High Impact Practices Partners' Meeting Report

October 21, 2014

Abt Associates
4550 Montgomery Avenue
Suite 800 North
Bethesda, MD 20814

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HIP Meeting Notes

Welcome

Caroline Quijada from Abt Associates opened the meetings and welcomed participants to the third HIP Partners meeting. Ms Quijada provided an overview of Abt Associates contribution and commitment to supporting the HIP work.

Jennifer Friedman from IPPF added her thanks and welcome to participants. She also announced that IPPF would provide support to translate briefs into Spanish and French. IPPF is particularly dedicated to improving the quality of care and expand services for family planning.

Mihira Karra welcomed participants on behalf of USAID and thanked the partners' contribution to increasing the visibility and acceptance of the HIPs. She expressed her appreciation to the support organizations and individuals to helping countries utilize and expand evidence-based programming. Mihira updated participants on recent changes in the Office of Population and Reproductive Health including the addition of two new deputies, Irene Koek and Aly Cameron. She added that there is a continued need for dissemination and promotion of the HIPs at the country level and that Ending Preventable Child and Maternal Death has brought an urgent need for measuring progress and the HIP work has an important role to play.

On behalf of Nuriye Ortayli, Gifty Addico from UNFPA thanked participants for their continued support and participation in the HIP work. Ms. Malarcher reviewed the agenda and objectives of the meeting.

HIP TAG Report

Jay Gribble gave an overview of the conclusions of the HIP TAG meeting which took place in May 2014 in New York. Key points included a recommendation to develop an overarching principle document for the HIPs which will include a discussion of how the HIP work is based on the principles of rights, equity, quality, etc. The TAG also recommended updating the briefs regularly, strengthening the text on scale-up and sustainability, and more emphasis on economic analysis.

IBP HIP Task Team Report

Nandita Thatte, Laurette Cucuzza, and Erin Schelar reported on work of the IBP HIP Task Team. The Task Team meets quarterly and activities have focused on distribution of materials at conferences, inclusion of HIP materials in trainings and on websites, and presentations of HIPs at partner headquarters and at regional meetings. The group has also begun collecting country case studies documenting implementation of HIPs.

Erin presented results from the IBP Strategic Plan Survey. The group found significant limitations to this way of monitoring implementation of HIPs and would like to develop better methods for documenting how countries are using HIPs. The survey found that use of HIP materials among Partners was mixed. There is a need to make the materials available at the country level. There is a lot of interest in the map, but we need to facilitate more participation in the map.

Suggestions from participants:

- Consider engaging the Technical Working Groups at the country level.
- Encourage countries to focus on a smaller number of activities for scale-up and institutionalization. Consider grouping activities in the Costed Implementation Plans so that if there are insufficient resources to do everything it is clear which activities are prioritized.
- Advocate with civil society and women's organizations
- Consider including geographic targeting as well.
- Support study tours for FP2020 reference groups
- Deputize HIP champions in each country, empower them. What about using IBP country teams to identify POC within teams?
- Develop a useful tool to survey partners, in order to get granular data.

HIP Website and Twitter Account

Debbie Dickson and Caitlin Thistle presented updates and plans for the HIP website and Twitter account. Plans are underway to translate the website and this should help with organization of the briefs. Also, Caitlin plans to increase visibility and activity on the Twitter account. Please ask your communication people to help with spreading the work.

Workplan Discussion

Gifty Addico gave an overview of the joint HIP workplan. Some important updates are that there will be no new briefs in 2016 as we will be working to update several existing briefs. Some suggestions for new activities were:

- Work with countries developing CIP to ensure they are briefed on HIPs and empower them to consider these interventions. 5-7 countries working on CIPs now.
- Create a short set of slides (5-8) that can be used to brief folks about the HIPs. Explains promising/proven, what is a HIP, etc. Consider narrating the presentation and put them on the website.
- Webinar- focus on each HIP and identify partner for each HIP, talks about what they are doing on the ground. Explain standards of evidence.
- RFP/RFA – Encourage AID to include HIPs as resource items in the announcement. Incorporate things that have been done and what can be worked off of.

Decision-Making Tool Overview

Alisa Wong from FP2020 gave an overview of work done to address the need for a HIP "decision-making tool". Emily Sonneveldt from Futures Institute and George Hayes from Marie Stopes International presented on tools that their organizations have been working on that may fill this need. Work is ongoing.

2015 HIP Briefs

Adolescent Briefs

Sylvia Wong from UNFPA and Shefa Sikder from USAID gave an overview of the process used to identify the 3 practices which will be developed into 3 briefs. Three main authors for the briefs provided and overview of how the practices are being defined and the extent of the evidence-base they've identified thus far.

1. Community-based interventions, Kate Plourde and Joy Cunningham from FHI 360
    - Definition: interventions that target geographically bound communities to improve knowledge and change norms while targeting youth with BCC information.
    - Challenge: authors typically do not tease out the impact of specific interventions, only program as a whole.
2. Adolescent-Friendly services, Jill Gay and Karen Hardee from Population Council
    - Definition: Integrate 'adolescent contraceptive friendliness' within the range of existing Fp and other service, INSTEAD OF created a separate facility for adolescents
    - Potentially add within MCH, HIV, PAC, IMZ services
    - Evidence to date is limited.
3. Economic Empowerment, Kim Ashburn from IRH
    - Mechanism for change – improved economic outcomes expands life options and leads to improved SRH outcomes

Participants raised a number of concerns including interventions are too broad and will run into problems with the evidence, interventions are so context-specific, and how can you have HIPs that take into consideration the context.

Jay Gribble from Futures Group provided a brief description of the Galvanizing Commitment brief. "Commitment" is defined as expressed, institutional, and resourced.

Closing Remarks

In order to make the most of these meeting we need your input. We are particularly interested in the following: full day versus half day meetings and how often should we meet? Is once a year enough or do we need to meet more often?

Participants shared appreciation for authors' work. Gifty reminded participants to engage UNFPA colleagues at the country level. The organizers thanked participants for their time and engagement and will be in touch regularly with updates. Please send feedback on what your organizations are doing to support HIPs. We'd love to hear it!

Appendix A

AGENDA

Abt Associates
4550 Montgomery Avenue
Suite 800 North
Bethesda, MD 20814

HIP Partners Meeting

October 21, 2014
9:00 – 4:30

Objectives

- Update on HIP work to date
- Finalize joint HIP workplan for 2015
- Finalize plans for decision-making tool
- Discuss and finalize development of 2015 HIP briefs

Tuesday, October 21, 2014

	Breakfast
9:00 – 9:15	**Welcome** Caroline Quijada, SHOPS Deputy Project Director, Abt Associates Jennifer Friedman, IPPF Suzanne Reier, WHO Nuriye Ortayli, UNFPA Shawn Malarcher, USAID
9:15 – 9:45	**HIP TAG Report** Jay Gribble, Futures Group
9:45 – 10:45	**IBP HIP Task Team Report** Nandita Thatte, USAID Laurette Cucuzza, Plan USA Erin Schelar, USAID
10:45 – 11:15	**Break**
11:15 – 11:45	**Website updates, web analytics, and Twitter** Debbie Dickson, K4H and Caitlin Thistle, USAID
11:45 – 12:30	**Workplan Discussion** Gifty Addico, UNFPA
12:30 – 13:30	**Lunch**
13:30 – 14:30	**Decision-making tool overview** Alisa Wong, FP 2020 Emily Sonneveldt, Futures Institute and George Hayes, MSI
14:30 – 16:00	**2015 HIP Briefs** ***Adolescent Briefs***: Overview of process: Sylvia Wong, UNFPA and Shefa Skider, USAID Briefs: Kate Plourde, FHI 360; Jill Gay, Population Council; Kimberly Ashburn , IRH ***Galvanizing Commitment:*** Jay Gribble, Futures Group
16:00 – 16:30	**Next Steps and Wrap Up**

Appendix B

Meeting Participants

Alfredo Fort, IntraHealth	afort@intrahealth.org
Alisa Wong, FP2020	alisawong@familyplanning2020.org
Angela Nash-Mercado, Jhpiego	Angela.Nash-Mercado@jhpiego.org
Candace Lew, Pathfinder	CLew@pathfinder.org
Debra Dickson, K4Health	ddickso1@jhu.edu
Defa Wane, Engender Health	dwane@engenderhealth.org
Elaine Charurat, Jhpiego	Elaine.Charurat@jhpiego.org
Elizabeth Berard, USAID	eberard@usaid.gov
Ellen Eiseman, Chemonics	EEiseman@chemonics.com
Erika Martin, USAID	ErMartin@usaid.gov
Erin Mielke, USAID	emielke@usaid.gov
Erin Schelar, USAID	eschelar@usaid.gov
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George Hayes, MSI	George.Hayes@mariestopes.org
Gifty Addico, UNFPA	gaddico@unfpa.org
Jay Gribble, Futures Group	JGribble@futuresgroup.com
Gwyn Hainsworth, Pathfinder	GHainsworth@pathfinder.org
Jen Drake, PATH	jdrake@path.org
Jennifer Friedman, IPPF (remote)	jfriedman@ippfwhr.org
Jill Gay	jillgay.rh@gmail.com
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Shegufta Shefa Sikder, USAID	ssikder@usaid.gov
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Tanvi Pandit-Rajani, JSI	tanvi_pandit@jsi.com
Tishina Okegbe, USAID	tokegbe@usaid.gov

Appendix C: HIP Workplan - FY 2014

Deliverables	Key Activities	Responsible Org	Contact	Completion date
New Briefs				
Girls in School Brief	draft/revise brief	Pathfinder/USAID	Shefa Sikder and Shannon Taylor	complete
	comment	All		complete
	fact check	KMS		complete
	TAG review	UNFPA/USAID/IPPF/WHO		complete
	copy edit and layout	K4H		Oct-14
Voucher Brief	draft/revise brief	Population Council/USAID	Ben Bellows/Elaine Menotti	complete
	comment	All		complete
	fact check	KMS		complete
	TAG review	UNFPA/USAID/IPPF/WHO		complete
	copy edit and layout	K4H		Oct-14
Management and Leadership Brief	draft/revise brief	MSH/USAID	Nandita Thatte/Temi/MSH	complete
	comment	All		complete
	fact check	KMS		Nov-14
	TAG review	UNFPA/USAID/IPPF/WHO		request interim
	copy edit and layout	K4H		Jan-15
French translation of new briefs		needed		
Spanish translation of new briefs		needed		
Portugese translation of briefs		Pathfinder		on going
Adolescent Steering Committee	Meet regularly to guide and advise on review process	UNFPA/USAID/IPPF/ WHO and authors listed below	Shawn Malarcher/ Cate Lane/Shannon Taylor/ Sylvia Wong/Dootja/Chandra Mouli	Oct 15th

Community-Based Programs for Youth	Lit Review: What interventions contribute to improved SRH knowledge ultimately contributing to increase contraceptive use, delayed sexual initiation, delayed first birth, and/or longer birth spacing among adolescents?	FHI360	Kate Plourde	Sep-14
Service delivery brief for adolescents	Lit Review: What interventions contribute to improved access to contraceptive services and products ultimately contributing to increase contraceptive use, delayed sexual initiation, delayed first birth, and/or longer birth spacing among adolescents?	Population Council	Jill Gay	Sep-14
Structural intervention brief for adolescents	Lit Review: What interventions/program investments contribute to improved social norms that ultimately contributing to increase contraceptive use, delayed sexual initiation, delayed first birth, and/or longer birth spacing among adolescents?	IRH	Rebecka Lundgen/Jessica	Sep-14
Galvanizing Commitment	HIP Brief	Futures Group	Jay Gribble	Dec-14
Dissemination/Implementation Support				
Develop dissemination strategy				
Document HIP implementation				
Develop template for documenting implementation				
Develop indicators for dissemination and implementation				
Create links on FP2020 and IBP websites				
Supporting Materials				
Standards of evidence guidance on reaching underserved populations and sustainability	HIP TAG			Jun-14

Checklist for organizing study tours	requested by FP2020	Columbia University, FHI 360	Shawn Malarcher	30-Jun
Decision-making tool		UN Foundation	Alisa Wong	
Website updates	translation		Debbie	
	add drug shops to the map	K4H	Dickson/Aysha	complete
Case studies on HIP implementation		Population Council		
Organizational Support				
HIP TAG Meeting		UNFPA host		Jun-14
HIP Partners Meeting		Abt Assoc host		Oct-14
IBP Task Team	Country Implementation Case Studies (TZ, Zambia, Mozambique)		Ados May / Nandita Thatte	quarterly
	HIP Webinar Series			
	Continued support for dissemintation of HIPs			
	Coordination with FP2020 on HIPs in Country (Uganda)			

HIP TAG Update

June 2014

Updates

- IBP Task Team on Implementation
- FP2020 Country Engagement Working Group
- 6 new briefs; translations into French and Spanish
- Need for a document that provides overarching principles—method choice, gender, rights, quality, and equity

Standards of Evidence

- Recommendations from Croyden Meeting
- Suggestions for improving HIP briefs
  - Independent appraisal of evidence in current briefs
  - "Conceptual framework"
  - Firewall between those generating evidence and TAG to avoid conflict of interest
  - Preregistration of research protocols

Standards of Evidence

- Determining "promising" vs "proven" HIPS
  - Service delivery vs enabling environment
  - Difficulty of finding one framework
- Standards for measuring access for underserved populations
  - Contextually defined; need for using equity analysis
  - Not all HIPs focus on reaching the underserved

Standards of Evidence

- Measuring sustainability
  - Is there a time frame?
  - Does "sustainable" mean supported by public sector?
  - Are all practices intended to be sustainable in perpetuity?
  - Adding explicit text on sustainability in briefs\
- Enabling environment
  - Variations across briefs is reasonable
  - Derivative products that give more details
  - Recommendation for one-page summary for policymakers

Brief Review

- Leadership and management
  - Critical to health systems
  - Cost-effectiveness and measurement not addressed
  - Practice not clearly defined; inputs were context specific
- Vouchers
  - Evidence fairly consistent
  - Are they scalable?
  - How do vouchers affect voluntary choice

Brief Review

- Girls in school
  - Focus on schooling on SRH (and not vice versa)
  - Correlational evidence

2015 Briefs

- Galvanizing commitment
  - What are levers leading to commitment
  - Need to include accountability
  - Process and expected results
- Adolescents
  - Specific topics to be selected
  - What is outcome of interest—delay sexual initiation or delayed pregnancy?
  - Possible client profiles: married adolescents, urban poor adolescents, and very young (10-14).

Additional Recommendations

- Updating two published briefs each year
- Emphasize dissemination/utilization of briefs
- Descriptions of **intended** audiences and those **actually** being served.
- Analytic approaches to assess whether HIPs reach disadvantaged population
- Strengthen “scale up” box
- More economic analysis

IBP Member Organizations' HIP Technical Assistance

High Impact Practices for Family Planning: IBP Member Involvement

Erin Schelar

HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

IBP Strategic Plan Survey

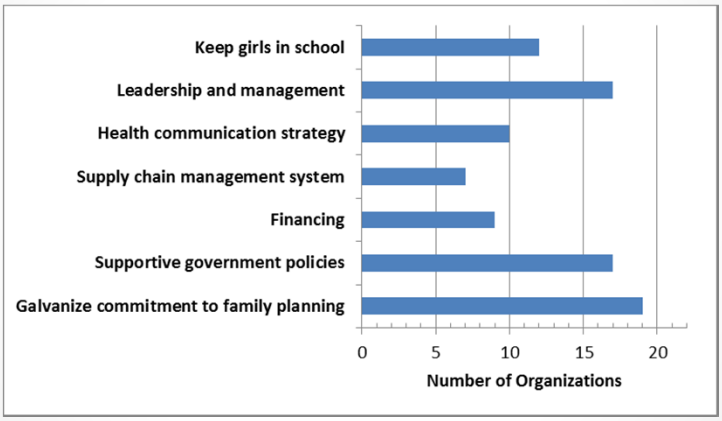
- Activities from November 2013 to April 2014
- 22 organizations responded
- Over ¾ reported involvement at headquarters level

Abt Associates
Evidence 2 Action
FCI
FHI 360
FIGO
IntraHealth
IRH
Jhpiego
JHU
JHU CCP
MEASURE Evaluation
PATH
Pathfinder
Plan USA
Population Council
Population Media Center
Population Reference Bureau
PSI
Public Health Institute
USAID
White Ribbon Alliance
WHO

HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

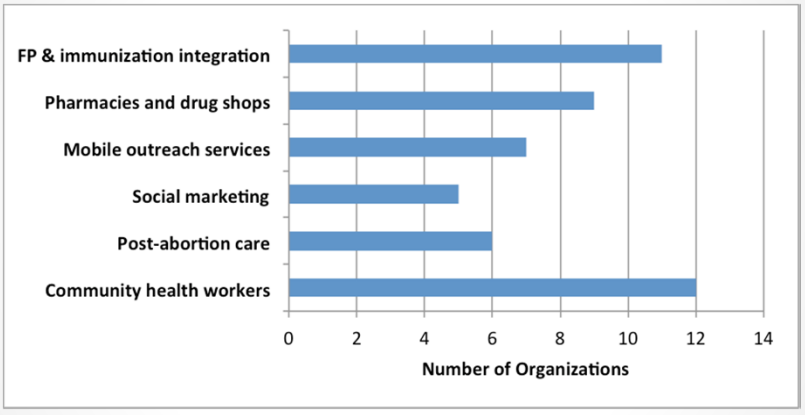
Enabling Environment HIP Involvement



HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

Service Delivery HIP Involvement



HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

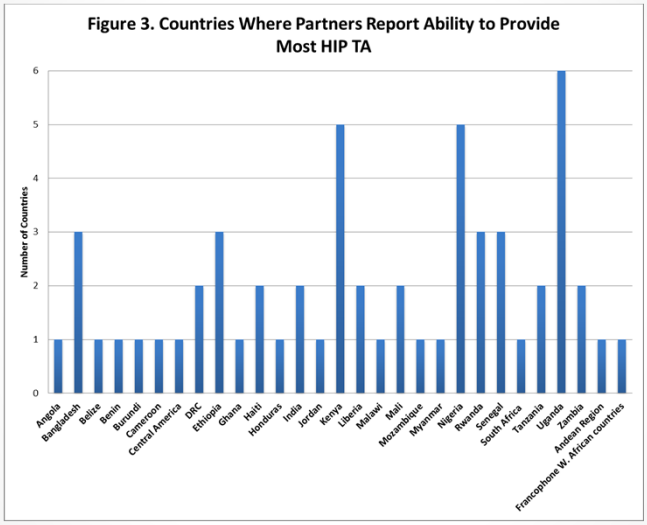
Service Delivery HIP Involvement

- Fewer organizations report service delivery HIP involvement
- For most service delivery HIPs, organizations also reported method provision
  - Standard days method: 37% to 80%
  - IUDs : 25% to 81%
  - Injectables: 81% to 100%
  - Pills: 80% to 100%
  - Condoms: 80% to 100%

HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

Country Level HIP TA



HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

Discussion

- Implications of current organization involvement in HIPs
- Next steps
- Get Involved
  - ✓ Support country programs to identify and implement HIPs
  - ✓ Build the evidence-base
  - ✓ Feedback on materials and tools
  - ✓ Enter activities on the Map:

    http://www.fphighimpactpractices.org/hips/map
  - ✓ Document, Document, Document!

Website: fphighimpactpractices.org

Contact: info@fphighimpactpractices.org

HIP HIGH IMPACT PRACTICES IN FAMILY PLANNING

IBP Initiative
Scaling up what works in family planning/reproductive health

HIPs Website Survey Responses

May 23, 2014 – Oct 17, 2014

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

HIPs Online Website Survey

- Feedback to evaluate the website experience, impact, and user satisfaction
- Feedback on use of HIP briefs, how they're used, contacts for follow-up
- Survey consisted of 10 Questions
- Launched on May 23, 2014
- Pop-up using FluidSurveys; Visitors are prompted only once
- 51 responses

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Location of Survey Respondents

Argentina	1
Australia	2
Bangladesh	1
Canada	1
Congo	1
Ghana	1
India	3
Indonesia	1
Kenya	3
Netherlands	1

Philippines	1
Rwanda	1
Senegal	1
South Africa	1
Tanzania	5
Thailand	2
Uganda	2
United States	20
Zimbabwe	2

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q1. In which region do you mostly work?

Response	Chart	Percentage	Count
Africa		53.1%	26
Asia		18.4%	9
Europe and Eurasia		2.0%	1
Latin American and the Carribean		4.1%	2
Middle East		0.0%	0
Global		22.4%	11
		Total Responses	49

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q2. What was the main purpose of your visit to the HIPs website?

Response	Chart	Percentage	Count
Research		45.1%	23
Advocacy		7.8%	4
Program Implementation		35.3%	18
Policy		9.8%	5
Training		19.6%	10
Personal Education		29.4%	15
Other, please specify...		13.7%	7
		Total Responses	51

Other responses:

1. Expand educational materials to adolescents, childbearing women and mature men through schools, community and faith base education
2. health team
3. I wanted to read success stories from other organizations and see how they're written and presented.
4. HIP Map
5. spread of family planning
6. A quick review of the HIPs
7. Find out more about what HIP stood for, and resources

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q3. Which of the following best describes how often you visit our website?

Response	Chart	Percentage	Count
This is my first visit ever		62.7%	32
First visit in the last 6 months		9.8%	5
2 - 5 visits in the last 6 months		21.6%	11
6+ visits in the last 6 months		5.9%	3
		Total Responses	51

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q4a. Where you able to find what you were looking for?

Response	Chart	Percentage	Count
Yes		74.5%	38
No		13.7%	7
Other, please specify...		11.8%	6
		Total Responses	51

Other responses:

1. Need more information how to document
2. I had no specific goal, just browsing
3. not yet
4. still to look up what I need to know
5. Found one quality assurance resource to add to our library collection
6. am still searching

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q4b. We're sorry to hear that. Please tell us a bit more about what you were looking for.

1. To collaborate with someone who can integrate existing educational program with new ideal natural method that can be embraced by childbearing women and men no matter their educational background or religious belief, without bias and political views.
2. I am looking for a manual that uses right based approach to empower women to demand for quality RMNCH services through training of the lady health workers
3. education and training, materials available
4. the definition of unmet needs in family planning
5. Existing success stories. Maybe there's no content yet?
6. success stories
7. Was hoping to find more open discussion of implementation issues around HIP...not the usual promo pieces that paint a rosy picture of the interventions but which are ultimately more about promoting the organizations involved than actually in helping other implementers.

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

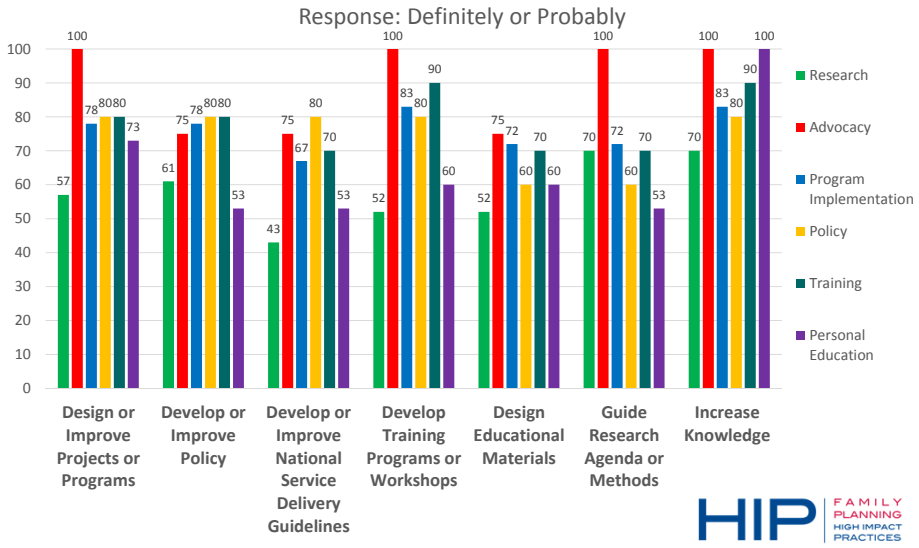
Q5. Have you accessed HIPs briefs in any of the following languages?

	Yes	No	Total Responses
English	36	5	41
French	6	15	21
Spanish	2	14	16

Q6. Please indicate whether or not you have used or are planning on using information from the HIP briefs for the following purposes:

	Definitely	Probably	Not Sure	Unlikely	Definitely Not	Total Responses
To design or improve projects or programs	20	9	7	2	0	38
To develop or improve policy	12	15	7	4	0	38
To develop or improve national service delivery guidelines	12	10	9	4	1	36
To develop training programs or workshops	18	9	7	3	1	38
To assist in designing educational materials	14	12	7	5	0	38
To guide research agenda or methods	18	10	5	4	1	38
To increase my own knowledge	33	5	1	1	0	40

Crosstab 1: Percentage of Respondents Would Use HIP Briefs by Purpose of Visit



HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q7. In addition to the choices above, have you used HIP briefs for other purposes?

1. None
2. no
3. no comment
4. knowledge sharing
5. Shared with relevant colleagues to update their knowledge and skills
6. no
7. no
8. I did original industrial biological research and discovered drugs which I used for a woman who presented with a dead fetus. I administered the proprietary medicine orally and the fetus was expelled and the mother became healthy. The proprietary medicine was tested at the Department of Pharmacology and it contained anticoagulant and contractile properties.
9. Yes , to initiate research on the strong topic / subject seem to us
10. no
11. Population Council pubs are frequently used for requested literature searches here at Jhpiego
12. For now, for general information purposes only (though might use to find out latest evidence by themes, e.g., adolescents)
13. keep myself updated

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Q8a. If you do plan to use one or more of the HIP briefs to design or improve your projects, may we contact you to find out how useful the HIP brief was and to get your input on how to make the HIP briefs more useful in helping to design programs?

Response	Chart	Percentage	Count
No thank you		34.1%	14
Yes, I can be contacted for future input		65.9%	27
		Total Responses	41

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

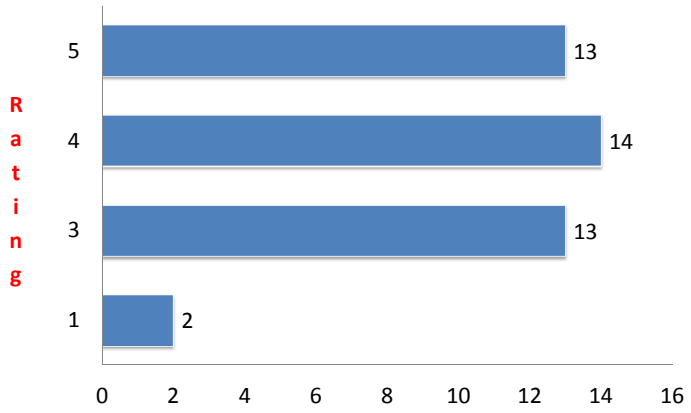
Q8b. Thank you for giving us permission to contact you. Please provide your email address:

- UnchartedNaturalArt@gmail.com
- ldulli@fhi360.org
- sharifhossain@popcouncil.org
- jkaswija@gmail.com
- rozinamistry@gmail.com
- tshimangapaulin@gmail.com,tshimanga@unfpa.org
- chrisostom.lipingu@jhpiego.rog
- gandanhamu@gmail.com
- medecinspartenaireshumanitaires@yahoo.fr
- sarahbrubinstein@gmail.com
- jejozami@gmail.com
- manjitk2020@hotmail.com
- smbukwa@gmail.com
- deborah.stein@jhpiego.org
- sknox@peoriacounty.org

mbyomakesh303@gmail.com
davidmatthe@yahoo.com
alousikasso@yahoo.fr
pisrfrdc@yahoo.fr
jkanama@engenderhealth.org
kakhadidja@gmail.com
oagdotse@gmail.com
lev9@georgetown.edu
jean.sack@jhpiego.org
afort@intrahealth.org
alanoabraham@yahoo.com
myintmohsoe@gmail.com
may_post@abtassoc.com
pile@unfpa.org
edaniel@pathfind.org

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

9. Based on today's visit, on a scale of 1-5, how would you rate your experience with the HIPs website overall?



10. In what ways can we improve the HIP website?

There are 19 response(s) to this question:

1. Not sure, not computer literate
2. Well I believe by broadening Family planning approach resources to more RMNCH related resources
3. no comment
4. frequent knowledge sharing
5. include other minor foreign langiages
6. meets expectations
7. Ensure linked pages are available for download. Improve downloading of documents as bulk vs a vs individual download
8. let be available for others, since it is not always opening
9. no suggestions at this time
10. sharing in website

10 Cont. In what ways can we improve the HIP website?

11. It is an improved website more can be done for modern technology
12. Yes, easily, I share with all during all opportunity
13. Provide more information from HIP countries
14. By mail
15. Reorder the HIP brief landing page to display the most used briefs rather than by the most recent posting date. Perhaps collapse all of the languages under each theme so there isn't a lengthy list of pages to search through.
16. Send alerts to new materials on HIP through HIPNET
17. For now, it's good. We'll see later...thanks.
18. In Myanmar, internet connections are slow. Yesterday I can not download anything although I am now studying in Thailand. Can you make downloads more easy.
19. just be sure to update updates in a timely manner

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Crosstab 2: Purpose of Visit by Region Where You Work

Region	Research	Advocacy	Program Implementation	Policy	Training	Personal Education	Other, please specify...
Africa	11	1	12	1	5	8	1
Asia	5	1	4	3	2	2	0
Europe and Eurasia	0	0	0	0	0	1	0
Latin American and the Carribean	2	0	1	0	0	0	1
Middle East	0	0	0	0	0	0	0
Global	5	1	1	1	2	2	5

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Crosstab 3: Purpose of Visit by Found what I was looking for

Response	Research	Advocacy	Program Implementation	Policy	Training	Personal Education	Other, please specify...
Yes	16	2	14	4	8	9	5
No	5	2	2	1	2	3	2
Other	1	0	1	0	0	1	0

Other responses:

Need more information how to document

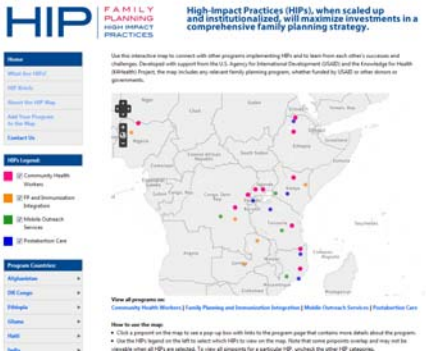
I had no specific goal, just browsing

not yet

still to look up what I need to know

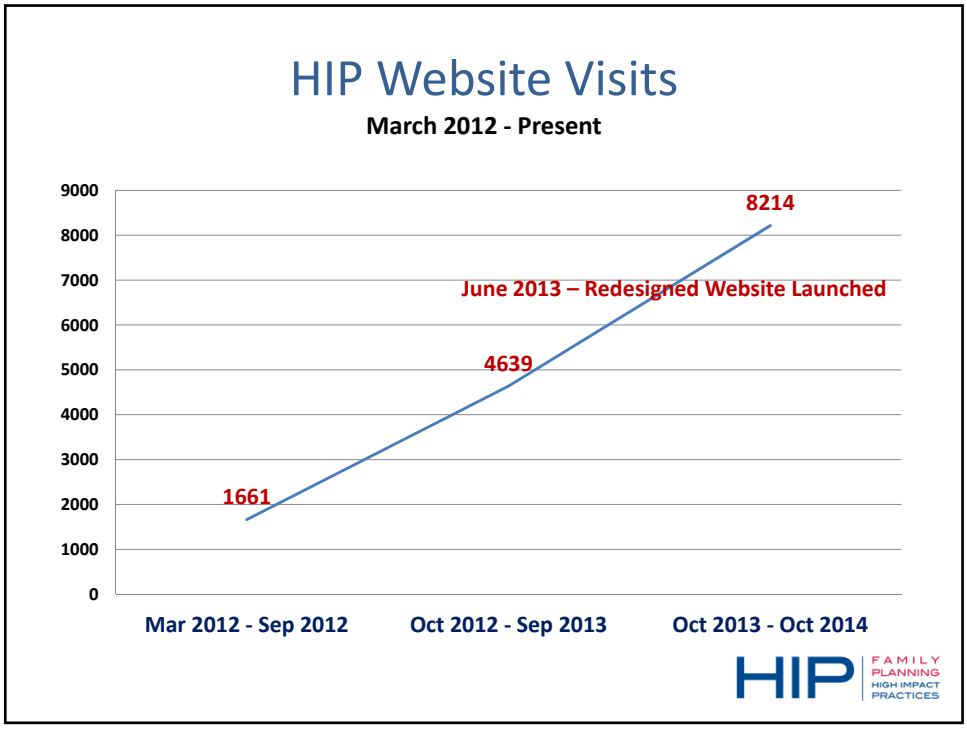
Found one quality assurance resource to add to our library collection

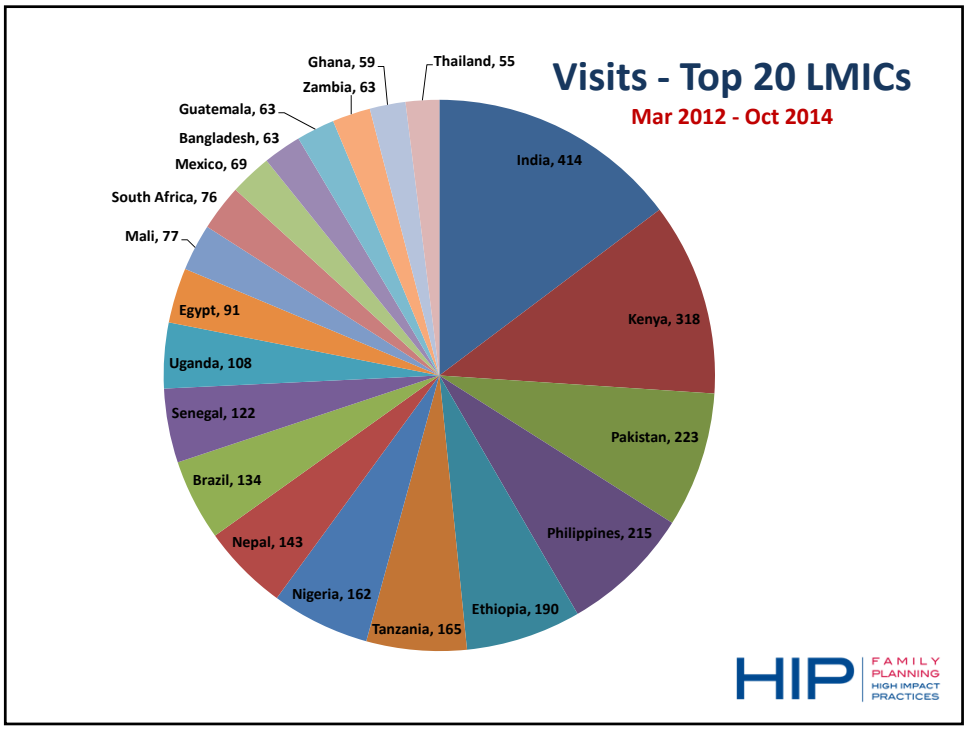
HIP Website Analytics



March 2012

June 2013


HIP Website Visits
March 2012 - Present
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
8214
June 2013 – Redesigned Website Launched
4639
1661
Mar 2012 - Sep 2012
Oct 2012 - Sep 2013
Oct 2013 - Oct 2014
HIP
FAMILY PLANNING
HIGH IMPACT PRACTICES

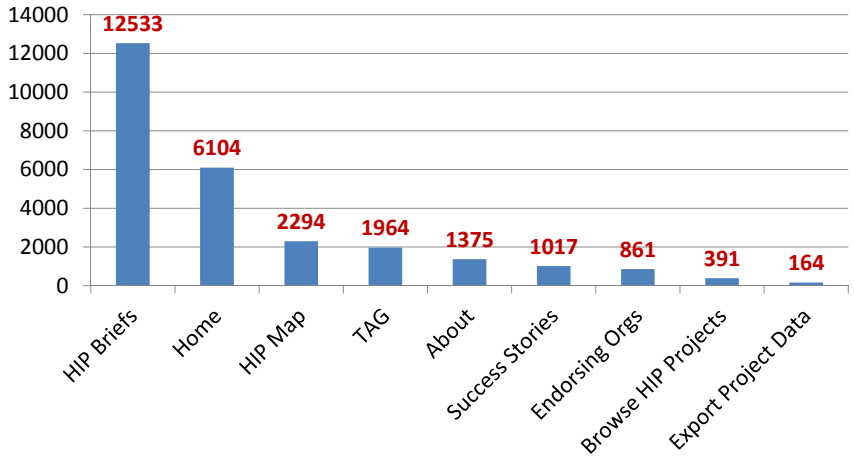

Visits - Top 20 LMICs
Mar 2012 - Oct 2014
India, 414
Kenya, 318
Pakistan, 223
Philippines, 215
Ethiopia, 190
Tanzania, 165
Nigeria, 162
Nepal, 143
Brazil, 134
Senegal, 122
Uganda, 108
Egypt, 91
Mali, 77
South Africa, 76
Mexico, 69
Bangladesh, 63
Guatemala, 63
Zambia, 63
Ghana, 59
Thailand, 55
HIP
FAMILY PLANNING
HIGH IMPACT PRACTICES

HIP Brief Downloads

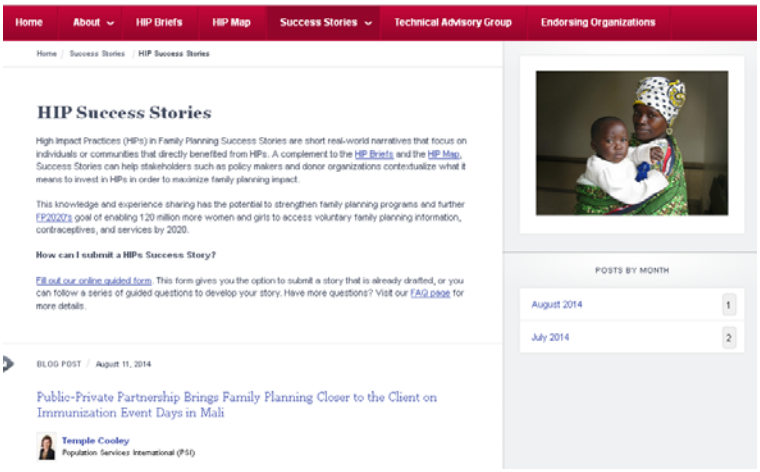
Brief	Number of Downloads
HIP List	1096
Postabortion Family Planning	392
Community Health Workers	388
Health Communication	325
Social Marketing	251
Family Planning and Immunization Integration	223
Supply Chain Management	201
mHealth	195
Drug Shops and Pharmacies	156
Policy	118
Mobile Outreach Services	72
Financing Commodities and Services	61

Page Views by Tab

June 2013 – Oct 2014



Success Stories



Launched June 10, 2014

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Family Planning/Immunization Integration Overcomes Obstacles to Contraceptive Use in Senegal

BLOG POST / July 21, 2014

Zack Taylor
USAID/Senegal

Mary de Boer
USAID/Senegal

As in many other West African countries, contraceptive use in Senegal has stagnated over the past twenty years. The barriers to acceptance are many—women often need the consent of their husband before accessing family planning (FP) services; religious taboos around limiting births are prevalent, particularly in rural areas; many women fear being stigmatized for using contraception and wrestle with culturally-predominant desires for large families; and, finally, the set-up of many health facilities precludes the confidentiality that many women desire when accessing FP for the first time. As a result, the 2011 Demographic and Health Survey (DHS) documented modern contraceptive prevalence at just 12 percent and unmet need for contraception among married women at 30 percent.

Public-Private Partnership Brings Family Planning Closer to the Client on Immunization Event Days in Mali

BLOG POST / August 11, 2014

Temple Cooley
Population Services International (PSI)

Overview

Mali's contraceptive prevalence rate (CPR) is one of the lowest in the world: only 10% of married women use modern contraception.[2] Women have on average 6.6 children in their lifetimes. Almost a third of married women (31%) have an unmet need for family planning.[3] Prospective unmet need is even higher (79%) among postpartum women.[4] Offering a range of contraceptive options, including long-acting reversible contraception (LARC), is critically important to meeting women's diverse needs and reproductive intentions. To expand contraceptive access to include highly effective LARC methods, Population Services International (PSI) launched an innovative outreach model in collaboration with the Malian Ministry of Health (MoH). This work was supported by Dutch Government's Choices and Opportunities Fund and USAID's Maternal and Child Health Integrated Program (MCHIP) from 2009 through 2014.

Kadia's Story

Kadia Bagayogo is a 39-year-old Malian woman. She lives with her husband Seyba and their nine children in a single room habitation, part of a larger multi-family commune in Banconi, a low-income neighborhood in Mali's capital city, Bamako. Kadia was 14 years old when she and Seyba married in 1985. Since then, Kadia has been pregnant 11 times, including two sets of twins and a miscarriage. None of Seyba and Kadia's nine living children attend school. The couple cites poverty as the reason. Seyba is a chauffeur, but is currently unemployed. Kadia works in the home and sometimes sells charcoal to help make money for the family. Seyba and Kadia's economic circumstances are not atypical in Mali, which is one of the 25 poorest countries in the world.[5] Like most women in Mali, Kadia does not use a

Kadia Bagayogo, mother of nine in Bamako, Mali

Family Planning Counseling and Services Benefit Mothers in Zarqa, Jordan

BLOG POST / July 14, 2014

Dr. Nisreen Bitar
Abt Associates

The Kingdom of Jordan is committed to reducing the total fertility rate in order to achieve social and economic progress and improve health status. A series of Demographic and Health Surveys in Jordan over the past decade show a lack of progress in key demographic indicators such as the Total Fertility Rate, hovering around 3.6 children per woman, and the Modern Contraceptive Prevalence Rate, which is stable at 42%. About 44% of these women obtain their family planning methods from the public sector compared to 56% who obtain them from private or NGO services (Jordan Demographic and Health Survey, 2012). USAID's Health Systems Strengthening II (HSS II) Project is helping the MOH to overcome this stagnation in use of modern family planning methods.

A range of modern methods are widely available in Jordan including condoms, oral contraceptives, injectables, implants, and IUDs. Voluntary surgical sterilization is also available. Use of traditional methods, especially withdrawal, is practiced by almost 20% of Jordan's couples (Jordan Demographic

On the Horizon

- Changing name of Success Stories tab to HIP Blog
  - Thoughts; other suggestions?
- Revamping the HIP Brief page
- Website Translation
  - French
  - Portuguese
  - Spanish

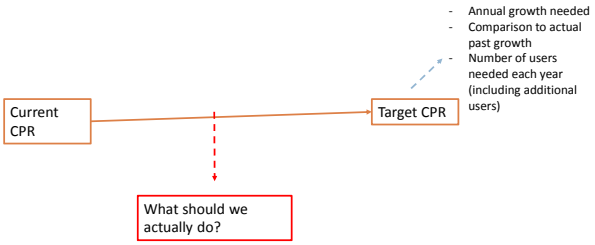
HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Family Planning Impact Modeling

WHAT WORKS?

Emily Sonneveldt
Futures Institute

Models



Questions that Need to be Answered

What should we do to increase CPR?

What CPR can we reach in a specific period of time based on our current efforts?

If we invest in a specific strategy (such as CBD), what level of prevalence can we achieve?

How much would it cost to reach a particular CPR target?

Can we achieve a better result by re-allocating funds?

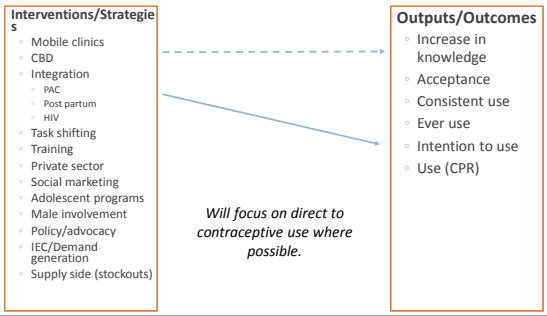
Building a New Model (no name yet)

Start with what we know
- Building an impact matrix

Move to one-country modeling
- How do all the parameters fit together

Expand to full model
- Likely integrated into Spectrum

What do we Know? (interventions and impacts)



First Step: Impact Matrix

Integration example

- 66 articles found
- 22 articles with data extracted
- HIV, Postpartum, ANC, MCH, water and sanitation (male involvement), immunization, economic land development
- Different models- referrals (on site and off site), direct provision, focus on different methods
- Different outcomes- continued use, new use, consistent use, ever use, method specific outcomes

Process is the same for all interventions

One Country Modeling

How the interventions interact with one another

- Not all impacts can be cumulative

Components of the country specific system that will either facilitate or limit implementation or impact

- Mauritania most women deliver in a health facility- could make postpartum family planning integration a successful strategy
- Lack of existing community based workers will produce a delayed impact of CBD efforts (assuming you have to first identify and hire them)
- Policy barriers can impact many strategies (integration, task-shifting)

Need to build in country specific parameters

Full Model

User friendly platform (Spectrum)

Enter default data when possible

Documentation on how to use

Support for country applications

When: Early next year

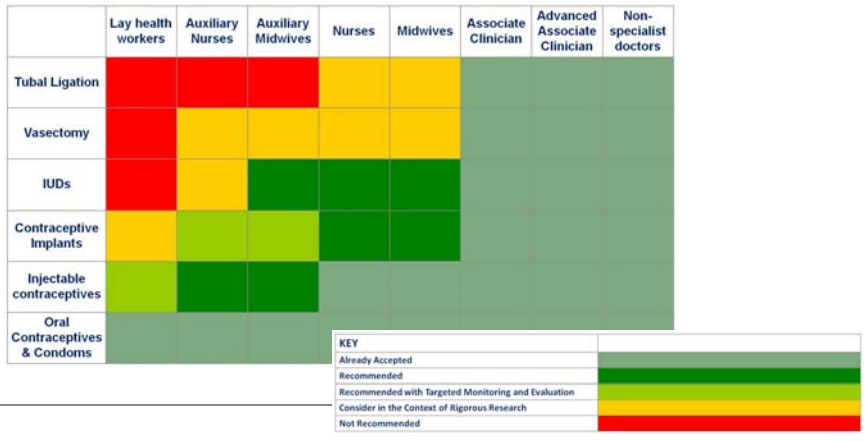
Impact: Task Sharing

A simple tool to show the potential impact of task-sharing FP services

George Hayes – Impact Analyst, MSI

Task sharing background

- WHO definition – “A partnership in which different levels of healthcare providers do similar work”.



The 'Impact: Task Sharing' model

- **Our model helps users to quantify task-sharing's benefits in specific national contexts.**
- The model enables advocates to **make the case** for changing task sharing regulations as a first step towards creating a more enabling environment for FP service delivery.
- I.e. If a more liberalised task-sharing policy framework was in operation **now**, what might the impacts be?
- **And** by projecting a number of different scenarios, advocates can estimate which task sharing reforms could be the most impactful in a particular country context.

SLIDE 3

How it works

Compare difference in maximum impact of each scenario:

Number of providers

Number of clients reached

Spending on salaries

Increased health impacts

SLIDE 4

Information the model needs

	Number of health workers in each cadre (rural optional)	Average salary of health workers	Current & suggested task-sharing policy	Amount of time spent with FP clients & time taken to deliver service (model has defaults)	Task share distribution	Method mix of FP clients	Number of clients served annually	Health worker salary budget
Increased Access	✓	✗	✓	✗	✗	✗	✗	✗
Freeing up doctor time	✓	✗	✓	✓	✓	✗	✓	✗
Larger health impact	✓	✓	✓	✓	✓	✓	✗	✓
Cost effectiveness	✓	✓	✓	✓	✓	✓	✓	✗

SLIDE 5

Results

1. Increase access to family planning services
   - Total providers who can provide the service (+ per WRA, rural)
2. Free up time for doctors and clinicians to spend on other high-level services
   - Minutes and weeks freed per 100 clients
   - Total time freed (based on client goal + method mix)
3. Achieve greater impact without increasing spending on salaries
   - Potential increase in # clients (based on salary goal + method mix)
   - Additional impact generated (all key Impact 2 results)
4. Provided services for less salary spend
   - Savings in salary spending (based on client goal + method mix)

SLIDE 6

Results (cont)

SLIDE 7

Considerations and limitations

- The model shows the *potential* impact of a policy change—e.g. the maximum impact that could be achieved if the policy was fully implemented. Just changing a policy may not mean these impacts will automatically be realised.
- This is a model, rather than a measure of real life. Results will only be as good as the data and assumptions that produces them.
- With the model having numerous data entry points, it is hard to generalise results. They will be specific to a projected scenario.

SLIDE 8

Find out more

- Visit www.mariestopes.org/impact-task-sharing to download the model and access guidance notes on how to use it.
- For any feedback or follow up questions, email george.hayes@mariestopes.org.

Overview of Process for Review of Adolescent HIPs

HIP Partners Meeting
October 21, 2014

Sylvia Wong, UNFPA
Shegufta Shefa Sikder, USAID

Technical Expert Group

Authors

- FHI 360, K4H Project: Kate Plourde, Joy Cunningham, Rose Wilcher, Robyn Dalton
- Institute for Reproductive Health, Georgetown University, FACT Project: Jessica Velcoff, Victoria Jennings, Rebecka Lundgren, Kimberly Ashburn
- Population Council, EVIDENCE Project: Karen Hardee, Jill Gay

Reference Group

- Bill & Melinda Gates Foundation: Clarissa Lord Brundage, Kimberly Hamilton
- IPPF: Doortje Braeken
- Pathfinder, E2A Project: Regina Benevides, Gwyn Hainsworth
- UNFPA: Sylvia Wong
- USAID: Cate Lane, Shawn Malarcher, Erin Schelar, Shefa Sikder, Shannon Taylor, Caitlin Thistle
- WHO: Chandra Mouli

Timeline

To date

- Feb 2014 – HIP Partners Meeting: Focus on adolescent interventions decided
- March 2014 – 3 groups identified to conduct literature scoping in 3 categories: 1) knowledge & attitudes, 2) health services, 3) structural interventions
- March-Sept 2014 – Literature scoping conducted & technical guidance provided by core group
- May-Sept 2014 – Client profiles developed
- Sept 2014 – Review of findings from literature reviews
- Oct 2014 – Presentation to HIP Partners

Future

- Oct-Dec 2014 – 3 authors develop draft briefs
- Jan-Feb 2015 – Endorsing partners review and provide feedback on content of briefs
- April 2015 – Revision of briefs to incorporate comments and fact check
- May 2015 – Briefs to be reviewed at HIP TAG

Beneficiaries –Who/Where?

Country **	% of 15-19 yr olds married/ in union	Country **	% all 15-19 women who are never married and ever had sex (DHS)
Niger	59%	Congo (Brazzaville)	69%
Mali	50%	Liberia	67%
Central African Republic		Cote d'Ivoire	52%
Bangladesh	46%	Colombia	49%
Mozambique	43%	Mozambique	46%
Chad	42%	Namibia	43%
Guinea	35%	Cameroon	39%
South Sudan		Uganda	37%
Madagascar	33%	Benin	36%
Nepal	32%	Haiti	34%
Burkina Faso	31%	Zambia	34%
Eritrea	29%	Ghana	33%
India	27%	Madagascar	32%
Somalia		Malawi	25%
Sierra Leone		Kenya	23%
Malawi	23%	Tanzania	23%
Nicaragua	22%	Guinea	23%
Zambia	17%	Nigeria	18%
Dominican Republic	19%	Burkina Faso	17%
Ethiopia	19%	Brazil	--

What is the context?

Married 15-19	Unmarried, sexually active 15-19
Between 5 and 25% report sex before age 15 which may be a sign of coerced or forced sex.	
Almost all births were "wanted" in both groups.	
Unmet need for FP high (between 14 and 41%)*	
Unmet need higher in rural v urban areas (except in the Dominican Republic)	Variable
Low condom use	Traditional method and condom use high in some countries
Public sector use among contraceptive users between 70 and 90% in several countries . However, the two countries with the highest mCPR among this population have high rates of private sector use (>60% in Indonesia and Bangladesh).	Private sector, pharmacy/drug shop, and friend support more than half of all contraceptive use (except in 3 countries)
High rates of polygamy in West Africa	
Poor	May have more access to wealth and literacy, working
Literacy rates highly variable.	Between 40-90% are literate
HIV prevalence rates are low (<1% among 15-24 yr old females) in most countries. Countries with higher rates are – Chad, Central African Republic, Mozambique, Malawi, Sierre Leone, and Zambia.	Generally higher rates of HIV
Very limited media access (exception Dominican Republic and Indonesia)	Higher levels of media exposure. Although a third of girls had no media exposure
More than 40% of ALL girls not in school (except Bangladesh, Dominican Republic, Namibia, Haiti, Kenya)	
Integration opportunities with skilled delivery or antenatal care highly variable.	

* except married in Niger -13% and Indonesia 6%, unmarried, sexually active Columbia, Namibia, Zambia, Malawi, and Kenya have unmet need of >12%

Recommended practices covered by HIP Briefs

Literature Review Category	Existing HIPs
Knowledge & Attitudes	mHealth
Health Services	Social marketing Pharmacies and drug shops Mobile outreach Vouchers
Structural Interventions	Health communication (mass media and SBCC)

Other practices

- ***School-Based Comprehensive Sexuality Education***: Recommended where school participation is universal and school systems are robust
- ***Parent Involvement***: Maybe more applicable for youth 10-14 and those who are not yet sexually active
- ***Peer Education***: Positive effects for increasing SRH knowledge among peer educators, not necessarily among beneficiaries
- ***Sports Initiatives***: Maybe most applicable for youth 10-14 and those who are not yet sexually active
- ***Integration of FP into immediate post partum (skilled delivery) care***: Most impactful where skilled delivery services are highly utilized

Practices to be developed into HIP briefs

Literature Review Category	Recommended Practice
Knowledge & Attitudes	Community-based interventions (adult-led CSE, community mobilization, interpersonal communication)
Health Services	Making existing health services adolescent-friendly
Structural Interventions	Livelihood and/or vocational training

Other recommendations

- There is a need for more evidence on the barriers to contraceptive use among **married** adolescents to better understand and design programs that meet their needs.
- Most programmes included complex resource-intensive interventions. More evidence is needed from large scale implementation and more streamlined approaches which are feasible at scale.
- Develop 2-page reference guide based on this review which includes the summarized findings and helps direct program managers to existing and new briefs based on their adolescent population and country context.

COMMUNITY-BASED INTERVENTIONS

Defining the Practice

- Community based interventions target geographically bound communities as a whole to improve knowledge and change norms while simultaneously targeting youth with BCC information
- Holistic approach may include:
  - Behavior change communication (videos, lectures, small group activities, community conversations, street theater)
  - Improved access to services (YFS, counseling, distribution of contraceptives, CHWs)
  - Distribution of contraceptives
  - Youth SRH education (peer education, community center)
  - Capacity building and/or stakeholder training

Mechanism of Action (CI)

Educate young people and engage community members→ influence family and community norms, empower young people → improve KASI and access → reduce adolescent pregnancy

Search Strategy

- Combined approach
  - Search for interventions to improve KASI
  - Search for interventions to address structural barriers
- Plan to conduct more targeted search for CB interventions meeting definition

Populations

- Commonly applied in resource-poor settings
- Married or unmarried
- In-school or out-of-school youth [males and females]
- Urban or rural settings
- Youth ages 10-24

USAID | KHealth

Results

- 8 measured changes in KASI
  - All positive
- 8 measured behavior changes
  - 6 demonstrated positive change on condom use, contraceptive use, delayed onset of sexual activity, reduction in number of sexual partners, increased RH communication, use of services, decreased intimate partner violence, alcohol use, and transactional sex
  - 2 demonstrated mixed results: 1 (+/-) 1 (+/0)

USAID | KHealth

Results Contd.

- 4 measured biological outcomes
  - 2 positive (1 pregnancy prevention, 1 delayed age at first birth and birth spacing)
  - 1 no effect (HIV)
  - 1 negative (pregnancy)
- 2 measured delayed age at first marriage
  - All positive

USAID | KHealth

Considerations

- Results presented include only evaluated interventions
- Majority of behavior change information is self-reported
- There are methodological challenges to teasing out relative impact of unique intervention components

USAID | KHealth

Summary

- Most promise in developing countries
- Ability to reach wide audience
- Addresses community and gender norms
- Resulted in increased age at first marriage (WHO recommended approach to delaying pregnancy)

USAID

K4Health

Thank you

Questions or suggestions

Jcunningham@fhi360.org

Kplourde@fhi360.org

USAID

K4Health

Mainstreaming Adolescent Friendly Contraceptive Services: A Review of Evidence (so far)

Jill Gay, Consultant
Karen Hardee, Project Director

ARH HIP Review Meeting

September 18, 2014

USAID FROM THE AMERICAN PEOPLE

Evidence

AFCS: Defining the practice

- Ensuring that AFCS are rights-based
  - Using the VHRBFP conceptual framework from an adolescent lens (Hardee et al., 2014)
  - WHO guidance for rights-based FP (WHO, 2014)
- Other corner stones:
  - Gender
  - Equity

Hardee, K., et al. 2014. "Voluntary, Human Rights-based Family Planning: A Conceptual Framework." *Studies in Family Planning. 45(1): 1-18.*

WHO, 2014. Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations. Geneva: World Health Organization.

AFCS: Defining the practice

- Integrating "adolescent contraceptive friendliness" within the range of existing FP and other services, rather than as separate for adolescents only
  - Clinic, community, school-based, social marketing, pharmacies/drug shops, mobile services, mHealth, etc.
  - Wherever contraceptives are or can be made available, services should be adolescent friendly
  - Potentially adding AFCS within:
    - ✓HIV services (2.2. million adolescents living with HIV globally, Idele et al., 2014)
    - ✓Maternal health: ANC and PP
    - ✓Infant and child immunization
    - ✓PAC
    - ✓Schools

Mechanism of action/theory of change

AFCS that are…

- Mainstreamed throughout FP programs (clinic-based, community-based, social marketing, etc.)
- Provided by trained providers (with positive attitudes towards adolescents)
- Confidential and private
- Offer a range of methods (not just pills and condoms)
- Bolstered by a strong enabling environment (e.g. policies supporting contraceptive access by adolescents)
- Supported by community leaders, members and families
- Free of charge or subsidized

…will lead to

- Increased contraceptive availability, affordability, accessibility and quality (AAAQ); and
- Increased use of contraception by adolescents

Mechanism of action/theory of change

AFCS that are…

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…will lead to

- Increased contraceptive availability, affordability, accessibility and quality (AAAQ); and
- Increased use of contraception by adolescents

Evidence to date is mixed:

- Youth-friendly services
  - + condom use and modern contraceptive use at first and last sex, AFCS scale up in 5 countries (Hainsworth et al., 2014) (pre/post)
  - + Contraceptive use, Disha, India (Kanesathasan et al., 2008) (pre/post)
  - + Pill or condom use, Kenya (Decker and Montagu, 2007) (comparison)
  - + Use of FP in YFS, Zambia, (Mmari and Magnani, 2003) (pre/post)
  - + Outcomes (various) AYA (4 countries), YFS, sex ed, mass media (Williams et al., 2007) (post statistical analysis using instrumental variables)
  - ▪ Correlation between YFS and contraceptive use (national level), Tanzania (Chandra Mouli et al., 2013) (pre/post)
  - — Question: what are the key components that lead to outcomes? Standalone adolescent services work but are difficult to scale up. Can YFS be streamlined and mainstreamed?

Evidence to date is mixed:

- **Provider training**
  - Increased contraceptive use Disha, India (Kanesathasan et al., 2008) (pre-post)
  - Better provider attitudes (Warenious et al, 2006)
  - Increased visits for FP in Georgia (Tavadze et al., 2009) (pre/post)
  - ***Question***: what training works best in which contexts?
- **Wide range of methods**
  - Much adult data, should be the same for adolescents
  - Use of IUDs in Mexico by PP adolescent mothers (Nunez-Urquiza et al., 2003) (survey)
  - ***Question***: how to move beyond providing just pills and condoms?
- **Free or subsidized services**
  - Voucher correlated with higher use of clinic (Meuwissen et al., 2006a) (Quasi-experimental)
  - Chile's national no-cost FP program results in high rates of contraceptive use (Parra Villaroel et al., 2013)
  - Clinic costs covered resulted in increased FP use (Karei and Erulkar, 2010) (comparison)
  - ***Question***: cost is a clear barrier; mechanisms for reducing cost?
- **Policy environment, rights-based FP:** need evidence

We need your help

Do you/your organization have:

1) Work on what aspects of AFCS resulted in contraceptive uptake with measured/documented outcomes?
2) Suggestions of what websites might have key documents?
3) Suggestions on the name of the practice – is "Mainstreaming Adolescent Friendly Contraceptive Services" ok?

Please send to JillGay.rh@gmail.com

THANK YOU

The Evidence Project is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-13-00087. The contents of this presentation are the sole responsibility of the Evidence Project and Population Council and do not necessarily reflect the views of USAID or the United States Government.

The Evidence Project seeks to expand access to high quality family planning/reproductive health services worldwide through implementation science, including the strategic generation, translation, and use of new and existing evidence. The project is led by the Population Council in partnership with INDEPTH Network, International Planned Parenthood Federation, Management Sciences for Health, PATH, Population Reference Bureau, and a University Resource Network.

Economic Empowerment Interventions

Kim Ashburn, Presenter
Jessica Velcoff
Rebecka Lundgren

ARH HIP Review Meeting

October 21, 2014

Defining Economic Empowerment

A young person's transition from not having to having economic resources that he or she needs to help achieve better life outcomes

Economic Empowerment: Defining the Practice

- Expanding economic opportunities:
  Financial literacy and savings; vocational and livelihoods training; access to transfers (cash and productive assets; conditional and unconditional); access to microcredit
- Integrating EE with other components – particularly gender:
  More effective EE programs are delivered in combination with gender or SRH education, life skills training, community sensitization, or community campaigns
- Ensuring programs are adapted to the needs and constraints of adolescents, and economic, social, and political context:
  - Programs are appropriate to needs and interests of adolescents, and to their particular economic, social, and political context
  - Generally microcredit programs are less suitable for younger women or girls who do not have existing small businesses, or access to capital to develop a business

Mechanism of action/ theory of change

- Strengthening economic outcomes through
  - financial/business knowledge and skills
  - vocational training
  - access to credit/cash or in-kind transfers
- Improved economic outcomes expands life options and leads to improved SRH outcomes
- Livelihood programs that **address gender inequality** can increase the effectiveness of EE programs. This in turn can increase the agency of girls and women and enhance their ability to make SRH decisions (Dworkin & Blankenship, 2009; Gibbs, Willan, Misselhorn, & Mangoma, 2012)

The Evidence: Cash and In-kind Transfers

- Direct injection of cash or in-kind assets skips step of improving economic outcomes
- Increases in labor participation, wages, and overall wellbeing among young women (Afswa et al., 2012; Erulkar & Chong, 2005); Pronyk et al., 2006)
- Increases in SRH knowledge (Dunbar et al., 2010; Erulkar and Chong, 2005)
- Delayed sexual debut and decreased number of sex partners, greater than 60% reduction in HIV and HSV2 (Baird, et al., 2010)

The Evidence: Vocational Training and Livelihood Programs

- Increased SRH knowledge including knowledge of FP methods (Bandiera et al., 2012; CEDPA, 2001; Grant, Mensch, & Sebastian, 2011)
- Improved communication with husbands and friends about FP (CEDPA, 2001)
- Increased use of contraceptives (Bandiera et al., 2012; Erulkar & Muthengi, 2007)
- Decrease in fertility rate (Bandiera, et al., 2012)
- Improved self-esteem and social capital (Lukas, 2008; Urdang, 2007)

The Evidence: Financial Literacy and Savings

- Increased interaction with financial institutions and ability to hold savings accounts (Hallman and Roca, 2000; Ssewamala et al., 2010)
- Remaining abstinent and fewer sexual partners (ref to be added)
- Increased autonomy in how to spend money and wider sense of control over own lives (Hallman and Roca, 2011)

The Evidence: Microcredit

- Some evidence of reducing poverty (Dworkin and Blankenship, 2009; Pronyk et al., 2008)
- Research gap - few programs specifically for adolescents, particularly boys, young men
- Microcredit for mothers of adolescent girls shows some effect on girls' reproductive health and economic opportunities (Urdang, 2007)