were also involved in programs implementing Models 2 or 3, with the only difference being that in addition to family planning education, the providers were also trained to offer family planning counseling or counseling and commodity provision. Alternatively, in some programs, these providers were only involved with the education component and other cadres were responsible for providing family planning counseling and/or commodity provision. The following three program examples highlight how programs used community-level providers to implement the three integration models.

- **Model 1:** The Peru Child Survival XVI program implemented Model 1 through community health agents, including health promoters, traditional birth attendants, and female leaders. All three cadres were trained to identify pregnant women, including high-risk mothers and children; provide education on maternal and child health, child spacing, and nutrition; and provide referrals to health centers for antenatal care, common childhood illnesses, and family planning services. In addition, midwives assisted pregnant women and their families to develop a birth plan, which included postpartum family planning and nutrition.
- **Model 2:** In the Title II Afghanistan Health and Livelihood Initiative in Ghor, community health promoters, in collaboration with the mother's and father's groups they helped establish, conducted growth monitoring and provided families with education on nutrition, family planning, and home gardening. During home visits, the promoters distributed BCC materials, which included messages on nutrition and birth spacing, and provided family planning counseling with a conscious effort to involve men by applying a family approach.
- **Model 3:** The Haiti Child Survival CSHGP that used community health promoters and traditional birth attendants provides an example for Model 3. The promoters organized and conducted community health education sessions, including on breastfeeding and family planning. The promoters were also trained to distribute barrier methods during home visits and to provide referrals to health center staff for first time users of hormonal methods. After the client received an initial counseling session at the health center from an auxiliary nurse, the promoter was also allowed to dispense hormonal methods, including oral contraceptives and Depo-Provera. Traditional birth attendants were trained on various health topics including family planning and nutrition education (although the type of family planning services provided by traditional birth attendants was unclear from program documents).

Community groups. Community-level providers were often organized in groups and a wide range of community-based groups were used as entry points or platforms to deliver family planning and nutrition and/or food security activities including care groups, women's empowerment groups, mother's clubs, father's clubs, breastfeeding support groups, farmer's groups, and associations for people living with HIV.

For example, the care group model was found across both CSHGPs and Title II programs, especially to promote family planning and nutrition education (Model 1) activities. A CSHGP in Malawi helped communities create care groups and trained care group volunteers as behavior change agents to visit households and promote key messages related to the program's six interventions: nutrition, malaria, child spacing, pneumonia case management, prevention of HIV/sexually transmitted infections, and maternal and newborn care. Some care groups also undertook communal cultivation of vegetables and other crops to help the elderly and the sick especially at times of acute food shortage. Similar examples were found in Title II programs in Burundi and Sierre Leone. Care groups were also used to implement Model 3 in programs such as the Census-based Impact Oriented Child Survival Program in Guatemala, the Tuendelee Pamoja Title II program in the Democratic Republic of Congo, and the Ramba Kibondo (Live Long Child) Program in Haiti (see case study in Appendix 1).

Other programs used mother's and father's clubs or women empowerment groups. In health sector programs, the groups discussed only health topics including nutrition and family planning. In some multisectoral programs, the topics discussed in these groups were not always limited to health, but also expanded to the agriculture and livelihoods sector. Group activities may also have been expanded to include access to microcredit and other activities that complemented health and nutrition messages such as home vegetable gardening (not only as a source of food produced at the household level, but also as a source of income generation).

Most PHE programs were delivered using a volunteer cadre of promoters usually recruited through the community group that was being leveraged as the entry point for the PHE interventions. In Ethiopia, peer educators were members of micro-watershed committees; in Rwanda they were coffee extension agents; in Zambia they were lead farmers belonging to producer groups; and in Nepal they were community forest user group members. In each country the strategy was essentially the same—adult and youth peer educators delivered integrated PHE messages through various community meetings. Some of them were also trained to serve as community-based distributors for family planning commodities, mostly condoms and pills, and provide referrals to the health centers for other family planning methods. In Uganda, conservation officers and community health workers within village health teams delivered PHE messages, including family planning counseling. They used various strategies such as door-to-door and group activities, including evening campfires (to reach more men) where they asked questions about family planning, distributed condoms, and provided referrals to health centers. The program also worked through tree nursery cooperatives. In the World Wild Life Fund's Successful Communities from Ridge to Reef program in Madagascar, volunteer peer educators followed up monthly PHE meetings with home visits to promote the PHE interventions. Half of the volunteers served as community-based distributors and half as "motivators."

Facility-level providers. Very few programs implemented integrated activities only through health facility providers; most included both health- and community-level providers. The Women and Infants' Health program and the follow-on Maternal and Child Health Initiative in Russia provide an example of family planning counseling and services that were integrated into the maternal and infant health care spectrum within health facilities. Key program components included promotion of client-friendly, family-centered antenatal care, essential care of the newborn, exclusive breastfeeding support, and family planning counseling and services. The programs targeted trained health professionals in health facilities including maternity hospitals, gynecological units, women consultation clinics and family planning centers, children's polyclinics, and HIV centers to plan and implement this integrated package. Other examples discussed earlier that used only facility-level providers include the LINKAGES Program in Jordan and the ACCESS-FP and FRONTIERS program in Kenya.

Private health providers. Social marketing approaches and private health providers were used by a couple of Model 3 programs linking community- and facility-level services. For example, in the Social Marketing Strategies for Maternal and Child Health Program in India, PSI developed a network of trained private health providers, retailers, and female community health volunteers to provide information and promote PSI's products related to four maternal and child health issues—maternal and newborn care, diarrheal diseases, birth spacing, and child nutrition. The providers included Indian Systems of Medicine and Homeopathy Practitioners who were trained to counsel women and offer socially marketed products during regular office visits. Volunteers implemented community education during mother's group meetings or home visits and used a coupon referral system.

In Bangladesh's Smiling Sun Franchise Program, trained providers in Smiling Sun clinics provided maternal and child health services, including maternal nutrition, child nutrition, safe delivery, and family planning as part of antenatal and postnatal care. The program supported the Government's strategy by promoting use of long-acting and permanent family planning methods and provided clinical training to service providers to ensure high-quality screening, address side effects, and clarify misconceptions related to the methods. Community service providers were trained to conduct door-to-door services to: spread key messages, including on birth spacing, delayed marriages, and nutrition; encourage people to visit Smiling Sun clinics; and sell health commodities including contraceptives, MoniMix (a vitamin and mineral sprinkle for children), safe delivery kits, and oral rehydration salts.

Government health workers. Supporting implementation of national health packages involving government health workers was used by programs implementing Model 2 and Model 3. For example, CARE India's Title II Reproductive and Child Health, Nutrition and HIV/AIDS Program supported implementation of India's Integrated Child Development Services and Reproductive and Child Health Programs. Integrated services were delivered by *anganwadi* (child care) workers at various contact points including at home visits, at *anganwadi* centers, and through health and nutrition days. Family planning/child spacing education, counseling, and referrals were integrated into the integrated nutrition and health program interventions, which included food supplementation, vitamin A, iron and folic acid, improved breastfeeding, and complementary feeding.

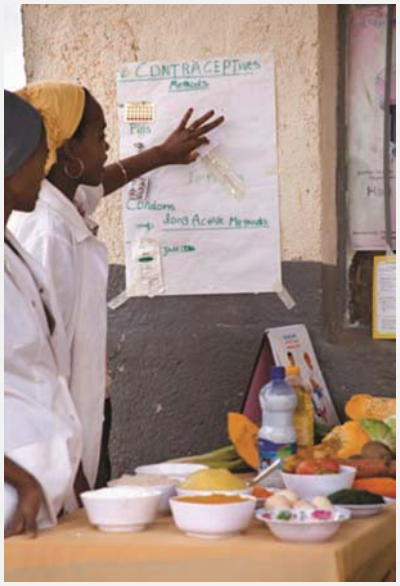
Several programs in Latin America, such as Title II and CSHGPs implemented in Guatemala, Honduras, and Nicaragua, used antenatal care and child health contact points, including growth monitoring and promotion and home visits as part of the national Integrated Community Child Health (*Atención Integral a la Niñez en la Comunidad* or AIN-C) strategy to provide counseling on recommended feeding practices and promote improved reproductive health, including the use of family planning, immunization, and prevention of HIV and sexually transmitted infections. LAM and the standard days method were promoted as part of the family planning method mix, and women were referred to health centers to obtain other family planning methods. The AIN-C strategy is delivered in the communities primarily through community health workers referred to as AIN-C monitors, or in some cases *brigadistas* or rural health promoters, and they delivered services through rally posts, convergence centers, basic health units, or *casa* bases. The Title II Development Activity Program in Nicaragua formed village health committees made up of a coordinator, health volunteers know as AIN-C promoters or *brigadistas*, and a food security promoter. The AIN-C promoters delivered nutrition and birth spacing messages during home visits to households with children at high risk for malnutrition and other factors suggesting significant household food insecurity. The AIN-C promoters organized mother's and father's clubs, a group of 10–12 members with children under 5 years or pregnant women, led by a group-elected leader. The lead mother and father assisted the AIN-C promoter in recruiting the rest of the club members. Club leaders were trained in leadership and appropriate adult education techniques. The mother's club members meet to discuss a range of maternal health topics including nutrition and birth spacing. In the father's clubs, topics also included agricultural production and family garden management

The bilateral Integrated Family Health Program implemented by John Snow, Inc. and Pathfinder International supports the Government of Ethiopia's Health Extension Program. The health extension workers implement 16 health packages, including family planning and nutrition (see Box 4). They identify "model families" and from these model families recruit volunteer community health workers to assist them with community outreach, such as holding community conversations on various topics including family planning, gender relations, and harmful traditional practices. With support from the Bill and Melinda Gates-funded Alive and Thrive project, the Integrated Family Health Program also trained several health extension workers in the essential nutrition actions who in-turn trained community health volunteers. Nutrition activities included promotion of breastfeeding, complementary feeding, vegetable gardening, and vitamin A and iron supplementation. The health extension workers provide family planning counseling and service provision in the community, at health posts, and at health centers (which include stabilization centers for malnourished children). They also provide nutrition demonstrations that are held at education sessions at the health centers. The program also supported the government in the introduction of Implanon (a single-rod contraceptive implant) through which 200 health extension workers were trained by master trainers (nurses and clinicians).

In an ongoing CSHGP in Malawi, the program is training the government's paid cadre of community health workers known as health surveillance assistants and their supervisor nurse midwives, to implement a community package called Integrated Maternal, Newborn and Child Health and Postpartum Family Planning. The health surveillance assistants conduct antenatal and postnatal home visits and use an integrated counseling card, which covers topics and desired behaviors from pregnancy, childbirth, postpartum pregnancy, and child health. The assistants were trained to provide injectables, oral contraceptives, and male and female condoms and make referrals to a skilled provider for other family planning methods.

Box 4. Health Packages within Ethiopia's Health Extension Program

1. Disease prevention and control (HIV and other sexually transmitted infections; tuberculosis; malaria; and first aid emergency measures)
2. Family health (maternal and child health; family planning; immunization; nutrition; and adolescent reproductive health)
3. Hygiene and environmental sanitation (excreta disposal; solid and liquid waste disposal; water supply and safety measures; food hygiene and safety measures; healthy home environment; control of insects and rodents; and personal hygiene)
4. Health, Education, and Communication



"Beza, the HEW [health extension worker] at Illalem, explains the ingredients and the recipe for the porridge, the benefit of each ingredient, and how to cook the porridge. Community volunteers take the lead in cooking the porridge. As the porridge cooks, Beza teaches the gathered women about other family health elements. They listen as she explains about the various choices of family planning methods, followed by how to set up a mosquito net properly for protection from malaria and other health packages."

Source: Pathfinder International and John Snow, Inc. 2013, pp. 1, 16

4 Program Documentation and Limitations

This review had a broad scope—to carry out a landscape analysis of program efforts to integrate family planning with nutrition and/or food security interventions. It captured a broad range of integration strategies across health and multisectoral programs as discussed in the previous section. However, the large scope and the heterogeneity in the types of programs, including the interventions and outcomes measured, posed challenges in the analysis and synthesis of findings, especially in identifying promising practices. The review also highlighted several important gaps in the evidence base and available program documentation, underscoring the need for stronger program documentation on the integration process and more systematic monitoring and evaluation efforts to capture the success of integrated programs. A summary of these challenges and gaps are discussed further in this section

Weak program documentation on the integration process

This review is based primarily on grey literature; program documents were not, in most cases, readily available, which presented a significant challenge and delays. Although extensive efforts spanning 5 months were made to obtain program documents from various sources, there was a lot of variation not only in the documents that were obtained, but also in the quality and level of documentation on family planning and integration within these documents. In many cases, since family planning was part of a larger package, program documents didn't focus specifically on family planning, and even fewer specifically on integration with nutrition and/or food security program components. This information gap doesn't suggest that these programs did not have program learnings about nutrition/food security and family planning linkages but highlights that these learnings are not well documented and reiterates the underlying limitation of trying to tease out these programmatic elements from broader packages.

The classification of programs into Model 1, family planning education, versus Model 2, family planning education and counseling, was often challenging because program documents didn't always make the distinction between education and counseling. However, to better understand the level of family planning provided at the nutrition and/or food security points of contact across these programs, an effort was made during analysis to differentiate between these two levels of family planning interventions. For Model 3, although 18 of the 65 programs included a commodity provision component, it was not entirely clear from the program documents if these programs provided family planning counseling at the nutrition and/or food security points of contact. Similarly, the actual intervention(s) and the specific role(s) of the providers across these interventions within these integrated programs was not clearly explained in the available documentation. The variation in terminology used to describe the various cadres of health workers and providers involved in delivering integrated services was also challenging. Variation in terms was observed not only across programs, but also across the various program documents within a single program. The findings presented in this report are based on reviewers' best understanding of program implementation and the family planning/nutrition/food security linkages from the available information. Although a few programs suggested that integrated efforts reduce costs anecdotally, only a handful of programs provided data on the cost of providing integrated services.

Although referrals to family planning services are occurring, information on the referral process is limited

Although referral for family planning services was found in a little over a third of the programs included in this review, in general, there was limited information in program documents on the type of family planning referral system in place. This is a common challenge experienced even with stand-alone family planning programs. In general, two types of referrals were found. The first type of referral that was

reported was when community-based providers (e.g., community health workers, volunteers, care group leaders, and peer educators) provided family planning education and/or counseling, and then referred clients to health facilities to obtain the services. The second was where the providers were only authorized to provide certain family planning methods (e.g., condoms, pills, and injectables) but would refer the client to a health facility for long-acting and permanent methods not available through the provider.

Measurement of the referral component was also weak—programs with a referral component rarely included an indicator specific to referrals. An example of indicators that were measured by one program includes: "number of women referred and/or utilizing family planning services," and "number of women provided with family planning services." With a few exceptions, such as use of a plastic ticket or a referral slip, for the majority of the programs with a referral component, it was unclear whether the referral was verbal, paper-based, or facilitated. It was also generally unclear whether the provider making the referral was formally linked to the health facility; to which provider(s) in the health center (nurse, mid-wife, or doctor) the referral was made; how the referral was being tracked by the person making the referral or by the health facility (counter-referral systems); and the extent to which those who received referrals went on to receive family planning services at the health center.

Significant variation exists in measurement of family planning across programs

Although most programs (82 percent) measured at least one family planning indicator, there was significant variation in the family planning indicators used across programs. Even when the same indicator was measured, there were variations across the programs in the indicator definitions, the target populations, and the data collection methods used. Indicators varied by funding stream and were driven by grantee requirements. For example, CSHGPs often measured a birth spacing indicator: "the percent of children 0–23 months who were born at least 24 months after the previous surviving child." Several PHE programs measured couple years of protection and included process indicators such as: "number trained in family planning," "number of community-based distributors," "number of new acceptors of family planning," and "source of supply of family planning." Programs receiving Flexible Funds measured the most number of family planning indicators per the grant program's reporting guidance. The most common indicator measured across all models was modern contraceptive use. The following are additional findings in regards to measurement.

- Not all programs promoting LAM measured LAM indicators. Indicators such as knowing the three criteria of LAM and LAM user rate were found.
- Process or program output indicators such as "number trained in family planning" was commonly measured across the various funding streams—however variations were also found such as "number trained in family planning or child spacing" or "number trained in healthy timing and spacing of pregnancy."
- Examples of family planning indicators used by programs to measure family planning at the facility level include: "percent of health facilities providing child spacing activities," "number of recipients receiving a contraceptive method per month," and "percentage of health care centers with a supply of free contraceptives."
- Very few programs included indicators specifically focused on counseling. A few examples included: "percent of mothers who received counseling about birth spacing during the post-partum period," "percent of mothers/caregivers who know three methods of family planning," and "percentage of family planning clients who received counseling on family planning choices, common side effects, and when to return to fertility."

- Other process indicators measured by Model 3 programs included: "number of family planning products sold" or "number of contraceptives distributed." One of the PHE programs also measured: "distance women had to travel to secure family planning supplies."
- Although programs are measuring process and outcome indicators on family planning and on nutrition and/or food security, less than 20 percent of the programs captured data on nutrition-family planning or food security-family planning integrated services. Examples of integration indicators captured from program documents included:
  - Percent of family planning consultations provided to people who reported an affiliation to a (dairy) cooperative
  - Percent of all health workers trained in Integrated Community Package; Proportion of women who receive full package of care visits
  - Number of providers trained in PHE; Number of people counseled in PHE
  - Number of local entities that provide drug, vitamin A seeds, weaning food, bed nets, birthing kits, family planning materials and/or ORS on a cost-recovery fund basis
  - Proportion of postpartum women receiving a contraceptive before discharge
  - Proportion of postpartum women delivering in the hospital receiving counseling on exclusive breastfeeding and LAM
  - Percent of antenatal care clients who knew criteria for LAM; Percent of postpartum women who knew criteria for LAM; Percent of mothers with children aged 0–23 months who received information regarding LAM during their pregnancy and postpartum visit

Evidence gap on effectiveness of family planning integration models

In an effort to identify "successful" integration models, an analysis of reported outcomes was conducted on completed programs with baseline and end-of-program quantitative data available for select family planning and nutrition and/or food security outcomes through evaluation reports. As in the case of family planning, there was also much variation in the indicators reported for nutrition and food security. Incomplete or unavailable documentation and variation in indicators measured across the programs limited the analysis to 21 of the 102 programs (13 CSHGPs, 8 Title II). The following outcomes were selected for analysis because they were measured by at least three of the programs that met the criteria for this analysis (see Appendix 4 for detailed analysis):

- Nutrition outcomes: stunting, underweight, wasting, early breastfeeding, exclusive breastfeeding, introduction of complementary feeding, infant and young child feeding composite indicator, and vitamin A supplementation for women and/or children
- Food security outcomes: household dietary diversity score, months of adequate food provisioning, and use of sustainable practices/improved technologies
- Family planning outcomes: use of modern family planning methods, birth spacing, and met need for family planning

The analysis highlighted that within these large integrated programs, it is possible to improve nutrition, food security, and family planning outcomes. In most cases, at least a subset of the relevant outcomes improved within a program. However, since the nutrition, food security, and family planning interventions were a part of broader packages, this type of evaluation data has limitations in being able to identify successful or promising integration models. This is because the programs involve several other interventions or inputs for each technical area (nutrition, food security, and family planning) that go

beyond the integration model extracted for this review, which was limited to what type of family intervention(s) were taking place at the nutrition or food security point(s) of contact. Only a handful of programs tested the effectiveness of an integrated approach versus a single sector approach, tested the feasibility or effectiveness of an integration model, or included evaluations with comparison groups. These programs' findings are discussed in the promising practices section, however, more evidence is needed in this area.

5 Potential Promising Practices for Programming

The following potential promising practices were identified based primarily on a synthesis of facilitators and barriers to integration reported in program documents. These themes emerged as recurrent or common themes across the programs included in the review and could offer a starting point for programs interested in this type of integration. In some limited instances research was conducted as part of a program to specifically test a family planning integration model or approach. When available, such research findings are included here to provide support for the promising practice. The limitations of extracting promising practices related to integration and using available evaluation data have been discussed previously.

Build on existing platforms. A strong community network or existing program infrastructure facilitates expanded services. Building on existing program infrastructure helps programs reduce costs (transport, training, and personnel), achieve rapid results, and prime communities for expanded services while building trust and allowing communities to benefit from the cumulative effect of a broad spectrum of continuous efforts. Leveraging existing convening mechanisms (farmer field days, nutrition weeks, rally posts, and growth monitoring sessions) and community structures (care groups and producer groups) that have already demonstrated success in effectively bringing people together at an established time and place also facilitates the addition of an expanded program model (e.g., the addition of family planning). Refer to the case studies for an illustration of how the Rambo Kibondo, Sak Plen, and Community Markets for Conservation programs used existing platforms like care groups, rally posts, and producer groups to integrate family planning (Appendix 1).

The Blue Ventures program in Madagascar is a good example of how an award-winning marine conservation NGO in Madagascar uses its biodiversity conservation platform to integrate a community health program. Since 2003, Blue Ventures has been working with coastal fishing communities in southwest Madagascar to protect ecological sites within the marine ecosystem by banning destructive fishing practices and promoting alternative livelihoods through community-based aquaculture efforts (seaweed and sea cucumber farms). Building on this strong platform and the existing relationships with these communities, in 2007, Blue Ventures adopted a PHE approach by including community education on the linkages between reproductive health, population growth, food security, resource use, and marine conservation. Peer educators deliver integrated messages on these topics, which are delivered through village outreach tours, radio, football tournaments, and group meetings. Through its community health program—*Safidy* (which means "freedom to choose")—Blue Ventures trains midwives to conduct outreach family planning clinics in different villages, and trains local women to serve as community health workers who provide community-based family planning and nutrition as part of maternal and child health services. They provide education and counseling on sexual and reproductive health and family planning; antenatal and postnatal education; and commodities including condoms, pills, injectables, vitamin A, iron-folate supplements, diarrhea treatment kits, and mosquito nets. They receive the contraceptives at cost-price from PSI and can sell them in their villages for a small price. Some community-based distributors are also certified to provide Depo-Provera injections using clinical protocols under the supervision of the midwives. The PHE approach has led to the development of a locally managed marine area of 678 km^2 known as Velondriake; a monthly income of up to US$20 per sea cucumber farmer and US$42 per seaweed farmer where 44 percent of sea cucumber farms and 55 percent of seaweed farms are led by women; and "9,730 months of oral contraceptives, 3,101 Depo-Provera injections, 293 implanon implants and 60 intra-uterine devices being provided to approximately 3,000 women of reproductive age during the first six years of the program" (Mohan and Shellard 2014).

Two pilot programs also offer findings on the feasibility and effectiveness of integrating family planning using existing platforms. The Assistance Technique Plus Project in Mali discussed earlier in this report pilot tested the integration of family planning messages and counseling through national nutrition weeks held twice a year. The pilot demonstrated: over 98 percent of immediate postpartum women reached by national nutrition weeks participated in family planning counseling sessions; the number of new family planning users from 6 months before the pilot period compared to 6 months after the pilot activity significantly increased and close to doubled in some districts; and acceptance from providers, clients, and communities for integration of family planning and nutrition (Nichols 2013).

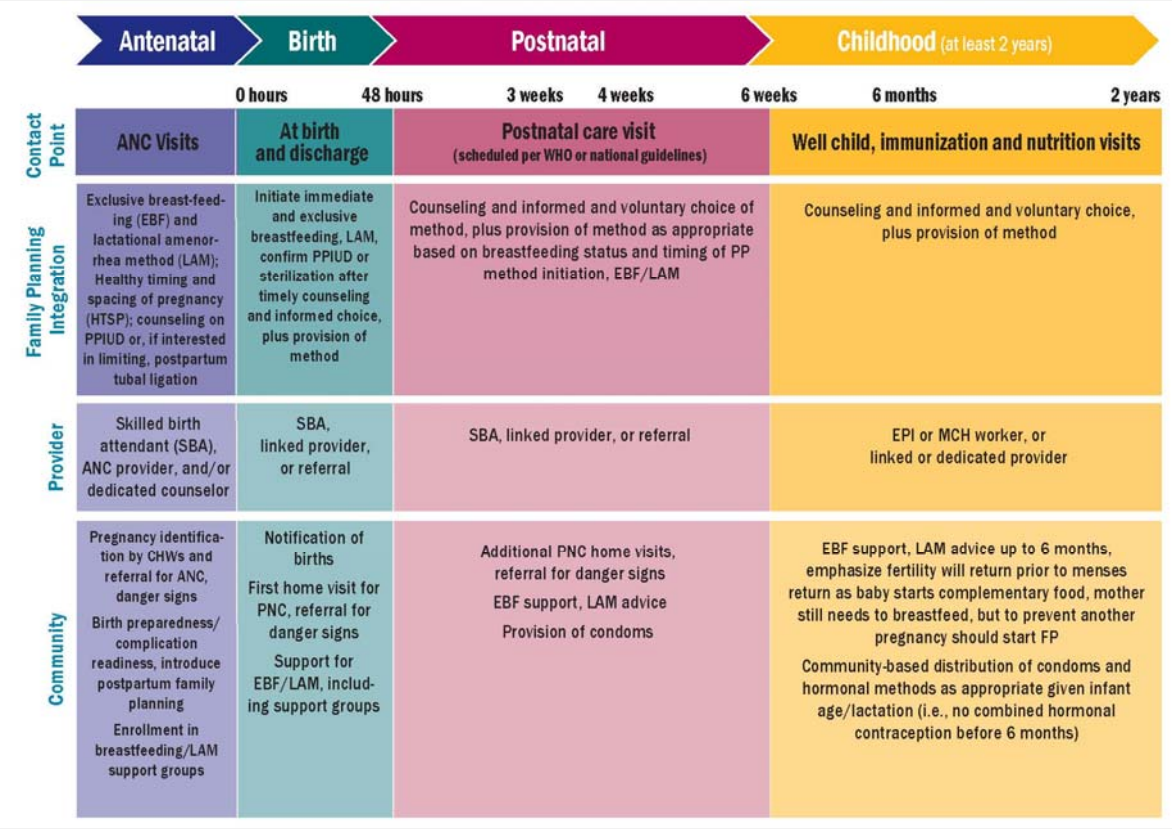
The other program, PROGRESS (also discussed earlier), collaborated with Land O' Lakes-supported dairy cooperatives on a pilot study to assess a model of providing family planning services through health camps as part of 1-day farmer field days. The pilot study of seven health camps showed high service utilization with over 80 percent of the 2,344 attendees receiving health consultations. Family planning counseling was the second most common service (18 percent) following general health exams (66 percent). A quarter of current family planning users restocked contraceptive supplies at the health camp. Among the 319 women surveyed, none of the women classified as having an unmet need (15 percent) for family planning initiated a modern method of family planning during the event. The reasons provided were either not wanting a contraceptive method or wanting a method not provided at the health camp. These women were provided a referral to the closest health facility where the method of choice was available (Otieno-Masaba et al. 2013).

Target the first 1,000 days. Focusing on the 1,000-day period (from a mother's pregnancy up until the child is 2 years of age) through a continuum of care model allows programs to reach mothers at a critical time for both nutrition and family planning. Promoting messages that are appropriately timed to reach women and their families at the right time to ensure that the messages are not too early or too late for the behavior that is being promoted is also critical.

This review highlighted the use of several relevant approaches and platforms that cover the 1,000-day period that can be used for nutrition and family planning integration such as ENA, World Vision's timed and targeted counseling, and the preventing malnutrition in children under 2 years of age approach (PM2A). Using the ENA approach, the LINKAGES program in Madagascar (2000–2005) demonstrated significant improvements in program districts in 10 indicators including early initiation of breastfeeding, exclusive breastfeeding, continued breastfeeding, nutritional care of the sick child, mother's increased intake of food during lactation, LAM use, iron-folate supplementation during pregnancy, and postpartum vitamin A supplementation (Guyon et al. 2006). The timed and targeted counseling approach to BCC used by World Vision in the Pragati CSHGP was found to be culturally appropriate and contributed to more than doubling the contraceptive prevalence rate in program zones over 4 years. The program was also successful in improving vitamin A supplementation and complementary feeding outcomes, but not exclusive breastfeeding rates (Toth 2008; World Vision 2008).[7] The MIYCN-FP Integration Working Group has developed a framework and examples of integrated counseling and services (see Boxes 5 and 6), which can be used by programs as a resource on the opportunities for integration during the 1,000-day window of opportunity.

[7] In collaboration with Johns Hopkins Bloomberg School of Public Health, World Vision is implementing the Child Health Target Impact Study (2012-2017) which is expected to provide additional evidence on the impact and the cost effectiveness of the timed and targeted approach. More information is available at: http://www.wvi.org/publication/child-health-target-impact-study.

Box 5. When to Integrate Maternal, Infant, and Young Child Nutrition and Family Planning



Source: MIYCN-FP Working Group 2014c

Box 6. Examples of Integrated Maternal, Infant, and Young Child Nutrition and Family Planning Counseling and Services

Time	Family planning counseling and messages	Nutrition counseling and messages
Adolescence	Advise young girls to wait until at least 18 years of age before becoming pregnant, for the healthiest outcome for themselves, their pregnancies, and their babies. Encourage the delay of early marriage and/or the use of family planning to prevent pregnancy too young. Counsel on and offer a range of FP methods.	Educate youth on the importance of good nutrition, especially girls.
Before pregnancy	Counsel on the benefits of healthy timing and spacing of pregnancies. For women living with HIV who want to get pregnant, encourage them to seek services at a health facility to learn about how to keep viral load low, track fertility, and adhere to treatment for a healthy pregnancy. Counsel on and offer a range of FP methods.	Counsel on the need to take iron/folate and use iodized salt for women who are trying to get pregnant or who think they are pregnant; the importance of maternal nutrition during pregnancy and breastfeeding; and the value of immediate and exclusive breastfeeding for six months. For women living with HIV, counsel on additional nutritional considerations.
During pregnancy	Counsel on family planning methods that can be initiated immediately after birth, such as LAM, a postpartum intrauterine device, or sterilization (postpartum tubal ligation or vasectomy) for couples who want to limit future pregnancies. Encourage giving birth with a skilled birth attendant.	Counsel on the importance of early use of iron/folate supplements and use of iodized salt during pregnancy; maternal nutrition and adequate weight gain during pregnancy; immediate and exclusive breastfeeding for six months; and continued breastfeeding while giving complementary foods from 6 to 24 months. For women living with HIV, counsel to exclusively breastfeed, which promotes HIV-free survival as compared to nonexclusive breastfeeding/mixed feeding.
Birth through 7 days	Counsel on LAM and the benefits of healthy spacing of pregnancies.	Encourage giving colostrum; provide support for immediate breastfeeding; and counsel on the benefits of exclusive breastfeeding for all mothers and children, including those living with HIV. Provide counseling on management of breastfeeding problems and nutrition for breastfeeding mothers; provide iron/folate supplements for mothers and counseling on vitamin A intake for mothers within eight weeks after birth in countries where it is policy to give vitamin A postpartum. In all countries, mothers should be encouraged to consume food that is rich in vitamin A on a daily basis.
6 to 8 weeks	Encourage postnatal care; remind women of the three LAM conditions; advise that return to fertility can occur prior to onset of menses in women who are not exclusively breastfeeding; and counsel on family planning methods compatible with breastfeeding if not using LAM (progestin-only hormonal contraception, intrauterine device, tubal ligation, vasectomy, condoms).	Continue to support exclusive breastfeeding to 6 months (baby does not need any other fluids, not even water); address any breastfeeding problems the mother may have and reassure her that she can produce enough milk. Ensure that mothers receive a vitamin A supplement by eight weeks after birth (if consistent with national policy), and provide iron/folate supplements for anemic mothers.
3 to 6 months	Counsel on healthy birth spacing, return to fertility, and family planning methods based on breastfeeding status; screen for LAM transition; provide family planning methods (see above); or refer mothers not practicing LAM.	Counsel on maternal nutrition and provide iron/folate supplements as needed. Continue to support exclusive breastfeeding.
6 to 9 months	Counsel on the need to initiate another modern family planning method even if menses has not yet started, and provide or refer for family planning methods.	Ensure introduction of complementary foods at 6 months, and counsel on providing energy- and nutrient-dense complementary foods and continuing breastfeeding for two years or beyond.
9 to 12 months	Counsel on family planning, and provide family planning methods or refer.	Counsel on nutrition for breastfeeding mothers optimal complementary feeding, and counsel on and provide support for continuing breastfeeding for two years or beyond.
12 to 24 months	Remind mothers about healthy birth spacing, and provide family planning methods or refer.	Support optimal complementary feeding and continued breastfeeding for two years or beyond, and counsel on the benefits of extended breastfeeding for the mother's health, such as reduced risk for some cancers and heart disease.

Source: MIYCN-FP Working Group 2011

Include home visits. Home visits offer an opportunity for nutrition and family planning counseling that can be tailored to individual needs and also provides an opportunity to target and involve family members who influence uptake of nutrition and family planning practices promoted by the program. Operations research is available to support this. The Healthy Fertility Study in Bangladesh tested the integration of postpartum family planning services into the community-based Projahnmo (Project for Advancing the Health of Newborns and Mothers) maternal and neonatal health program. Using a quasi-experimental design, two intervention groups received an integrated maternal and neonatal health/family planning package and two comparison groups received only the maternal and neonatal health package. With interpersonal communication and counseling at the core of its BCC strategy, female community health workers delivered maternal and neonatal health and family planning messages through home visits according to a schedule (see Table 4). During home visits, the female community health workers discussed women's plans for antenatal and postpartum care with a specific focus on joint problem solving for potential barriers women and their families face in accessing care and adopting behaviors such as exclusive breastfeeding and family planning. In addition to family planning education and counseling, community health workers were equipped midway through the study to provide oral contraceptives, condoms, and injectables to postpartum women and referrals to health centers for other family planning methods. At the same time, community mobilizers (a team of one male and one female) conducted monthly community sensitization meetings with men, religious leaders, teachers, and mothers-in-law. During these meetings, women who successfully practiced LAM were recognized and served as "LAM Ambassadors" and promoted the use of LAM with other women in the community. Findings from the study showed that the integrated model was associated with a decrease in the incidence of pregnancy within the first 36 months of delivery and reduced risk of preterm birth (see Box 7 for further key findings) (MCHIP 2014; Ahmed et al. 2013).

Table 4. Healthy Fertility Study: Timing of Delivery of BCC Messages Specific to the Intervention Area

Behavior Change Communication Messages	Visits Integrated with Maternal and Neonatal Health Program			Additional Visits in Intervention Arm Only	
	During Pregnancy	Day 6 Postpartum	Day 29–35 Postpartum	Months 2–3 Postpartum	Months 4–5 Postpartum
Benefits of longer birth intervals, risks of shorter birth intervals	√	√	√	√	√
Essential newborn care, including exclusive breastfeeding	√	√	√		
LAM, promotion of 6 months of exclusive breastfeeding	√	√	√	√	√
Timing of return to fertility		√	√	√	√
Transition from LAM to other modern contraceptive methods			√	√	√
Discussion of contraceptive methods, potential side effects, and strategies to minimize side effects			√	√	√
Referral to health facility for contraceptive methods, if needed			√	√	√

Source: MCHIP 2014, p.7

Box 7. Key Findings from the Healthy Fertility Study in Bangladesh

- The integrated model led to a more than 20 percent increased cumulative probability of modern method adoption through a 36 months postpartum period
- Integrated activities have led to a decrease in the incidence of pregnancy within the first 36 months of delivery, which is the period of highest risk for a mother and baby
- Integrated activities were associated with a 21 percent reduction of probability of shorter birth intervals and 20 percent lower risk of preterm birth
- Integration of family planning services within a larger MNCH platform is feasible and does not have a negative impact on service coverage or health impact
- The incremental costs for adding family planning to community-based maternal and neonatal health services for a 5-year period was $101.24 per 100,000 of the population (or annualized incremental cost of US$20.25 per 100,000)

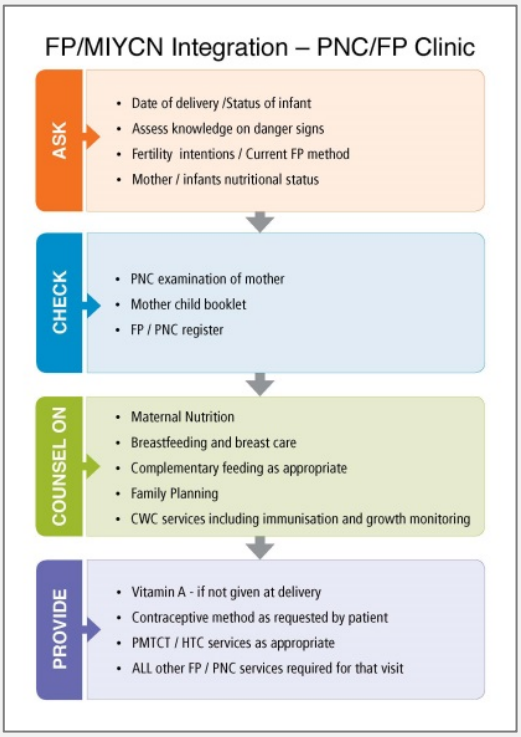
Source: MCHIP 2014, pp.25, 32

In the USAID Mission-funded Strengthening Communities through Integrated Programming program in Mozambique, community health workers, locally known as *animadoras*, received a small stipend and were involved in a range of activities including facilitating nutrition rehabilitation groups for moderately malnourished children, growth monitoring, and distributing condoms and contraceptive pills to clients. In addition, *animadoras* worked with youth farmer club members who were trained to be peer educators to provide practical training and information on conservation, agricultural practices, nutrition, safe food handling, and adolescent and reproductive health. The program implemented two different integrated packages: a "complementary" intervention package in nine districts to complement ongoing activities implemented by a Title II program where each *animadora* targeted 30 pregnant women or women through group meetings where various health topics are discussed. The program also implemented a "specialized package" where each *animadora* conducted home visits to 10 targeted households. A study was conducted to examine to what extent these community health workers promoted family planning as part of the integrated package and the costs of implementing the community health worker program component. Results confirmed relatively high coverage rates and that the *animadoras* can successfully deliver family planning information across both intervention packages. However, the study authors concluded that the specialized package that included household visits might be slightly more effective than the complementary package (group meeting approach) in "encouraging women to take action to prevent pregnancy" (Subramaniam et al. 2013). The costing analysis showed that incorporating this cadre of workers to implement integrated services can be "relatively cost-efficient compared to other community-based programs in relation to specific outputs (cost per capita, cost per household covered, and cost per beneficiary served)," and advocated for further study on "cost effectiveness of integrated CHW [community health worker] programs in terms of health outcomes (i.e., cost per CYP [couple years of protection] or unwanted pregnancy averted)." (Subramaniam et al. 2013).

Work at both the community and facility level. Multiple contacts at both the community and facility level facilitates integration by helping to reinforce consistent messages, to meet increased demand generated at the community level, and to enable provision of a greater mix of contraceptive methods. An example of this is the facility and community-based MIYCN-FP Integration Demonstration Program in Kenya. With technical support from the MCHIP program, the Kenya Department of Health and Public

Sanitation is implementing a demonstration program in six health facilities and affiliated community units. All clients visiting maternal and child health clinics receive MIYCN-FP integrated messages and services at antenatal, intrapartum, postnatal, family planning, and child health visits. Clients access both services in the same room, provided by the same health provider or are counseled in one unit and accompanied for service to the other respective unit. Community health workers provide MIYCN-FP education messages through mother support groups, home visits, community dialogue sessions and health action days (see Box 8). Findings from the first year of implementation showed that BCC materials were available and displayed at various service points in all facilities; supportive supervision findings showed a 50 percent increase in demand for nutrition and family planning services and an 80 percent increase among clients and health care workers in MIYCN-FP knowledge; and 90 percent of clients reported satisfaction with services based on client exit interviews (Kimiywe et al. 2013; Maitri et al. 2013).

Box 8. Job Aids for the MIYCN-FP Integration Demonstration Program in Kenya



Source: Kenya Ministry of Public Health and Sanitation; MCHIP 2012

Engage men and empower women. Integrated programs recognized gender integration as a critical component to overcoming barriers women face not only in using family planning but also to adopting optimal nutrition behaviors and reaching their full potential in the agricultural and economic sectors. The importance of addressing gender barriers to improving family planning outcomes was reiterated in several program documents. In some cases, male resistance to family planning was discussed as a barrier to program implementation and in other cases male engagement or male endorsement was discussed as a facilitator or promoter to improving family planning outcomes. Some programs included a male engagement component, others worked through women's empowerment groups or microcredit and other alternative livelihood activities. A review of PHE programs concluded that the three advantages or value-added elements that an integrated approach brought to family planning efforts included: "greater access to men who are drawn in by the livelihoods and natural resource management issues; greater access to youth who are attracted to sessions discussing resource management, livelihoods, and health; and giving access to income and credit to help women become more valued in their communities and be able to participate more in decisions regarding their fertility" (Pielemeier 2005).

Respond to community needs. Framing integrated approaches around perceived community needs facilitates multisectoral integration efforts. Responding to a community's immediate needs (e.g., health and livelihoods) can help win its trust and improve receptivity to longer-term conservation or natural resource management efforts, and promote community ownership and motivation. Sequencing the interventions in a strategic way so that short-term visible results occur and trust is gradually developed as new program elements are added was a useful strategy for several programs. Messaging that frames the integrated intervention as a win-win for both sectors aids integration efforts. The livelihoods component within multisectoral programs was seen by many programs as being critical to overall success of the integrated approach. Integrating reproductive health, including family planning, within a broader livelihoods and conservation context helps to engage and motivate youth as it offers youth and communities an alternative to abstinence promotion.

PHE Program Support for an Integrated Approach

The integrated approach of PHE is more advantageous for the user community in that it provides them with access to diversified services in an integrated manner. With a sectoral approach, you address one issue at a time and it is restricted to either environment or health or population issues. With the PHE approach, you are able to address the interdependent challenges that the community and households are dealing with and you provide a package of solutions that can address those problems. We see the benefits of the integrated approach in our work. These activities are integrated at household and micro-watershed levels and improve the health, food security, income and availability of natural resources.

– Executive Director of Ethio Wetlands and Natural Resources Association
(PHE Ethiopia Consortium 2012, pp. 20–21)

The IPOPCORM program in the Philippines worked through local government units and NGO partners to achieve food security using a three-pronged integrated approach involving coastal resource management, supporting alternative livelihoods to reduce fishing pressure, and improving access to family planning as a way of easing population pressure. Using a quasi-experimental evaluation design, the program tested the hypothesis that there will be a significant improvement in coastal resource management and reproductive health outcomes by delivering services in an integrated way compared to delivering each separately. The study found that the integrated approach was successful in all nine reproductive health and food security indicators and outperformed the single sector CRM intervention for five of the nine indicators, suggesting that the integrated approach "yields a larger impact on human health and food security compared to the sectoral management approaches" (D'Agnes et al. 2010).

The Environment and Health Project in Madagascar also used a quasi-experimental evaluation design to test if the integrated PHE approach was more effective than a single sector (health or environment alone) approach and to identify the most effective model to integrate multisectoral programs that include population, health, agriculture, and natural resource management. Results showed that integration communities performed better in 29 of 44 indicators including contraceptive prevalence rate, stunting, and tree planting (Kleinau et al. 2005).

Align with national and local priorities. Integration efforts have greater potential to succeed and to be sustained when program goals for nutrition, food security, and family planning are aligned with national-level policies and guidelines. Similarly, aligning the program vision with the local government vision and obtaining local government support for integrated efforts has also been identified as key to success and to ensuring sustainability of programs. For example, strong partnerships with the national and district Ministry of Health was a key facilitator of success noted by both health and multisectoral programs. Engaging community leaders, especially religious leaders, when first introducing family planning into a community is critical to addressing cultural and social resistance to family planning and in mobilizing the community to access services. For example, using culturally sensitive messaging such as healthy timing and spacing was integral to the Extending Service Delivery program's efforts to engaging religious leaders as agents of social change in Yemen. The program found that providing scientific and updated information on a range of reproductive health and family planning topics helped prepare the leaders to address misconceptions and dispel rumors, and provided them with a choice of issues to address during their Friday sermons, home visits, and other gatherings (Freij 2010).

Ensure a regular supply of commodities and provide a private space for services. Availability of a regular supply of family planning commodities in the community is critical to the success of family planning integration efforts. Irregular supply of commodities and stock-outs often pose a challenge in communities where family planning has been integrated into broader platforms. Establishing or linking to a community-based distribution system was key to increasing family planning access and integration efforts. Integrated programs also report that adding a private location to discuss family planning in facilities and, in some cultures, providing a private space for nursing mothers facilitated service delivery.

Adequate staff experience, training, and incentives. Inadequate numbers of staff (high client/provider ratios) and lack of incentives for volunteers are challenges experienced by integrated programs. Having motivated and adequately compensated program staff facilitates integration of a new program element like family planning, especially in the case of actual or perceived heavy workloads. Multisectoral program teams are often comprised of single sector experts working together. Identifying managers that have some sectoral experience but also a good understanding of integrated community development is imperative for program success. Cross-training of providers, including unpaid volunteers, to perform multiple tasks across sectors creates integration champions, improves their motivation, and facilitates a truly integrated cross-sectoral approach to addressing interconnected community challenges. For example, in the BALANCED Pwani Program in Tanzania, training savings and credit cooperative society members as PHE peer educators and training Ministry of Health community-based distributors in savings and credit and conservation activities (such as beekeeping and other alternative livelihoods activities) facilitated a "more integrated whole-system approach." These peer educators were usually fishermen, farmers, women traders, and youth and they were trained to spread PHE messages, counsel men and women together about family planning, and make referrals to community-based distribution outlets or government health services for family planning

> "Designing and implementing a comprehensive integrated program at scale is difficult! People's natural tendencies are to work in parallel activities rather than integrated activities. Staff need ongoing mentoring in making this work. For planning purposes program staff are working in integrated teams (for example, agricultural strategies have been developed in conjunction with the GESI [gender equity and social inclusion] team to make sure that we maximize our impact on women's and children's nutritional status."
>
> Source: Suaahara: Building Strong and Smart Families. 2012. "Annual Performance Report: September 1, 2011 through July 31, 2012." USAID.

supplies. This approach facilitated more people providing consistent integrated messages and resulted in a low dropout rate of the volunteers (92 percent of the volunteer community-based distributors and 88 percent of the peer educators remained active throughout the program) (BALANCED Project 2013).

Some programs recommend dedicated program staff for family planning, especially if this element is being added midway through an existing program. Collaboration and partnerships with local NGOs, including small conservation organizations with the capacity to reach communities, especially in ecologically sensitive areas, facilitates implementation across sectors and outreach to hard-to-reach, remote communities with limited resources. A few PHE programs reported that conducting regular cross-program meetings on how the programs integrate and are interdependent also facilitates effective integration.

6 Recommendations for USAID

The review findings point to several recommendations for consideration by USAID in their efforts to further strengthen and promote nutrition and family planning integration or food security and family planning integration more systematically. The recommendations also address gaps in the knowledge base that were identified previously as documentation limitations.

Define "success" for family planning-food security-nutrition integration

Since family planning, nutrition and/or food security are most often delivered as part of larger integrated packages, USAID should clearly define nutrition and family planning, and food security and family planning integration and also what constitutes success as it relates to this type of integration. What is expected or what is being promoted with respect to integration must be clearly articulated in requests for proposals that promote family planning integration. The key questions to be addressed include if success should be measured by one or more of the following measures:

- Improvements in both nutrition or food security and family planning outcomes? Or just family planning? If so, what level of outcomes?
    - Health status (pregnancy, unplanned pregnancy, stunting, underweight) and impact level food security indicators such as household hunger scale or months of adequate household provisioning?
    - Behavioral outcomes such as family planning use, exclusive breastfeeding, food production, use of sustainable agriculture practices and/or technologies?
- Process measures that capture coverage, quality, or cost-effectiveness of nutrition, food security, or family planning integrated service delivery?
- "Added value" of integrated programs versus delivering each component separately?

A recent review of the evidence on interventions which integrate global health and other key human development sectors recognized that "simply combining standardized indicators typically used for evaluation in each relevant sector may not be sufficient. These complex, multi-layered models for development may require more nuanced and sophisticated measurement tools than have been relied on in the past" (FHI 360 2014). Similarly, recognizing the complexities of multisectoral integrated programs, the PHE programs are still in the process of determining the best way to evaluate their success by considering evaluation methods including realist evaluations and methods that "evaluate the interactivity that makes PHE special," "leverage the comparative advantages of each individual sector in a PHE project," and "recognize the non-linear interactions, positive and negative feedback loops and unintended consequences" of integrated approaches (Environmental Change and Security Program 2014; Pielemeir 2014; Mohan 2014). Other ongoing efforts to define and measure the various dimensions of integrated programs in the health sector (see MEASURE 2014) and non-health sector (see Jody and Buchsbaum 2014; Masters et al. 2014) can offer additional insights in defining success for family planning and food security integration or family planning and nutrition integration.

Ensure adequate funding and time for implementation

Despite local and core stakeholder support and buy-in for integrated approaches, donor and government funding for integrated programs remain structured as vertical funding mechanisms. The USAID Multi-Sectoral Nutrition Strategy recognizes the benefits of and encourages integrated programs. However, to facilitate this vision, USAID will need to build bridges across the current

traditional vertical funding mechanisms to facilitate cross-sectoral collaboration across its various Bureaus and Offices. Expanding the use of sectoral funding, co-funding of programs, or co-location of programs in overlapping target areas are options for consideration.

Supplemental funds through mechanisms such as Flexible Funds and Mission funding specifically targeted to expanding family planning access facilitated integration efforts. Inadequate funding for implementation and/or scale up of family planning or for an expanded integrated program model was a common barrier reflected across programs reviewed. Another common barrier reported by programs were short time frames especially of add-on funding such as Flexible Funds, which makes true integration a challenge. USAID should consider increasing program period of performances especially for add-on funding grants.

Harmonize reporting requirements

Given the high degree of variability in the reporting requirements for programs aiming to improve food security and nutrition outcomes across the various USAID offices and bureaus, USAID should consider having clear and harmonized guidelines for reporting on the family planning component and for reporting on integration. Programs should be required to clearly report on:

- Which of the following family planning result(s) the program seeks to achieve:
  - Increased knowledge and interest in family planning
  - Improved quality of family planning service delivery in facilities and in the community
  - Increased access to family planning services
  - Improved social and policy environment for family planning services and behaviors
- The level of family planning interventions provided (family planning education, counseling, commodity provision, or referrals)
- Providers involved in delivering the intervention using standard terminology for the various cadres
- Measures taken to monitor compliance with USAID family planning voluntarism and informed choice requirements
- How the services are integrated with nutrition and/or food security program elements and facilitators and challenges to integration
- A limited set of harmonized indicators that reflects USAID's vision for successful integrated programs.

Fund rigorous research focused on testing effectiveness of integration models

The approach and levels of family planning to be integrated into broader platforms will depend on numerous factors within the particular context in which they will be implemented. In order to improve the evidence for what works and what does not in nutrition and family planning integration and food security and family planning integration, USAID should consider the following:

- Develop an applied research agenda around family planning-food security-nutrition integration
- Fund programs to conduct formative research to provide the information needed to assess how to best incorporate family planning into program platforms delivering nutrition or food security interventions
- Fund operations or implementation research to specifically test the feasibility, acceptability, fidelity, and effectiveness of integration models within broader integrated programs to understand which strategies work well (or do not work well) when combined and which strategies are more cost-

effective. This review can provide a starting point and some insights into the types of integration models and/or platforms to evaluate going forward. For example:

  - The effectiveness of rally posts versus mobile clinics as a platform to deliver nutrition and family planning services
  - Comparing the outcomes of offering the three integration models described in this review within one program

- Research that compares outcomes of integrated versus non-integrated services and outcomes of different integration models, including the costs and quality of services
- Research examining the effectiveness of family planning referral-based models for uptake of family planning services within nutrition and food security programs

Develop guidance and provide technical assistance for integrated programs

Programs interested in integrating family planning with nutrition or food security program elements will need to give some thought when selecting a model since one model might not be inherently better than another and the usefulness of a model depends on the context the model is being implemented in. As interest and the evidence base continues to grow, USAID should develop program guidance or strategic considerations for strengthening this type of integration in programs. Additional dialogue through technical and expert consultations is needed to bring together both the empirical evidence on why it is important to integrate family planning with nutrition or food security and the limited, but growing programmatic evidence to be able to develop this type of guidance. Programmatic considerations should also include best practices for ensuring quality of care, voluntarism, and informed choice in the provision of family planning services.

USAID-supported efforts have begun to work on integrated MIYCN-FP and PHE programming conceptual frameworks including considerations for monitoring and evaluation (MIYCN-FP 2014a and 2014b; WHO 2013b; D'Agnes and Margoulis 2007). More efforts and support in this area are needed, especially for integrated family planning and food security interventions. Programs, especially in the non-health sector, including small conservation organizations, will need technical assistance to expand their organizational capacity to advocate for, conduct training and supervision, and especially to conduct monitoring and evaluation related to the expanded service delivery model.

Promote dialogue and cross-learning across health and multisectoral programs

Since nutrition and family planning integration occurs in both health and multisectoral programs often through similar strategies and platforms, USAID can promote increased dialogue and opportunities for learning between these types of programs. Similarly, the lessons and experiences of integration strategies and synergies provided by multisectoral PHE programs could potentially be applied to food security interventions within programs funded by Food for Peace and Feed the Future, given the similarities of some of the interventions promoted across these programs, especially around sustainable agricultural practices, natural resource management, and livelihoods. This offers opportunities for more dialogue and cross-learning across such programs. This review also highlighted the significant challenges of obtaining program documents that could assist this type of learning. USAID should continue to support efforts to improve access to documentation through existing mechanisms such as the USAID Development Experience Clearinghouse, communities of practice, and other knowledge management strategies. Programs should also be encouraged and funded to document their integration experiences through case studies, technical briefs, webinars, and other dissemination channels.

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Appendix 1. Integration in Action: How Three Programs Integrated Family Planning Services

Case Study: Ramba Kibondo (Live Long Child) Child Survival Program

Case Study: Sak Plen REP (Full Sack Resiliency Enhancement Program)

Case Study: Community Markets for Conservation (COMACO), Ltd.

CASE STUDY

Ramba Kibondo (Live Long Child) Child Survival Program

Program Overview

World Relief/Burundi implemented the CSHGP Ramba Kibondo (Live Long Child) Program in four communes of Kibuye Health District, Gitega Province, in Burundi. The program implemented a community-integrated management of childhood illnesses (C-IMCI) program, using a care group model focusing primarily on nutrition (40 percent of the program's efforts), malaria (30 percent), control of diarrheal disease (20 percent), and immunization (10 percent).

Drivers of Integration

Although family planning was considered in the program's initial design, there were not sufficient funds for implementation. Interest and motivation to include family planning grew when the program did not see sufficient improvements in childhood malnutrition rates. Implementation also coincided with an important time in Burundi's history for the acceptance of the country's demographic challenges, especially by the religious and cultural leaders through the 2010 Gitega Declaration. In the declaration, leaders encouraged "the Government to engage in research and programs that are comprehensive and effective, while respectful of human and religious values." In 2011, World Relief received a Flexible Fund Grant, which allowed the program to integrate family planning in the last 9 months of implementation (from March to November 2012).

Integration Strategies

The program implemented two strategies to integrate family planning. At the community level, it used its existing community mobilization platform—the 209 care groups comprising close to 3,000 volunteers—as the entry point to deliver birth spacing interventions. The care groups were initially set up to deliver C-IMCI messages, including nutrition, and were involved in health education, data collection, and referrals to the health center. At the health center level, two providers per facility, primarily nurses trained in C-IMCI, including nutrition, were trained in family planning counseling and service delivery of modern and natural methods with funds from the Flexible Fund Grant. The figure

Ramba Kibondo Care Group (Source: World Relief, "Final Qualitative Assessment Report for the Flex Fund Grant to World Relief Burundi Ramba Kibondo CSP," cover photo)

Funding: USAID Child Survival Health Grant (2007–2012) and Flexible Fund Grant (2011–2012)

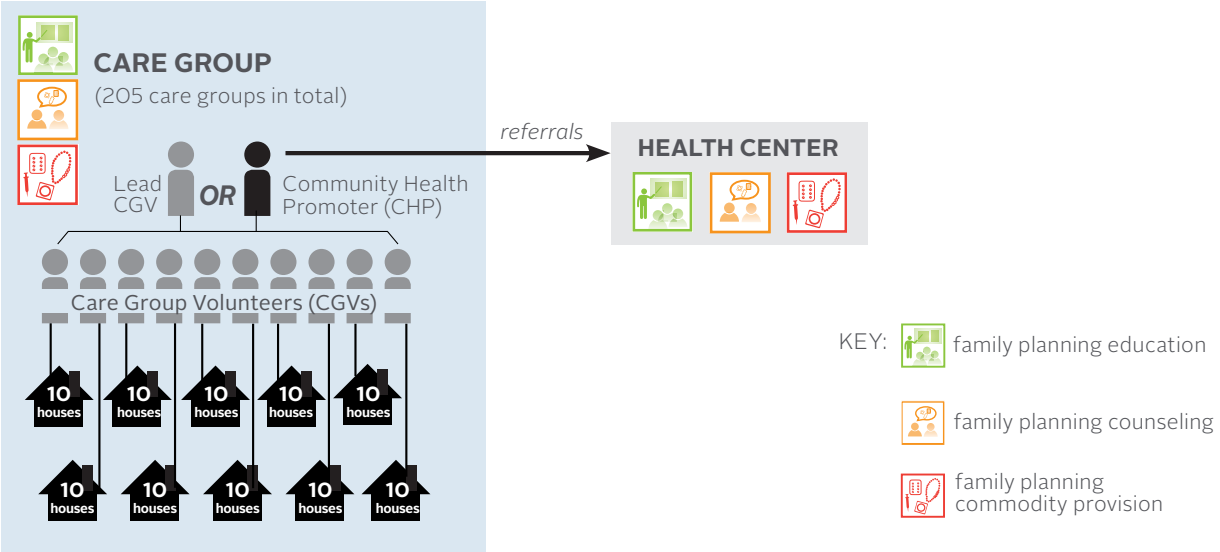
Goal: To reduce the morbidity and mortality among children under 5 years of age and women of reproductive age

Estimated beneficiary population: 87,269 children under 5 years and women of reproductive age

Objectives:

- Improved linkages between households, communities, and the formal health system
- Improved availability and access to essential health commodities at the community level
- Increased knowledge and adoption of key family practices for child health by child caregivers with support from community leaders and health providers

Platforms for Family Planning Integration



above outlines the various platforms used by the program for family planning integration.

Care groups consisted of 10 to 12 volunteer community health educators, mainly female, referred to as care group volunteers. Each care group was trained and supervised by a paid World Relief health promoter, who was in turn supervised by a World Relief supervisor. The program paired these promoters and supervisors with a health promotion technician in specific Ministry of Health (MOH) health centers to facilitate care group–health system integration. The program trained MOH community health workers, primarily male, who were integrated in the care groups and also served as the link to the health center. Some care group volunteers were also elected into health center staff management committees made up of community health workers, a primary school teacher or pastor, the head of the health center, and local leaders. Household and sub-commune data were collected through the care groups by the community health worker and/or the care group leaders under the supervision of the health promotion technician and management committee president. The data was aggregated and fed into the health center to which the care group is linked.

Each care group volunteer was responsible for working closely with 10 neighbors to share the information they were trained on and to encourage behavior change, thereby creating a multiplier effect in reaching every household with women of reproductive age and/or children under 5. The community health workers and care group volunteers were trained in community case management of acute malnutrition and in promoting optimal infant and child feeding. Each care group also had a "light mother" who was responsible for following mild to moderately malnourished children for 2 months after they attended a positive deviance/hearth session. Using materials from Food for the Hungry (see image) that were adapted to the Burundian context, the program trained community health workers and care group volunteers on how to teach communities about birth spacing and on how to do community-based distribution (CBD) of family planning. For the 100 care groups without a community health worker, care group leaders were trained in family planning. Religious leaders, pastors, and church volunteers were also trained on integrating birth spacing messages.

The program used existing MOH training materials and guidelines to train nurses on how to deliver modern and natural family planning methods. Although community health workers and care group leaders were trained on CBD, the MOH stopped the CBD program in Gitega and other provinces soon after it began, following community concerns and resistance from religious groups. The government did not have a CBD strategy in place, but has since developed one and resumed training to roll out the CBD strategy at

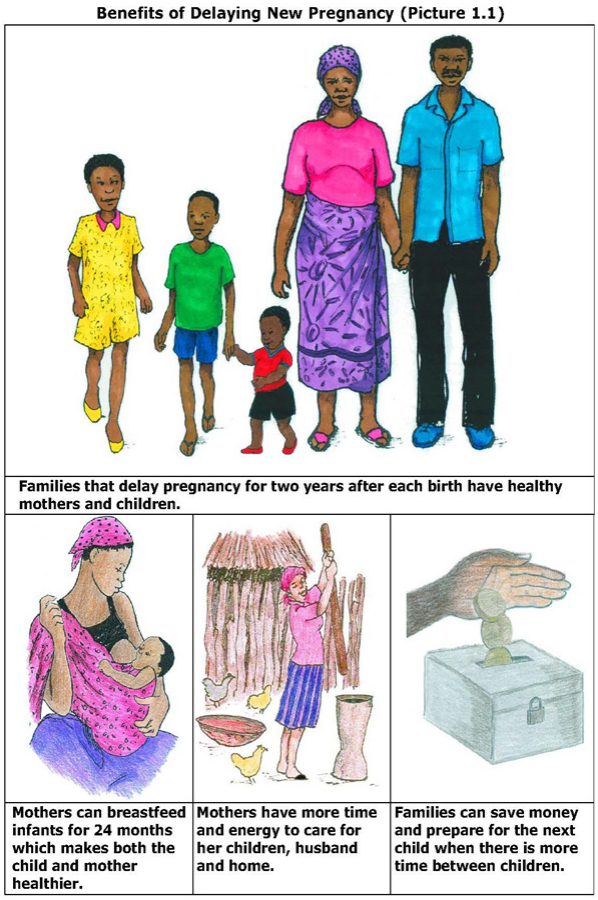
the national level. During this program, the community health workers referred women to health centers for family planning services and worked with health center staff to follow up with dropouts. By the end of the program, 170 community health workers, 100 care group leaders, 50 health center staff, and 130 religious and local leaders were trained in family planning.

Results

According to the final evaluation report, the "care group model successfully reached every beneficiary household in the Kibuye Health District" and was successful in meeting targets set for all key nutrition indicators. For example, from baseline to final evaluation, the program reported that children who were underweight was reduced from 16.4 percent to 4.2 percent; children exclusively breastfed increased from 86.4 percent to 95.8 percent; and infants and young children fed according to minimum appropriate feeding practices increased from 25.6 percent to 92.7 percent.[1] Despite the short implementation period of 9 months, the program was able to increase the use of modern family planning methods from 16 percent at baseline to 42.7 percent at final evaluation.

Integration Facilitators

- **Existing community mobilization platform:** The existing care group platform facilitated the addition of family planning into ongoing activities. Since family planning was added toward the end of program implementation, care groups had already established trust among the community and this helped to initiate birth spacing discussions within communities where family planning was rarely talked about. Using the same people also helped to reduce costs.
- **Availability of training materials:** The program greatly benefited from the availability of existing care group tools on family planning from Food for the Hungry, which were adapted to the Burundian context. This was particularly helpful given the short implementation period for the family planning component.
- **Involving religious leaders and men:** It was critical to involve both men and religious leaders to introduce family planning in communities due to the strong cultural and religious beliefs around family planning.



Food for the Hungry's 2011 "Family Planning Flipchart" tool (p. 5 pictured above) was adapted and used by the program.

> "When birth spacing is short, it has impacts on the last children… When you get more pregnancies… the consequence is that you don't have enough food for feeding the children."
>
> – World Relief Ramba Kibondo Child Survival Program Manager

[1] World Relief. 2012. "World Relief Burundi Ramba Kibondo 'Live Long Child' Child Survival Project, Final Evaluation Report 2012." pp. 11, 17–18.

Having male community health workers as part of the care groups was also effective. In addition, the Flexible Fund Grant allowed the program, in partnership with the MOH, to hold a workshop for Gitega's local religious and administrative authorities to reaffirm the spirit of the Gitega Declaration. This 1-day workshop laid the groundwork for the series of dialogues that then took place through local-level workshops and the care groups, all aimed at gradually changing the opinions and behaviors around family planning in Kibuye District.

Integration Barriers

- **Social and cultural resistance to family planning:** The qualitative assessment of the Flexible Fund Grant confirmed that religious beliefs were the most important barrier to family planning promotion. The cultural preference for male children, religious beliefs that do not promote family planning, and rumors about family planning side effects all contributed to challenges in promoting family planning. While the program's wide community mobilization network was effective in increasing awareness and knowledge of modern and natural family methods among community members, especially in clarifying inaccurate perceptions and information about family planning that were prevalent, it was not without challenges.
- **Short timeframe for family planning implementation:** The family planning component funded through the Flexible Fund Grant that was added in the last year of implementation only allowed for a short 9-month implementation period, which was limiting.

> "Some people…don't allow us to visit them and to talk about family planning… We are sometimes insulted. Even if we are insulted, we persevere despite the insults and some people adopt family planning."
>
> – Bukirasazi care group volunteer

Source: World Relief, "Final Qualitative Assessment Report for the Flex Fund Grant to World Relief Burundi Ramba Kibondo CSP," p. 11

Lessons Learned

- It is important to begin family planning discussions with the need for birth spacing and consequences of short birth spacing rather than moving directly into family planning methods. Starting off with family planning methods can lead to resistance from communities.
- It takes time to convince some communities about the benefits of birth spacing and there is a need to understand, respect, and accept local cultural and religious beliefs around family planning to be successful. Longer-term programs involving religious leaders and including men-to-men peer support are all critical elements of success in such settings. Having trained individuals who are able to competently respond to queries and concerns about family planning and provide realistic examples from the community during discussions are also important factors to successfully achieve changes at the community level with respect to family planning.
- Care groups are an effective strategy to mobilize communities and integrate family planning messages into maternal and child health messages since they complement each other and offer a small-group, participatory forum which is critical to understand and share concerns around family planning.
- The various levels of partnership, collaboration, and health system linkages set up by the program through community health workers, management committees, and religious leaders was a key factor for success of the care group model. In communities with strong religious beliefs against family planning, more research on enhancing the credibility and success of natural methods is needed.

CASE STUDY

Sak Plen REP (Full Sack Resiliency Enhancement Program)

Program Overview

World Vision/Haiti implemented a Title II development food assistance program, Sak Plen REP (the Full Sack Resiliency Enhancement Program), in six communes of the Upper Plateau, two communes of La Gônave, and eight communes of the Lower Plateau and Artibonite. Sak Plen REP built on many of the activities and structures that were set in place in some of the communes that benefitted from the preceding development food assistance program.

Drivers of Integration

Driven by Haiti's high maternal, prenatal, and neonatal mortality rates, from the start of the program, family planning was included in the broader maternal and child health and nutrition (MCHN) health service package as a way of improving access to reproductive health services (this was also done in the preceding development assistance program). World Vision/Haiti's National Health Coordinator reflected that they tried to define a package from the beginning of the program that responded to the needs of the community and to train staff in those integrated services, so as to avoid the mentality of providing separate services. Integration was also facilitated by the fact that World Vision received a Flexible Fund Grant in 2007 that allowed for the integration of family planning into their Area Development Programs in Haiti, India, and Senegal.

Integration Strategies

Sak Plen REP leveraged several platforms within its community network to integrate family planning either as part of the integrated MCHN health package or the agriculture and livelihoods program components. Community health promoters (CHPs) and nurses were the two cadres of providers that played a critical role in most of the strategies. At the health facility level, program nurses were trained in delivering the integrated MCHN package, including monitoring health centers and mobile teams to ensure quality of service delivery. The nurses were also trained in maintenance of family planning supplies, providing family planning counseling, promoting the lactational

Community members gather at a rally post, where health services are provided monthly. (Photo from World Vision/Haiti, program midterm evaluation)

Funding: USAID Office of Food for Peace Title II (2008–2013), supplemented with Flexible Fund Grant

Goal: Reduce food insecurity and increase resiliency of vulnerable and extremely vulnerable rural households

Estimated beneficiary population: 540,369 (pregnant and lactating women, children 6–23 months of age, malnourished children 24–59 months of age, youth, farmers' groups and associations, and lead farmers)

Objectives:

- Improved nutritional and health status of targeted vulnerable groups
- Improved productive and profitable livelihoods

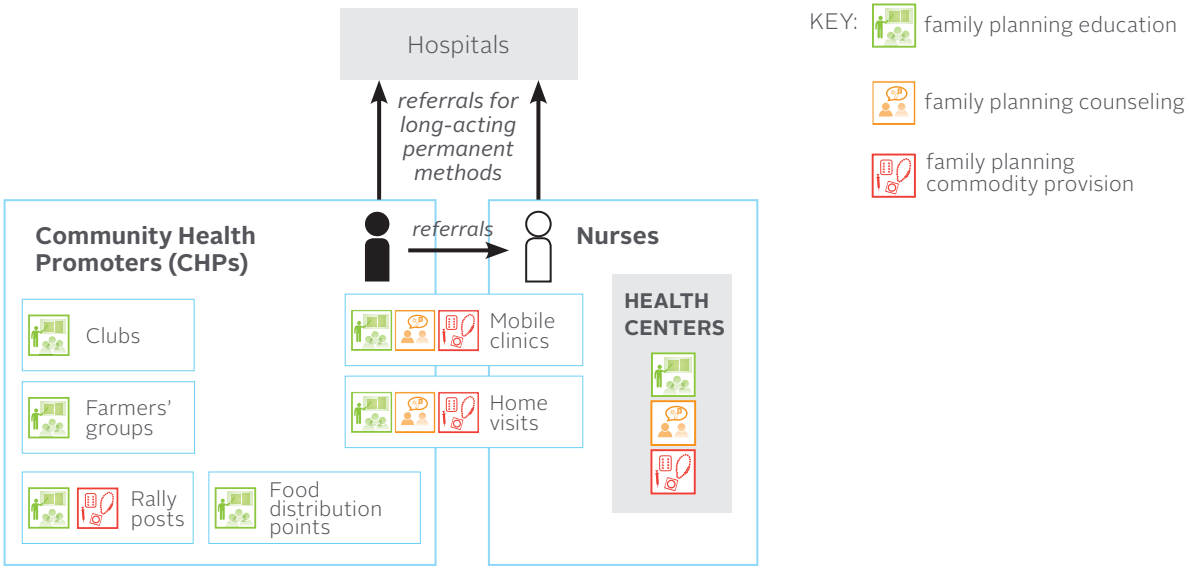
amenorrhea method and family planning in prenatal and postnatal visits, making home visits to new family planning users, and following up with drop-outs. The program-hired nurses were responsible for training and supervising the CHPs.

Community health promoters were either men or women, literate, and chosen by their community. CHPs were paid by World Vision and were trained on various health topics including family planning, nutrition (e.g., exclusive breastfeeding, growth monitoring and promotion, child feeding practices, and diet diversity), treatment of diarrhea, immunization, hygiene, and HIV. They were also trained on how to facilitate Mothers' Clubs, conduct home visits to inquire about malnourished infants and children, and follow up with mothers and children who did not come to a rally post. They were trained to provide family planning education and counseling and referred interested individuals to nurses at the health center for a medical check-up. CHPs provided family planning commodities, such as condoms, pills, and injectables, under the supervision of nurses via community-based services and at their homes (referred to as "Home Depots"). CHPs provided referrals to the health clinic for intrauterine devices. Both cadres provided referrals to the hospital if a woman was seeking a long-acting permanent method and the program transported women to local hospitals. In addition to health centers and home visits, other platforms through which family planning integration was achieved are described next and shown in the figure below.

Rally posts. Community members accessed health services at rally posts that were set up at a designated place and time once a month. CHPs were involved with conducting multiple activities at these events such as distribution of family planning contraceptives, oral rehydration salts and chlorine tablets, immunization, vitamin A supplementation, deworming, growth monitoring and promotion activities, and delivering brief 15 minute health education sessions on various topics that were rotated monthly, including on nutrition and family planning. CHPs used a register to report on children they attended to.

Mobile clinics. Mobile clinics were conducted by nurses with support from the CHP once a month. At these clinics women had access to several MCHN services, including antenatal and postnatal care, and nutrition services, such as iron and folate supplements, growth monitoring and promotion, vitamin A supplementation, and promotion of exclusive breastfeeding. The nurses conducted medical examinations and, for women seeking family planning services, provided family planning counseling. CHPs provided health education and distributed contraceptives.

Platforms for Family Planning Integration



Clubs. Mothers' Clubs were an important component of the program's broader education and behavior change communication strategy to reduce child malnutrition, increase food security, and integrate MCHN activities with agriculture production. Mothers' Clubs targeted caregivers of children under 5 years of age and caregivers were grouped based on the age of their child. To be included in the program, mothers were required to have at least three prenatal consultancies and were then invited by a CHP to attend Mothers' Club meetings and were also eligible for food rations. Regular attendance at Mothers' Club meetings was a condition for receiving food rations. During the club meetings, which occurred at the monthly rally posts, CHPs delivered 45–60 minute long behavior change communication sessions covering a new health topic every month including nutrition and family planning, which followed a 6-month rotation schedule. Household production diversification activities (such as biointensive vegetable gardening, fruit tree planting, and small animal husbandry) led by Sak Plen REP technicians hired by the program were also conducted through the Mothers' Clubs in order to promote dietary diversification.

Although CHPs were trained to facilitate and lead the Mothers' Clubs under the supervision of nurses, in response to recommendations from the midterm evaluation, in 2011 the program introduced the concept of Lead Mothers. This was an adaptation of the Mother Care Group model, where mothers were trained to lead Mothers' Clubs and create a network of Lead Mothers as a way to improve sustainability of this strategy.

The program also used Fathers' Clubs and Grandmothers' Clubs to deliver the same topics covered in the Mothers' Clubs. However, these groups were not as established as Mothers' Clubs. The other opportunity fathers had to participate in health education was through Mothers' Clubs since the meetings were attended by caregivers of the children under 5, which were sometimes fathers.

Food distribution point. Food rations were provided once a month at designated sites referred to as food distribution points. These sites were also used for other health activities including family planning, growth monitoring and promotion, and delivery of preventive health messages. Family planning service provision never occurred on the same day as food distribution in accordance with USAID family planning requirements.

Mothers' Clubs targeted caregivers of children under 5 years of age. (Photo provided by World Vision/Haiti program staff)

Farmers' groups and associations. The program integrated family planning into the agricultural component through farmers' groups and associations. In areas where there was a program agriculture component, CHPs sometimes visited these groups to provide family planning educational messages during their meetings.

Results

The evaluation of Sak Plen REP reported that the program was successful in demonstrating improvement in 11 of the 14 key indicators. For the nutrition outcomes, no change was reported for stunting (25.1 percent to 25.3 percent). Children underweight decreased from 23.5 percent to 10.7 percent. The composite infant and young child feeding indicator (exclusive breastfeeding, continued breastfeeding, and complementary feeding) increased from 18.1 percent to 30.2 percent. For food security, average months of adequate household food provisioning decreased from 5.4 to 3.5 and household dietary diversity score showed no change (from 5 to 5.2). Use of modern family planning methods increased from 43 percent to 58.3 percent.[1]

[1] World Vision. 2013. "Annual Results Report: Multi Year Assistance Program (MYAP): FFP-A-00-08-00024"; World Vision. 2014. "Final Evaluation of the Haiti Title II Multi-Year Assistance Programs (MYAP)." p. 10.

Integration Facilitators

- **Leveraging an existing platform:** The program was able to build on the structure and gains made by the preceding development food assistance program to continue providing and expanding family planning services.
- **Flexible Fund award:** Being awarded a Flexible Fund grant allowed the program to expand its family planning activities by hiring more nurses and CHPs, including staff dedicated to family planning, and lessen the workload created by the high demand for family planning services. Having adequate numbers of trained staff to provide services was critical to program success.
- **Social acceptance of family planning:** Utilization of services was greatly facilitated by acceptance of family planning in the communities and the fact that Haitians wanted to access family planning services.
- **Using CHPs to distribute family planning commodities:** Using CHPs as a distribution point for family planning commodities reduced travel distance for clients to access services.
- **Consistent family planning commodity supply chain:** Program staff held monthly meetings with the Ministry of Health and Area Development Programs staff to discuss family planning supplies and transportation and developed a logistics system to ensure that family planning supplies were always available to CHPs and clinics. The program was successful in achieving an average 90 percent no stock-out rate and 100 percent of facilities were offering three or more methods.

Integration Barriers

- Limited human resources to meet growing family planning demand for services and commodities: High demand for family planning created a heavy workload for the different cadres of workers.
- Transportation issues: It was difficult for mobile clinics to reach certain communities because the roads were in poor condition.

Lessons Learned

- As explained by World Vision/Haiti's National Health Coordinators, "One of the most important lessons that we learned was that it is possible to integrate family planning into a nutrition program through a community network, of course you have to take into account the context because the contexts are not always the same."
- Involving communities in program processes facilitates implementation because they are more willing to utilize the health services.
- The preventing malnutrition in children under 2 approach which focuses on the 1,000-day period from pregnancy to 2 years of age allows programs to reach mothers at the most critical time, not only for nutrition, but also for family planning. It is important to have young people involved in family planning activities because many family planning clients are young mothers.
- The CHPs contributed to improving access to health services and strengthening the health system. The program also showed that CHPs can successfully deliver injectables.
- Mothers' Clubs and home visits were effective in terms of facilitating understanding of family planning because of the interactive nature of these contacts between the CHPs and the beneficiaries.
- Building the capacity of Ministry of Health and health facility staff is critical to ensuring sustainability to continue meeting the demand for family planning services.

CASE STUDY

Community Markets for Conservation (COMACO), Ltd.

Program Overview

Community Markets for Conservation (COMACO) is a limited-by-guarantee, non-profit company that is managed by Wildlife Conservation Society and has been operating in Zambia's Luangwa Valley since 2003. COMACO targets food insecure households and individuals involved in environmentally destructive livelihoods such as poaching or charcoal production and supports them to improve their food and income security in exchange for their commitment to conserve the Luangwa Valley ecosystem. Using a market-driven community-based approach to conservation, COMACO trains these small-scale farmers in sustainable agricultural practices and provides them access to high-value markets for commodity surpluses as a reward for conservation compliance and preservation.

Drivers of Integration

The decision to incorporate a population, health, and environment (PHE) approach to the COMACO model in 2010 was prompted by several factors including: growing family sizes that were posing a threat to natural resources and food security; the limited availability of information and methods about family planning in rural Zambia; and the long distances (often up to 12 kilometers) to health clinics. COMACO's Grants Administrator explained, "We realized it was not enough to just preach conservation farming and to provide households with alternative livelihoods skills and distribute [farm] inputs and buy their produce to market it to the shopping outlets. We realized that for the whole cycle to be complete, we needed to combine conservation with family planning. We realized it was important to integrate family planning into the livelihoods structure because only then would the family live a fulfilled life. If they knew how to plan their family size it would be easy for them to have enough labor on their farm plot. It would be easy for them to grow enough food to feed their household. And it would be easy for them to make their own income to take their children to school to provide for medical needs..." The integration of family planning activities was made possible with USAID funds

Producer group members gather for a field day led by lead farmers. (Photo provided by COMACO program staff)

Funding: COMACO is supported by various donors including The Royal Norwegian Embassy, CARE International, and the World Bank. Family planning activities were funded by the USAID BALANCED Project Seed Grant (2010–2012) and Flexible Fund Grant (2011–2012).

Goal: Reduce hunger and poverty and conserve ecosystems and wildlife

Estimated beneficiary population: 50,000 farmers

Objectives:

- Improved farmer skills
- Improved market access
- Improved resilience from diversified incomes and alternative livelihoods
- Reduced risks of natural resource degradation

through a seed grant from the BALANCED Project and a Flexible Fund grant. The objectives of the family planning integration activities was two-fold: increase awareness among COMACO families of family planning and its role in health, food security, poverty alleviation, and environmental conservation; and improve access and use of family planning methods and services.

Integration Strategies

COMACO's integration strategy was to utilize its existing producer group structure, led by paid extension officers and volunteer lead farmers, to disseminate information on family planning, distribute oral contraceptives and condoms, and to make referrals to health centers for other methods such as injectables and intrauterine devices. Each lead farmer reports to an extension officer responsible for 2–3 producer groups and each producer group is made up 10–20 farmers. Lead farmers are responsible for ensuring that farmers in producer groups are compliant with the sustainable agricultural practices promoted by COMACO.

The first step in the integration process was to coordinate with the Ministry of Health (MOH) and seek the approval and support of COMACO's planned family planning activities. Using materials from the MOH and the BALANCED Project, COMACO developed PHE and family planning messages to be incorporated as learning pages into the company's existing *Better Life Book*, a manual which includes information on conservation farming, food security, and health topics including nutrition (see image). The MOH approved these materials and signed a memorandum of understanding with COMACO, which granted the company to begin implementation of family planning activities.

In collaboration with the COMACO family planning coordinator, BALANCED Project staff from PATH Foundation, Inc., in the Philippines conducted PHE training of trainers sessions for the company's paid extension officers who in turn selected literate volunteer men and women lead farmers and trained them to serve as adult PHE peer educators. These peer educators were trained on PHE messages, community-based distribution of condoms and oral contraceptives for first-time and continuing users, and referral to the health center for other methods. MOH staff also participated in the training. COMACO trainers recruited children 15–19 years of age from

An example of family planning learning pages from COMACO's Better Life Book. (Source: COMACO program staff)

Producer group members using the Better Life Book to learn about the links between conservation, food security, and family planning. (Photo provided by COMACO program staff)

schools and families of producer group members, and trained them to be youth PHE peer educators.

The COMACO family planning coordinator and the extension officers are responsible for obtaining family planning supplies from the health posts within their operational areas and delivering them to lead farmers to distribute at the community level. The lead farmers and extension officers are responsible for monthly project monitoring, such as recording the number of family planning meetings conducted, condoms and oral contraceptives distributed, and referrals made. Existing monitoring forms were adapted slightly to capture the family planning activities. Lead farmers receive farm inputs from COMACO to maintain demonstration farms to showcase best practices to their producer groups on soil management, beekeeping, and poultry husbandry. However, unlike extension officers, lead farmers do not receive a salary from COMACO.

The platforms through which family planning integration was achieved using COMACO's existing producer group structure are described next.

Field days and monitoring visits. Field days, which occur monthly and sometimes quarterly, bring producer group members together with their lead farmers and extension officers to discuss various agricultural and health topics relevant to a specific producer group and include a 2–3 hour question and answer session. Family planning is one of the many topics covered during field days. Using the *Better Life Book* learning pages and other fact sheets developed for training, lead farmers disseminate information on family planning methods and help farmers understand the relationships between markets, sustainable farming practices, conservation, and health and family planning. Lead farmers provide condoms and oral contraceptives to new and existing users. For new pill users, lead farmers are trained to provide information about how to take the pills at the same time every day and to visit a health center if they experience menstrual irregularities. Farmers who are interested in other family planning methods are given a referral to a health center. The referral forms and family planning supplies are provided by the MOH and local health centers.

In addition to field days, lead farmers sometimes meet with farmers from their producer groups as frequently as once per week because lead farmers have monitoring responsibilities related to conservation compliance. These visits also provide lead farmers an opportunity to discuss family planning and distribute commodities as needed.

Training of COMACO peer educators in family planning. (Photo provided by COMACO program staff)

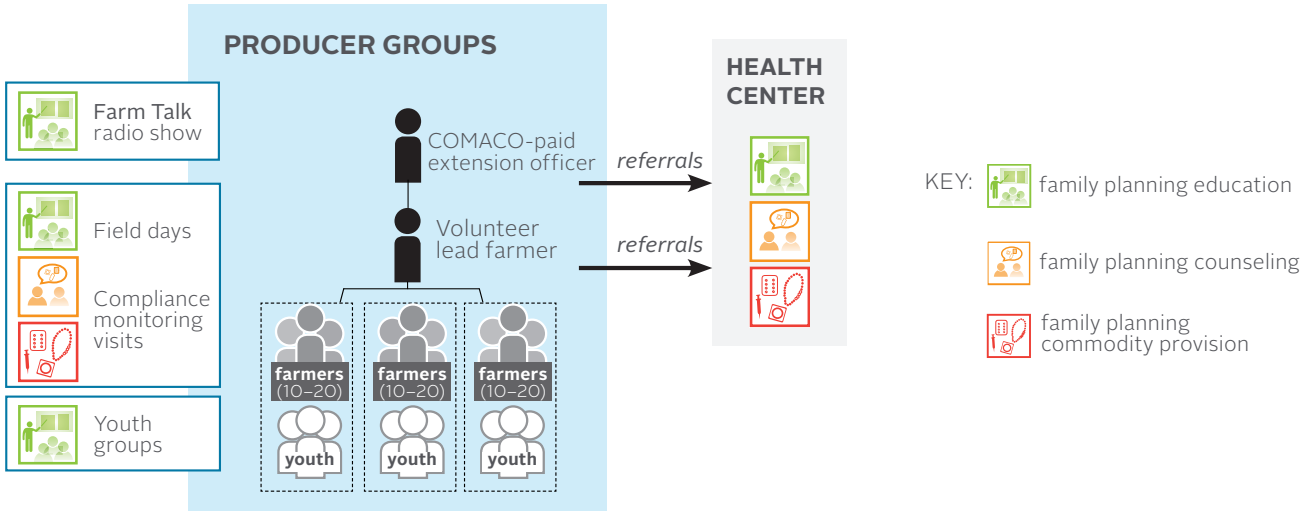
Youth Groups. Youth peer educators (15–19 years of age) were trained in conservation and adolescent sexual and reproductive health using the *Better Life Book* and other materials provided by the MOH. Using poems and short role-plays with key messages, youth peer educators disseminate information to their in and out of school peers during after-school activities. The extension officers and lead farmers monitor the youth group activities.

Farm Talk Radio Program. PHE messages were also integrated into COMACO's Farm Talk radio program. Airing three times a week, the program provides information on markets, production techniques, weather updates, and farmer testimonials. During 2000–2012, COMACO procured 1,000 radios that were distributed to producer groups and lead farmers were trained on how to discuss the topics aired.

Results

In final grant reports, COMACO reported that its wide network of trained peer educators contributed to increasing awareness of family planning and the role of family planning in health, food security, poverty alleviation, and environmental conservation. Based on project monitoring data, this network included 760

Platforms for Family Planning Integration



adult and 220 youth PHE peer educators operating in 6 districts (Chama, Chinsali, Lundazi, Mambwe, Nyimba, and Serenje).[1] COMACO reported that the *Better Life Book was* distributed to nearly 4,000 producer groups. In terms of improving access to family planning services, in Mambwe district, COMACO reported that a total of 6,267 individuals accessed either condoms or pills from peer educators, and 175 clients were referred to the health center for other methods.[2]

Integration Facilitators

- **Partnerships and technical assistance:** COMACO benefited from support from the MOH, the BALANCED Project, and the Flexible Fund grant. Staff from the BALANCED Project provided technical assistance in developing PHE materials as well as designing and delivering training programs for the peer educators. The MOH supported COMACO by participating in training, approving educational and training materials, working with peer educators to follow up on referral cases, and providing free condoms and oral contraceptives for community-based distribution. Creating a referral system between COMACO peer educators and local MOH clinics (see image of referral slip) facilitated

Client No._____

Name of Agency: _____

Location: _____

Referral Slip

Date: _____

Name of Client: _____

Age: _____

Marital Status:_____

Location or Name of Village Leader: _____

Referred to:

Reason for Referral:

Action Taken:

Referred by: _____
PHE Adult Peer Educator/PHE CBD

Received by: _____
Designation:
Date: _____

Referral slip used by adult peer educators to refer clients to a health facility. Source: COMACO program staff

[1] These figures represent a combination of results reported in two separate final grant reports to the BALANCED Project and Flexible Fund and have been verified by COMACO program staff.

[2] Simwanza, Ruth. 2013. *Integrating Family Planning Services into WCS Zambia's COMACO Livelihood and Conservation Model. Final Report BALANCED seed grant.* Lusaka, Wildlife Conservation Society/COMACO; Wildlife Conservation Society. 2012. *Integration of family planning into livelihood, food security and conservation program in Zambia.* Flexible Fund Grant Report. Lusaka, Zambia.

integration. The Flexible Fund grant allowed COMACO to expand family planning activities to additional districts.

- **Engaging lead farmers, especially males in family planning activities:** Farmers were more open to discussions on sensitive topics such as family planning and accessing commodities from lead farmers, who are considered their peers. Culturally, family planning is considered a woman's issue in Zambia. Specifically targeting males to serve as peer educators helped to increase participation of men in family planning educational sessions.

Integration Barriers

- **Young age of some lead farmers:** In Zambia, it is considered taboo for young individuals to talk to elders about topics such as sex and family planning. Since some of the lead farmers were young, the elderly initially did not feel comfortable learning about family planning from them. However, integrating family planning messages into conservation messages improved the acceptability of this approach.
- **Inconsistent family planning commodity supply chain:** COMACO depended on the MOH and local health posts for family planning commodities. The supply of oral contraceptives to COMACO peer educators was sometimes affected due to the short supply of these products during which time hospitals and health centers preferred to distribute these commodities themselves.
- **Short performance period of grants:** Since the grants for integrating family planning were short-term, all of the training was completed in a short span of time. There was not enough time for COMACO staff to reflect, learn, and apply lessons to program implementation.

Lessons Learned

- To keep volunteer lead farmers motivated, incentives needed to be intensified. Since adding family planning activities to the responsibilities of the lead farmers increased their workload, COMACO decided to provide lead farmers with a bonus about every 3 months in order to keep them motivated. Other incentives included providing lead farmers with t-shirts, additional training, and bicycles to facilitate their mobility to conduct program outreach and monitoring activities.
- Combining family planning with conservation efforts received a positive response from producer group members, especially young couples. As the COMACO Grants Administrator explained: "We are just proud to say that it's [family planning] part of our on-going activities now and it is something we are working on increasing and not stopping because we have seen the benefits of including family planning. So we'll continue with the approach."
- As explained in a presentation by the Grants Administrator: "We should not always wait for Government to introduce programmes, we can initiate too and have Government adopt!"[3]

[3] Nabuyanda, Ruth. September 13, 2012. "Integration of Family Planning into Livelihoods, Food Security and Conservation in Zambia." Presentation at Flexible Fund 10-Year Program Learning Meeting, Washington, DC.

Appendix 2. Additional Information on Methods

Food Security and Nutrition Outcomes

A food security and nutrition program was defined in this review as a development (non-emergency) program implemented in the past 10 years (2003–2013) that measures at least one of the food security and/or nutrition outcomes shown below.

Food Security Outcomes	Nutrition Outcomes
• Food production • Food expenditure • Share of expenditure on food • Calorie consumption • Household Dietary Diversity Score • Household Hunger Scale • Food Consumption Score • Coping Strategies Index • Household Food Insecurity Access Scale • Months of Adequate Household Food Provisioning • Use of sustainable agriculture practices (i.e., crop, livestock, and/or natural resource management) and/or technologies • Use of financial services for agricultural and/or non-agricultural income generation	• Stunting • Wasting • Underweight • Early initiation of breastfeeding • Exclusive breastfeeding under 6 months • Continued breastfeeding at 1 year • Introduction of solid, semi-solid, or soft foods • Minimum dietary diversity • Minimum meal frequency • Minimum acceptable diet • Consumption of iron-rich or iron-fortified foods • Low birth weight • Mid-upper arm circumference • Lactation amenorrhea method (LAM) rate • Iodine deficiency • Vitamin A deficiency • Iron deficiency and anemia

Targeted USAID Funding Streams

Programs within the following USAID funding streams implemented over a 10-year period (2003–2013) were specifically targeted for this review. Programs active in 2003 or 2013 were included in the review. For example, a program that ran from 1999–2003 or 2011–2015 (an ongoing program) was included, since program implementation fell within the 10-year period of interest to this review.

Child Survival and Health Grants Program (CSHGP): Through the CSHGP, housed in the Bureau for Global Health's Office of Health, Infectious Diseases and Nutrition, "USAID contributes to accelerating reductions in maternal, newborn, and child mortality at national and global levels in priority countries." CSHGP grantees implement integrated packages of interventions in various technical areas including maternal and newborn care, nutrition, immunization, pneumonia case management, family planning, prevention and control of malaria, control of diarrheal disease, and HIV. The Maternal and Child Health Integrated Program support team provides technical assistance to grantees.

Title II development food assistance programs: Title II development food assistance programs are managed by USAID's Office of Food for Peace housed in the Bureau for Democracy, Conflict, and Humanitarian Assistance. These Title II programs target the underlying causes of hunger and malnutrition and aim to reduce chronic malnutrition among children under 5 years of age; improve the

nutrition of pregnant and lactating mothers; increase and diversify household income; and strengthen and diversify agricultural production and productivity. Using a multisectoral approach, these multi-year programs typically focus on three programmatic areas: (1) agriculture and livelihoods to strengthen and improve household food security of beneficiary households; (2) maternal and child health and nutrition services to improve the nutritional status of mothers and children; and (3) community-based disaster risk reduction and early warning and response to promote community resilience and mitigate food security shocks.

Feed the Future Programs: Feed the Future is President Obama's global hunger and food security initiative launched in 2009. Feed the Future programs have two objectives—to accelerate inclusive agriculture sector growth and improve nutritional status especially of women and children. With a focus on smallholder farmers, particularly women, the initiative targets its efforts in 19 focus countries in Africa, Asia, and Latin America and the Caribbean. USAID leads the implementation of Feed the Future through its Bureau of Food Security.

Flexible Fund Program: The USAID Private Voluntary Organization Flexible Fund (2002-2012) was managed by USAID's Office of Population and Reproductive Health in the Bureau for Global Health. Through this grant program, USAID promoted community-based family planning globally with a focus on improving access to family planning information and services especially among hard to reach populations, engaging new partners including faith-based organizations, and building capacity of private voluntary organizations and nongovernmental organizations to deliver quality family planning. Similar grants are now managed by the Advancing Partners and Communities project.

Population, Health and Environment Programs: Population, Health and Environment (PHE) refers to a cross-sectoral community-based approach to development that links conservation (natural or coastal resource management), livelihoods, and health (especially family planning and reproductive health) interventions. USAID supports PHE programs across various USAID Bureaus and Offices including the Global Health Bureau and Bureau for Economic Growth, Education and Environment.

Call for Programs

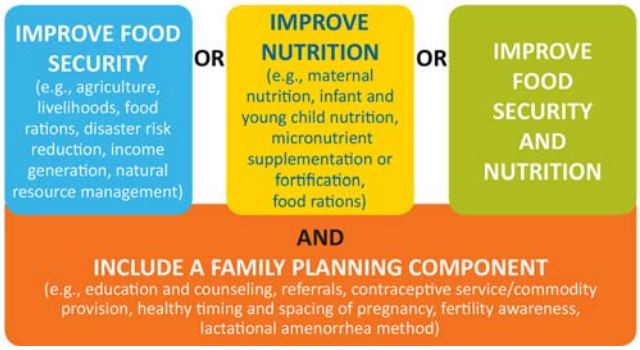
Dear colleague,

The USAID-funded Food and Nutrition Technical Assistance III Project (FANTA), managed by FHI 360, is conducting a program review with support from the Office of Population and Reproductive Health to identify promising practices for integration of family planning into food security and nutrition programs. The review will primarily focus on USAID-funded development (non-emergency) programs implemented over the past 10 years (2003–present).

We are looking for programs that include objective(s) to

- **Improve food security** (e.g., agriculture, livelihoods, food rations, disaster risk reduction, income generation, natural resource management) **AND/OR**
- **Improve nutrition** (e.g., maternal nutrition, infant and young child nutrition, micronutrient supplementation or fortification, food rations)

Programs eligible to be considered for the review will also **include a family planning component** (e.g., education and counseling, referrals, contraceptive service/commodity provision, healthy timing and spacing of pregnancy, fertility awareness, lactational amenorrhea method).



Do you work with or know of any such programs? If so, please answer a few questions using the link below to help us identify relevant programs for this important review.

https://www.surveymonkey.com/s/6HSWY7C

Your participation is voluntary, but we would appreciate your help!

If you have any questions, please contact Reena Borwankar at rborwank@fhi360.org.

USAID FROM THE AMERICAN PEOPLE

FANTA III FOOD AND NUTRITION TECHNICAL ASSISTANCE

fhi360 THE SCIENCE OF IMPROVING LIVES

Terms for Electronic Database Searches

Nutrition	OR Food Security	AND Family Planning
Nutrition	Food security	Family planning
Undernutrition	Food insecurity	Lactational amenorrhea method
Malnutrition	Food security program(s)	Lactational amenorrhea
Nutrition program(s)	*Agriculture (Pop)*	LAM
Food fortification	*Livelihood (Pop)*	Birth spacing
Food supplementation	*Subsistence (GH)*	HTSP
Micronutrient(s)	*Employment (GH)*	Healthy timing and spacing of pregnancy
Vitamins and minerals	Natural resource management	Contracept*
Feeding program(s)	*Resource management (GH)*	
Breastfeeding/"breastfeeding"/ breast-feeding	*Natural resources (Pop)*	
Food ration(s)	Resilience	
Food rationing (GH)	Income gener*	
Food supply (Pop)	*Income (GH)*	
Growth promotion	*Income generation programs(Pop)*	
Growth promotors (GH)		
Growth monitoring		
Growth charts(GH)		
Growth rate (GH)		
Growth (Pop)		
Dietary divers*		
Nutrient sources (GH)		
Diet (Pop)		

Databases searched: POPLINE (Pop) and Global Health (GH)

Screening

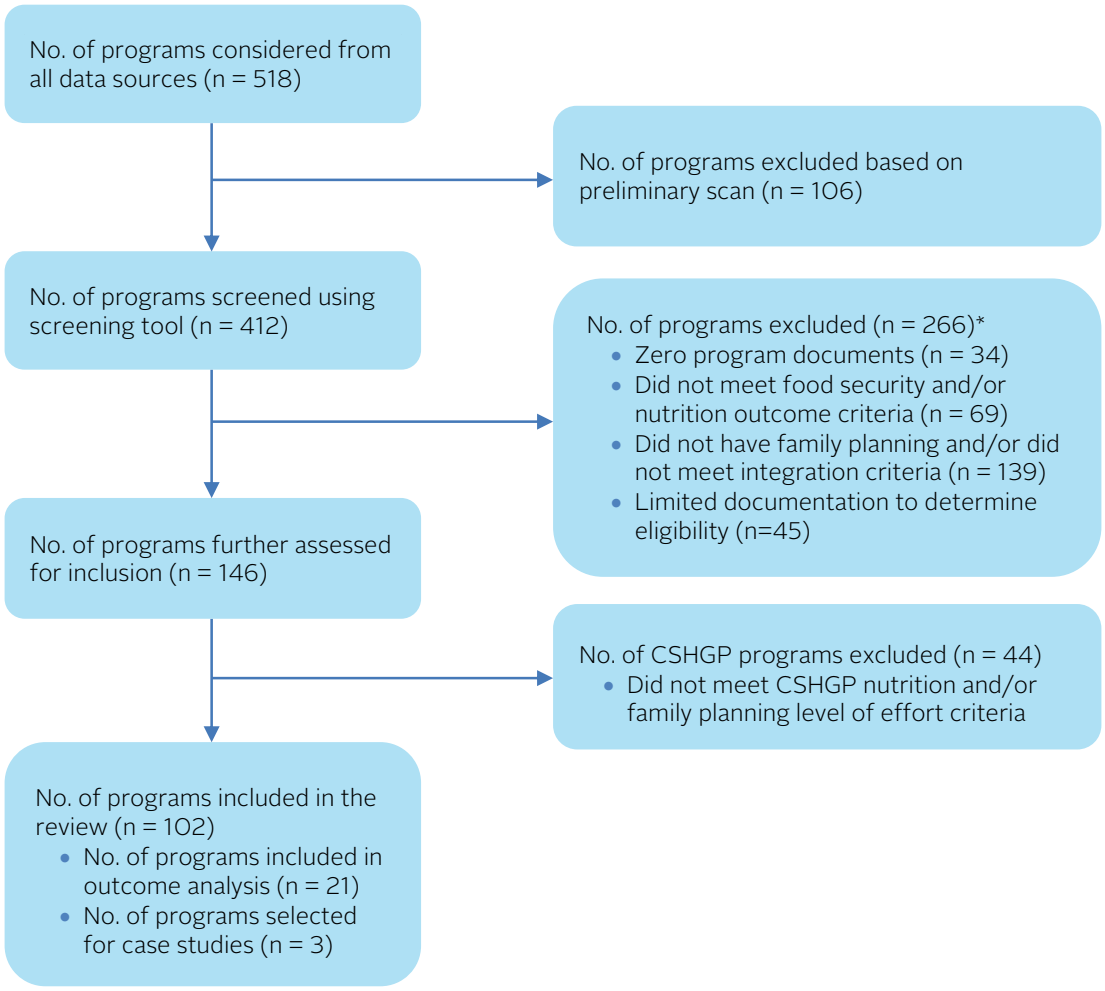
518 programs were identified for initial consideration for inclusion in the review. Due to the large numbers, a preliminary scan was conducted by a single screener, which eliminated 106 programs. These programs were not included in the database because they did not meet the primary inclusion criteria or because of difficulty in obtaining program documents. The remaining 412 programs were screened by a team of 12 trained screeners using a 51-item screening tool.

More than half (266 of the 412) of the programs initially identified were eliminated because they did not meet the primary inclusion criteria and/or the integration criteria. There were 34 programs for which no program documents were obtained, but were included in the database since they belonged to one of the primary funding streams targeted. Some programs did not meet more than one inclusion criteria. About a quarter (69) of the programs excluded did not meet the definition of a food security/and or nutrition program. The majority (139) were excluded because they did not have a family planning component and/or did not meet the integration criteria. Also, in the case of 45 programs, limited documentation resulted in an inability to determine conclusively if the program met the food security and/or nutrition outcome criteria and/or the family planning component criterion.

Since 74 CSHGPs met the review criteria, the review only included programs in which nutrition (including breastfeeding and vitamin A) made up at least 20 percent of the program's level of effort and

specified some level of effort for family planning per the "program summary data sheet." All CSHGPs for which FANTA did not have access to the program's summary data sheet were included. Also, all CSHGPs with a Flexible Fund grant regardless of the program's level of effort for nutrition and family planning were included. In total, 102 programs were included in the review.

Flow Chart of Screening Process



* Some of the programs did not meet more than one inclusion criteria.

Appendix 3. Programs at a Glance by Models

This section provides additional details on the programs included in the review by model.

Model 1 Programs

Total	19 programs (18.6% of total), including two which included family planning referral			
Funding	13 Title II; 5 CSHGP; 1 other USAID program			
Region/ Countries	11 in Africa (2 each in Burundi and Uganda; 1 in Ethiopia, Ghana, Guinea, Madagascar, Malawi, Sierra Leone, and South Sudan)	2 in Asia (1 in Azerbaijan and Bangladesh)	5 in Latin American and the Caribbean (2 in Guatemala; 1 in Haiti, Nicaragua, and Peru)	1 in the Middle East (Yemen)
	10 programs in PRH countries (Bangladesh, Ethiopia, Ghana, Haiti, Madagascar, Malawi, South Sudan, Uganda, and Yemen)			
Other Highlights	• 3 health sector and 16 multisector programs • 6 programs included a family planning objective • Family planning interventions included a male involvement component in 4 programs, a faith-based component and a youth component in 1 program each.			

Model 2 Programs

Total	18 programs (17.6% of total), including 6 with family planning referral			
Funding	5 CSHGP (2 Flexible Fund grants); 5 other USAID; 4 Title II; 2 non-USAID; and 2 PHE programs			
Region/ Countries	6 in Africa (1 in Ethiopia, Guinea, Liberia, Madagascar, Malawi, and Mali)	6 in Asia (2 in the Philippines; 1 in Afghanistan, Cambodia, Myanmar, and Uzbekistan)	5 in Latin American and the Caribbean (3 in Honduras, 1 in Guatemala and Haiti)	1 in the Middle East (Jordan)
	9 in PRH countries (Afghanistan, Ethiopia, Haiti, Liberia, Madagascar, Malawi, Mali, and the Philippines)			
Other Highlights	• 11 health sector and 7 multisector programs • 10 programs included a family planning objective • Family planning interventions included a male involvement component in 6 programs, faith-based component in 3 programs, and youth component in 3 programs.			

Model 3 Programs

<table>
<tr><td>Total</td><td colspan="5">65 programs (63.7% of total), including 30 with a family planning referral component</td></tr>
<tr><td>Funding</td><td colspan="5">20 CSHGP (8 Flexible Fund grant); 18 other USAID (2 Flexible Fund grant); 16 PHE (2 Flexible Fund grant); 10 Title II programs (2 Flexible Fund grant); and 1 Other non-USAID</td></tr>
<tr><td rowspan="2">Region/ Countries</td><td>33 in Africa
(8 in Madagascar; 5 in Kenya; 3 each in Ethiopia, Tanzania, and Uganda;* 2 each in Burundi, Guinea, Malawi, and Zambia; 1 each in DRC, Liberia Mozambique, and Rwanda)</td><td>17 in Asia
(5 in Nepal; 3 each in India and Cambodia; 2 in Bangladesh; 1 each in Kyrgyzstan, Philippines, Tajikistan, and Timor-Leste)</td><td>11 in Latin America and the Caribbean
(6 in Haiti; 2 each in Guatemala and Nicaragua; 1 in Honduras)</td><td>2 in Europe and Eurasia
(1 each in Albania and Russia)</td><td>2 in the Middle East
(1 each in Egypt and Yemen)</td></tr>
<tr><td colspan="5">47 programs in PRH priority countries (Bangladesh, Democratic Republic of the Congo, Ethiopia, Haiti, India, Kenya, Liberia, Madagascar, Malawi, Mozambique, Nepal, the Philippines, Rwanda, Tanzania, Uganda, Yemen, and Zambia)</td></tr>
<tr><td>Other Highlights</td><td colspan="5">• 32 health sector and 33 multisector programs
• 45 programs included a family planning objective.
• Family planning interventions included a male involvement approach in 29 programs; youth component in 18 programs, and faith-based component in 12 programs.</td></tr>
</table>

* One program was implemented in Kenya and Uganda and has been counted in both countries.

Appendix 4. Summary of Reported Outcomes Analysis

A subset (21 of the 102 programs) qualified for analysis of outcomes, which focused on completed programs with baseline and end-of-program quantitative data available for select family planning and nutrition and/or food security outcomes through final evaluation reports. Each outcome is classified as showing positive, negative, mixed, or no change from baseline to final evaluation. A positive or negative change was defined as at least one percentage point difference up or down respectively from the baseline measure; no change was defined as no change or less than a one percentage point difference between the baseline and final evaluation measure. It should be noted that within each outcome, there was variation in definitions and populations measured and the findings should be interpreted with this in mind.

Of the 21 programs included in this analysis, 13 are CSHGPs, 8 are Title II-funded programs, and 5 received a Flexible Fund grant. The distribution of the programs in this analysis across the three family planning integration models is as follows: 4 programs integrating family planning education (Model 1), 1 program integrating family planning education and counseling (Model 2), and 16 programs integrating family planning education, counseling, and commodity provision (Model 3). Note that the small number of programs within each model further limited the analysis.

	Programs reporting outcome		Positive change				Negative change				No change			
	N	%	N	N by FP Models			N	N by FP Models			N	N by FP Models		
Outcome	21	100		1	2	3		1	2	3		1	2	3
Stunting	9	42.9	4	1	0	3	3	1	0	2	2	0	0	2
Wasting	7	33.3	2	1	0	1	2	0	0	2	3	1	0	2
Underweight	15	71.4	13	3	0	10	2	0	0	2	0	0	0	0
Early breastfeeding	10	47.6	9	1	1	7	1	1	0	0	0	0	0	0
Exclusive breastfeeding	13	61.9	11	2	1	8	1	1	0	0	1	0	0	1
Introduction of complementary feeding	9	42.9	6	0	1	5	3	1	0	2	0	0	0	0
Composite infant and young child feeding	5	23.8	3	1	0	2	1	0	0	1	1	0	0	1
Vitamin A	8	38.1	6	2	0	4	0	0	0	0	2	0	0	2
Food security outcomes														
Household dietary diversity score	6	28.6	0	0	0	0	0	0	0	0	6	2	0	4
Months of adequate provisioning	5	23.8	1	0	0	1	3	0	0	3	1	1	0	0
Use of sustainable agriculture practices and/or technologies	3	14.3	3	0	0	3	0	0	0	0	0	0	0	0
Family planning outcomes														
Use of modern family planning methods	11	52.4	9	2	0	7	1	0	0	1	1*	1	0	0
Birth spacing	11	52.4	8	3	1	4	3	0	0	3	0	0	0	0
Met need for family planning	7	33.3	6	1	0	5	0	0	0	0	1	0	1	0

* The result was mixed because multiple measures were provided for the outcome that showed inconsistent results.

Appendix 5. Programs Included in the Review and Documentation Considered

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
Africa									
Burundi	Title II	Catholic Relief Services	Catholic Relief Service Burundi Multi-Year Assistance Program (MYAP)	2008–2012	2		X	X	1
	Title II	Catholic Relief Services	PM2A-Tubaramure	2009–2014	3	X		X	1
	Other USAID	Pathfinder International	Extending Service Delivery (ESD) Associate Award to Burundi; Burundi Maternal and Child Health Project (MCHP)	2007–2011				X	3*
	CSHGP; FF	World Relief	Ramba Kibondo "Live Long Child" Child Survival Project	2007–2012	3	X	X	X	3*
Democratic Republic of Congo	Title II	Food for the Hungry	Tuendelee Pamoja	2011–2016	1			X	3*
Ethiopia	Other USAID	Academy for Educational Development	LINKAGES (Ethiopia)	2003–2006	1			X	2
	Other USAID; FF	Adventist Development and Relief Agency	Adventist Development and Relief Agency Family Planning and Reproductive Health Project	2003–2006	3			X	3
	PHE	Ethio Wetlands and Natural Resources Association	Integrated Wetland and Watershed Management: A Landscape Approach towards Improved Food Security, Poverty Reduction and Livelihood Enhancement; BALANCED seed grant	2009–2011				X	3*
	Other USAID	Pathfinder International and John Snow, Inc.	Integrated Family Health Program; E2A Project	2008–2013		X		X	3*
	Title II	Relief Society of Tigray	Development Food Aid Program (DAP)	2011–2016	1				1

[1] CSHGP = USAID Child Survival and Health Grants Program; FF = USAID Flexible Funds; PHE = Population, Health, and Environment; Title II = USAID/Food for Peace Title II Development Food Assistance Program
[2] In some cases, multiple programs are listed where the activity of interest to this review was conducted as part of, or in coordination with, a broader program.
[3] Program dates that were not always clear from the materials reviewed are indicated as n/d; in some cases the dates for the broader program, which the activity was implemented under, is used.
[4] Might include semi-annual, quarterly, annual report(s), and/or final report for program and/or flexible funds.
[5] Might include a joint evaluation/assessment, or qualitative evaluation/assessment.
[6] Might include one or more of the following: detailed implementation plan, technical brief, research report, journal article, video, PowerPoint presentation, newsletter, training materials, or counseling materials.
[7] Refers to the level of family planning interventions at the food security and/or nutrition points of contact: 1 = education; 2 = education and counseling; 3 = education, counseling, and commodity provision; * = referral to family planning services

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
Ghana	Title II	Opportunities Industrialization Centers International	Enhancement of Household Agriculture, Nutrition, Risk Reduction and Community Empowerment (ENHANCE)	2004–2010	5	X	X	X	1
Guinea	CSHGP; FF	Adventist Development and Relief Agency	Child Survival (CS) XVI Project	2000–2005	3	X	X	X	2*
	Title II	Africare	Guinea Food Security Initiative	2000–2008	6		X	X	3
	Title II	Opportunities Industrialization Centers International	Food and Livelihood Security in Pita and Telimele	2004–2010	7	X	X		1
	CSHGP; FF	Save the Children	*Initiative pour la Santé Communautaire* (ISCOM) (The Community Health Initiative for the Districts of Kouroussa and Mandiana Guinea)	2002–2006	1	X	X		3*
Kenya	Other USAID	FHI 360; Land O' Lakes International Development	Program Research for Strengthening Services (PROGRESS) Project; Kenya Dairy Sector Competitiveness Program (KDSCP)	2008–2013				X	3*
	Other USAID	Kenya Ministry of Public Health and Sanitation, Department of Family Health through the Divisions of Nutrition and Reproductive Health	Maternal, Infant, and Young Child Nutrition and Family Planning Integration; Maternal and Child Health Integrated program (MCHIP)	2011–2014			X	X	3
	PHE	Pathfinder International	Health of People and Environment within Lake Victoria Basin project (HoPE-LVB)[8]	2011–2014				X	3*
	Other USAID	Population Council	Strengthening Postnatal Care Services Including Postpartum Family Planning in Kenya; Frontiers in Reproductive Health (FRONTIERS)/ACCESS-FP	2006–2008				X	3*
	PHE	World Wildlife Fund	Successful Communities from Ridge to Reef (Kenya)	2003–2008	10			X	3
Liberia	CSHGP	Africare	Innovation, Research, Operations, and Planned Evaluation for Mothers and Children (I-ROPE)	2010–2014	2				2
	CSHGP; FF	Curamericas	Nehnwaa Child Survival Project	2008–2013	5	X	X	X	3
Madagascar	Other USAID	Academy for Educational Development	LINKAGES (Madagascar)	1997–2006	1			X	2

[8] This program was also implemented in Uganda. For analysis it was considered as one program.

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
	PHE; FF	Environment Health Project/ Voahary Salama	Environment Health Project	2001–2004	2			X	3
	Title II	Adventist Development and Relief Agency	TANTSAHA	2004–2009	4	X	X	X	3
	PHE	Blue Ventures-Safidy	Blue Ventures	2007–2014	6			X	3
	Title II	CARE	Title II Development Activity Program	2003–2009	6	X	X	X	1
	Other USAID; FF	Chemonics International Inc.	Santénet (Kaominina Mendrika)/Santénet2	2004–2013	9			X	3*
	PHE	Conservation International	Healthy Families, Healthy Forests: Combining Reproductive Health with Biodiversity Protection for Effective Programming	2002–2005	3			X	3*
	Other USAID	John Snow, Inc.	The Malagasy Healthy Families (MAHEFA) Initiative	2008–2012			X	X	3
	PHE	John Snow, Inc.	Madagascar Green Healthy Communities	2002–2005	1			X	3
	PHE	World Wildlife Fund	Successful Communities from Ridge to Reef (Madagascar)	2003–2008	10			X	3
Malawi	Other Non-USAID	Malawi Ministry of Health and University College London	*MaiMwana*	2002–n/d				X	2
	Other USAID	Partnership for Child Health Care, Inc., comprised of the Academy for Educational Development; John Snow, Inc.; and Management Sciences for Health	BASICS III (Basic Support for Institutionalizing Child Survival) Malawi	2004–2009	2	X	X	X	3*
	CSHGP; FF	Save the Children	*Mwayi wa Moyo* ("A Chance to Live") Project	2011–2016	2				3*
	CSHGP	World Relief	Tiweko Rose Child Survival Project (CSP)	2000–2004	1	X	X		1
Mali	Other USAID	Abt Associates, Inc.	Assistance Technique Nationale Plus (ATN Plus); TASC3 mechanism	2008–2013	4			X	2*
Mozambique	Other USAID	Pathfinder International	Strengthening Communities through Integrated Programming (SCIP)	2009–2014	4			X	3
Rwanda	PHE	Texas A&M University	Sustaining Partnerships to Enhance Rural Enterprise and Agribusiness Development (SPREAD) Project	2006–2012		X		X	3*
Sierra Leone	Title II	ACDI/VOCA	Sustainable Nutrition and Agriculture Promotion (SNAP) Program	2010–2015	2			X	1

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
South Sudan	Title II	Adventist Development and Relief Agency	Southern Sudan Health Nutrition and Empowerment Project (SSHiNE)	2010–2012	3				1
Tanzania	PHE	Coastal Resources Center at the University of Rhode Island	Building Actors and Leaders for Advancing Community Excellence in Development (BALANCED)/The Pwani Project	2009–2012	1			X	3*
	PHE	Jane Goodall Institute	The Lake Tanganyika Catchment, Reforestation, and Education (TACARE) Family Planning Project	1997–2007				X	3*
	PHE	Pathfinder	Tuungane	2011–n/d				X	3*
Uganda	Title II	Africare	Uganda Food Security Initiative-Phase II (UFSI-II)	2002–2006	4		X		1
	Feed the Future	FHI 360	Community Connector	2012–2017	4			X	1*
	Other USAID	Management Sciences for Health	Strides for Family Health	2009–2014	4			X	3
	PHE	Pathfinder International	Health of People and Environment within Lake Victoria Basin project (HoPE-LVB)	2011–2014				X	3*
	Title II; FF	Save the Children	Enhancing Food Security through Poverty Alleviation	2004–2008	6		X		3
Zambia	CSHGP	Project Concern International	Nutrition, Child and Community Health and HIV/AIDS Educational (NCHE) Child Survival Project (CSP)	2002–2007	1	X	X		3
	PHE; FF	Wildlife Conservation Society	Community Markets for Conservation (COMACO); Building Actors and Leaders for Advancing Community Excellence in Development (BALANCED) Seed Grant	2010–2013	2			X	3*
Asia									
Afghanistan	Title II	World Vision	Health and Livelihood Initiative in Ghor (HEALING)	2008–2011	3		X		2
Azerbaijan	CSHGP	Mercy Corps International	Azerbaijan Child Survival Project-Building Partnerships, Saving Lives	2001–2006		X	X		1
Bangladesh	Other USAID	Chemonics	Bangladesh Smiling Sun Franchise Program (BSSFP)	2007–2011	3	X	X		3*
	CSHGP	Concern Worldwide	The USAID-Concern Worldwide-Municipality Partnership Child Survival Program (CSP)	2000–2004		X	X	X	1
	Other USAID	Jhpiego	Healthy Fertility Study	2007–2013				X	3*

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
Cambodia	CSHGP	Adventist Development and Relief Agency	Child Survival XVII	2001–2006	3	X	X		3*
	PHE	Conservation International	Healthy Families, Healthy Forests: Combining Reproductive Health with Biodiversity Protection for Effective Programming	2002–2008	5			X	3
	Other USAID	Jhpiego	Integrated Postpartum Care Program for Midwives in Cambodia; ACCESS-FP/Maternal and Child Health Integrated program (MCHIP)	2008–2010	1			X	2
	CSHGP	World Vision	Kean Svay Extension Child Survival Project	2000–2003	1	X	X		3
India	Title II	CARE	Reproductive and Child Health, Nutrition and HIV/AIDS Program (RACHNA)	2001–2006	3	X	X	X	3
	CSHGP	Population Services International	Social Marketing Strategies for Maternal and Child Health Project	2002–2005	1	X	X		3*
	CSHGP; FF	World Vision	Pragati Child Survival Project	2003–2007	2	X	X	X	3*
Kyrgyzstan	CSHGP	Project HOPE, The People-to-People Health Foundation, Inc.	Project HOPE: Child Survival Project (CSP); Healthy Lifestyles for Women and Children Program	2002–2006	2	X	X	X	3
Myanmar	Other Non-USAID	Joint Initiative on Maternal, Newborn and Child Health	Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH)	2010–2012	1				2
Nepal	PHE	CDM International Inc.; World Wildlife Fund; Resource Identification and Management Society	Integrating Population and Health into Forestry Management Agendas in Nepal; Environmental Health IQC (EH IQC) Contract	2003–2008	1		X	X	3
	CSHGP; FF	HealthRight	Partnership for Maternal and Neonatal Health (PMNH); Integrating Family Planning and Maternal and Newborn Care Services in Rural Nepal	2009–2013	3	X		X	3
	Other USAID	Partnership for Child Health Care, Inc., comprised of the Academy for Educational Development; John Snow, Inc.; and Management Sciences for Health	Nepal Child Survival; BASICS II	1999–2004	1			X	3
	Other USAID	Save the Children	Suaahara	2011–2016	4			X	3*
	Other Non-USAID	World Neighbors	World Neighbors Terai Program	2000–n/d				X	3*

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
Philippines	PHE	PATH Foundation Philippines, Inc.	Integrated Population and Coastal Resource Management (IPOPCORM) Initiative	2001–2007	1		X	X	3
	PHE	Save the Children	People and Environment Co-Existence Development Project (PESCO-Dev)	1999–2004				X	2*
	PHE	World Wildlife Fund	Successful Communities from Ridge to Reef (Philippines)	2003–2008	10			X	2*
Tajikistan	CSHGP	Aga Khan Foundation	Maternal and Child Nutrition and Integrated Communications (MCN/IC) Project	2000–2004	1	X	X		3*
Timor Leste	CSHGP; FF	Health Alliance International	Improving Maternal & Newborn Health in Timor Leste	2004–2008	5		X	X	3
Uzbekistan	CSHGP; FF	PROJECT HOPE	Child Survival Navoi Project: Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan	2002–2007	2	X	X	X	2
Europe and Eurasia									
Albania	CSHGP; FF	American Red Cross	Albania Child Survival Project	2001–2008	3	X	X	X	3
Russia	Other USAID	John Snow, Inc.	Women and Infants' Health (WIN); Maternal and Child Health Initiative (MCHI)	1999–2007	2	X	X	X	3
Latin America and the Caribbean									
Guatemala	Title II	Asociación SHARE de Guatemala	Rural Development Program (RDP)	2000–2006	3		X	X	1
	Title II	Catholic Relief Services	SEGAMAYA, Multi-Year Assistance Program	2006–2012	6	X	X	X	2
	CSHGP	Curamericas	Census-Based, Impact-Oriented Child Survival Project	2002–2007	1	X	X	X	3
	Title II	Mercy Corps	PROCOMIDA; Community Food Diversification Program for Mother and Child	2009–2014	4	X		X	1
	CSHGP	Project HOPE, The People-to-People Health Foundation, Inc.	Project HOPE	2001–2005	2	X	X	X	3
Haiti	Title II	ACDI/VOCA	Haiti Multi-Year Assistance Program (MYAP)	2008–2013	5	X	X		3
	Title II	Catholic Relief Services	Kole Zepol	2008–2012	5	X	X		3
	CSHGP	Foundation of Compassionate American Samaritans	FOCAS Child Survival Project	1997–2003	3	X	X	X	3*

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
	CSHGP	Haitian Health Foundation	*Kominote Oryante pou Mere ak Bebe via Inovasyon e Teknoloji* (*Kombit Project*) (Communities Organized for Mothers and Babies With Innovation and Technology)	2004–2009	1	X	X	X	2
	CSHGP	Project HOPE	Haiti Child Survival Project	2001–2006	4		X	X	3*
	Title II	Save the Children	Development Activity Program (DAP)	2002–2007	6	X	X		1
	Title II	World Vision	Development Activity Program (DAP)	2002–2008	7	X	X		3
	Title II; FF	World Vision	*Sak Plen REP* (Full Sack Resiliency Enhancement Program)	2008–2013	8	X	X	X	3
Honduras	Title II	Adventist Development and Relief Agency	Development Assistance Program (DAP) in Support of Subsistence Farmers	2004–2009	5	X	X		2*
	CSHGP	Catholic Relief Services	Community-Based Child Survival	1999–2003	2		X	X	2
	Title II	Save the Children	*Proyecto de Gestión Rural en Seguridad Alimentaria* (PROGRESA)	2005–2010	6	X	X	X	2*
	Title II	World Vision	Food Security Enhancement and Risk Reduction Program for Far Western Honduras	2004–2009	5	X	X		3*
Nicaragua	CSHGP	Adventist Development and Relief Agency	Healthy Children in Healthy Communities	2001–2006	1	X	X		3
	Title II	Adventist Development and Relief Agency	Development Activity Program (DAP)	2002–2009	8	X	X		1
	CSHGP	Project HOPE	Project HOPE: Jinotega Child Survival Project (CSP);Improving the Health of Mothers and Children of Rural Jinotega, Nicaragua: An Integrated Approach in Partnership with the Public and Private Sector Providers in Coffee-Growing Areas	2002–2007	2	X	X	X	3*
Peru	CSHGP	CARE	Child Survival XVI	2000–2004	1	X	X		1*
Middle East									
Egypt	Other USAID	Pathfinder International; Population Council	Scaling up the provision of family planning messages in antenatal and postpartum services in Upper Egypt; Extending Service Delivery (ESD)	2009–2011	1			X	3
Jordan	Other USAID	Academy for Educational Development	LAM Project; LINKAGES	1998–2004	1			X	2

Country	Funding Source[1]	Primary Implementing Organization(s)	Program Name[2]	Program Dates[3]	Program Annual Report (No.)[4]	Program Midterm Evaluation/ Assessment Reports[5]	Program Final Evaluation/ Assessment Reports	Other Program Documents[6]	Family Planning Integration Model[7]
Yemen	Other USAID	Pathfinder International	Scaling Up Best Practices Yemen Improvement Collaborative/Yemen Basic Health Services Project; Extending Service Delivery (ESD)	2006–2011				X	3
	CSHGP	Adventist Development and Relief Agency	Child Survival IV	1999–2003		X	X		1

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