PHE partnerships guide

Version 1

blue ventures
beyond conservation

PHE
Population
Health
Environment
Madagascar Network

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About this guide

This guide consists of 15 chapters covering the core values, skills and knowledge needed to develop and implement effective cross-sector Population-Health-Environment (PHE) partnerships. It starts with a thorough introduction to the PHE approach, followed by an organisational capacity assessment and development planning section to enable you to tailor your use of this guide to your needs. It's an interactive pdf document, so it can be navigated using the hyperlinks (in blue) and the chapter buttons at the top of every page.

This guide is primarily designed for use by the staff of environmental organisations wishing to develop cross-sector PHE partnerships with health service providers in line with priority community needs and their organisational missions. Many chapters will also be relevant to the staff of health organisations wishing to develop cross-sector PHE partnerships with environmental organisations working in under-served zones. And of course livelihoods-focused organisations working at the interface of sustainable development and natural resource management are also ideally placed to develop and implement collaborative PHE initiatives with relevant partners.

This guide draws on the PHE implementation experiences of Blue Ventures and other members of the Madagascar PHE Network in order to provide practical advice structured in a conversational format with case study examples. As such it should be highly relevant to organisations working in Madagascar and much material will be applicable to organisations working in other countries as well.

This guide is accompanied by various complementary resources including an integrated PHE community outreach tool (illustrated PHE story cards) available via the Madagascar PHE Network's website here. Please note that a comprehensive online library of documents relating to PHE programming has been collated by the Population Reference Bureau and can be found here.

This guide should be considered a living document and as such it will be updated regularly. Please don't hesitate to contact Blue Ventures (pheinfo@blueventures.org) if you have any suggestions for improvement or requests for elaboration. We look forward to incorporating your feedback into future versions of this guide.

Credits and acknowledgements

This guide was written and produced by Laura Robson, Blue Ventures' Health-Environment Partnerships Manager.

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This guide should be referenced as follows: *Robson, L. (2017) PHE partnerships guide. London, UK / Antananarivo, Madagascar: Blue Ventures Conservation.*

1. Introduction to PHE

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know the core components that constitute a PHE approach ▪ Understand the rationale for a PHE approach ▪ Know how PHE initiatives can be implemented (including strengths and challenges associated with different institutional arrangements) ▪ Know what questions you can ask yourself in order to assess whether it's appropriate for your organisation to develop a PHE partnership or explore other institutional arrangements for implementing a PHE initiative ▪ Know the benefits of PHE initiatives for communities, environmental organisations and health organisations (including evidence that PHE is more cost-effective than single-sector approaches) ▪ Understand that PHE does not equate to population control ▪ Know how PHE contributes to national and international policy goals	▪ Environmental organisations ▪ Health organisations ▪ Policy makers ▪ Funders

What is PHE?

"Population-Health-Environment" or "PHE" is a term used to describe a holistic approach to sustainable development that reflects the connections between people, their health and the environment.

PHE initiatives are designed to address the multidimensional challenges facing isolated rural communities living in areas of high biodiversity and/or natural resource dependence with limited access to health services.

PHE initiatives typically integrate **voluntary family planning** and **other health services** with **community-based natural resource management efforts**. PHE initiatives may also encompass biodiversity conservation and alternative livelihood initiatives as well as measures to improve water, sanitation & hygiene (WASH) and/or nutrition.

PHE initiatives should be designed to uphold human rights, including the reproductive rights of all individuals to choose freely the number and spacing of their births as well as the management rights of communities with regards to their natural resources. PHE initiatives seek to promote gender equality by engaging men in discussions about family health while involving women in natural resource management decision-making.

Population	Health	Environment
Voluntary family planning	Sexual and reproductive health	Community-based natural resource management
	Maternal and child health	Biodiversity conservation
	Water, sanitation and hygiene	Alternative livelihood initiatives
	Nutrition	
Cross-cutting themes		
Commitment to human rights		
Integrated community outreach linking health and environmental topics		
Focus on gender equality		

Although PHE initiatives usually integrate the core components outlined in the box on the previous page (i.e. voluntary family planning + at least one other relevant health service / initiative + at least one relevant environmental initiative), they should be tailored to the priorities of local communities and may therefore look quite different in different contexts or ecosystems.

What is the rationale for a PHE approach?

Isolated rural communities living in areas of high biodiversity and/or natural resource dependence often face a number of interconnected challenges including limited access to family planning and other health services, limited livelihood options and limited capacity for effective natural resource management. These challenges can lead to poor community health outcomes, food insecurity and the degradation of ecosystems upon which local livelihoods depend.

Organisations wishing to support communities to overcome these challenges often have their own specific priorities and specialised expertise. For example, environmental organisations might try to support communities to establish and enforce natural resource management rules in order to combat environmental degradation. Meanwhile, health organisations might try to offer health services through mobile clinics in order to improve community health outcomes.

However, the effectiveness of these kinds of single-sector interventions is limited. For example, natural resource management efforts are likely to be undermined if community health needs are not addressed; communities suffering from health problems are less able to engage in management efforts, and couples with unmet family planning needs may have more children than they would like to choose - thereby placing undue demands on the very natural resources and ecosystems that they're trying to conserve. Meanwhile, community health outcomes are unlikely to improve if environmental degradation and associated food insecurity / malnutrition are not addressed. Having recognised the inseparable links between these challenges, many organisations are finding the PHE approach to be a highly logical and effective way of supporting communities to live more healthily and more sustainably alongside the ecosystems of which they're custodians.

Poor community health outcomes, unmet family planning needs, food insecurity, resource depletion and environmental degradation interact and compound each other in increasingly negative ways. PHE is a joined-up approach designed to stop and reverse these vicious cycles by kick-starting a series of positive chain reactions: enabling couples to plan and better provide for their families, improving their food security, and equipping them with the skills they need to manage their resources sustainably. Only by working in such a holistic way can we unlock real change for people, their health and the environment.


Photo credit: Emilie Courtesy

How can PHE initiatives be implemented?

Institutional arrangement	Advantages / strengths	Disadvantages / challenges
Partnership between environmental and health organisations	➡ No need to hire core staff with technical expertise outside of your organisation's sector - this may also make it easier to secure organisational buy-in ➡ Limited risk of perceived mission drift ➡ Dedicated funds may not be required where the already funded activities of partners overlap geographically ➡ Allows rapid PHE programme implementation and experimentation - possibly leading to other institutional arrangements in the future ➡ Saves costs by sharing operational infrastructure (e.g. boat / car pooling, equipment, etc) between partners ➡ Enables access to new networks and relationships through partners ➡ Leverages existing technical expertise and respective credibility of each organisation ➡ Ensures high quality of sector-specific activities	➡ Cross-training of staff needed to ensure effective collaboration (see chapter 7) ➡ Close coordination and effective communication needed for integration of activities including community outreach (see chapters 7 & 15) ➡ Sharing of operational infrastructure and data may require a formal agreement (see chapter 5) ➡ May need to work on ensuring commitment to important values from all partners e.g. reproductive rights (see chapter 3)
Sector-specific teams working within the same organisation	➡ Easier to ensure that teams communicate, coordinate and integrate their community outreach activities compared to working in partnership with another organisation ➡ Saves costs by sharing operational infrastructure (e.g. boat / car pooling, equipment, etc) and support staff (e.g. logistics, finance, etc) across teams ➡ All operational infrastructure and data are owned by your organisation ➡ May be easier to ensure high quality of sector-specific activities compared to one interdisciplinary team ➡ Can combine sector-specific grants	➡ May need to hire core staff with technical expertise outside of your organisation's sector - this requires time, funding, commitment, etc ➡ Risk of perceived mission drift ➡ May take longer to develop / implement a PHE programme in this way compared to working in partnership with another organisation - less scope for experimentation ➡ Your organisation may initially lack credibility in the other sector(s) ➡ Cross-training of staff may be needed to ensure effective collaboration (see chapter 7) ➡ Sector-specific teams may be less likely to buy into the bigger PHE vision compared to one interdisciplinary team
Interdisciplinary team working within the same organisation	➡ Easier to achieve full integration of activities including community outreach compared to working in partnership with another organisation or coordinating several teams within the same organisation ➡ Strong communication and coordination within the team can enable adaptive programme management ➡ Highly cost-effective ➡ All operational infrastructure and data are owned by your organisation ➡ Interdisciplinary team more likely to buy into the bigger PHE vision compared to sector-specific teams	➡ May need to hire core staff with technical expertise outside of your organisation's sector / experience of working across sectors - this requires time, funding, commitment, etc ➡ Risk of perceived mission drift ➡ May take longer to develop / implement a PHE initiative in this way compared to working in partnership with another organisation - less scope for experimentation ➡ Your organisation may initially lack credibility in the other sector(s) ➡ Cross-training of staff may be needed to ensure effective cooperation (see chapter 7) ➡ May not be feasible to operate as one interdisciplinary team if serving a large number of communities ➡ May be harder to ensure high quality of sector-specific activities compared to sector-specific teams ➡ Often difficult to secure cross-sector grants

Adapted and elaborated significantly from USAID's PHE Programming Manual (2007)

Environmental and health organisations are often trying to tackle overlapping challenges in the same geographic zones but from different starting points. This represents a huge opportunity for collaboration!

PHE initiatives can be implemented by environmental and health organisations working together to combine their respective technical expertise and share operational infrastructure to reach isolated communities. PHE initiatives can also be implemented by interdisciplinary or sector-specific teams working within the same organisation.

These different institutional arrangements have various advantages and disadvantages (outlined in the box on the previous page) that you should weigh up when deciding which approach is most appropriate for your organisation.

The interdisciplinary team approach is often referred to as the PHE "gold standard" because in theory it enables the deepest level of integration, but in reality this tends to be the least commonly used approach as it requires much greater organisational buy-in and time-consuming / costly internal development of multi-sector expertise. Sector-specific teams working within the same organisation also generate many of these challenges, so partnerships between environmental and health organisations often represent the most popular institutional arrangement.

Since PHE initiatives are very frequently implemented by environmental and health organisations working together[1], and in light of the challenges outlined above, this guide focuses on offering practical advice to environmental and health organisations seeking to develop cross-sector PHE partnerships. Nevertheless, much of the information provided (e.g. in relation to fundraising, cross-training staff, designing integrated community outreach activities, monitoring and evaluation, external communications, etc) is also relevant to organisations seeking to implement PHE initiatives by interdisciplinary or sector-specific teams.

Whatever the institutional arrangement, all PHE initiatives are guided by the understanding that working in a holistic way can generate important synergies and better outcomes than when single-sector interventions are delivered in isolation. PHE activities can be implemented with varying degrees of integration:

Parallel: sector-specific projects are implemented in the same geographic zone without coordination or communication between different organisations or project teams; activities are separate.

Coordinated: sector-specific projects are implemented in the same geographic zone with some level of coordination and communication between different organisations or project teams; activities are coordinated but not fully integrated.

Integrated: a multi-sector programme is implemented in a single geographic zone by different organisations or project teams (or a single interdisciplinary team) working closely together; activities are fully coordinated and integrated.

Adapted from USAID's PHE Programming Manual (2007)

1 *Examples include: HoPE-LVB in the Lake Victoria Basin (Kenya and Uganda) implemented by Pathfinder International with the Ecological Christian Organisation and Nature Kenya; Safidy along the west coast of Madagascar implemented by Blue Ventures Conservation with Marie Stopes Madagascar, PSI, USAID Mikolo and Mahefa Miaraka; Tuungane around Lake Tanganyika (Tanzania) implemented by The Nature Conservancy with Pathfinder International and the Jane Goodall Institute; the PATH Foundation partnering with Family Health International and others along the Danajon Bank (Philippines); Conservation Through Public Health partnering with FHI 360 in Bwindi (Uganda).*

Whether implemented through cross-sector partnerships or by a single organisation, the different elements of PHE initiatives should ideally be conceptually linked **and** operationally coordinated at the community level. That is to say, environmental and health activities should not simply be delivered in parallel but rather should be fully coordinated at every level and integrated as far as possible.

Not only does a fully integrated approach enable cost savings by pooling transport and sharing operational resources among different organisations and/or project teams, it has also been found to be effective in broadening community participation. For example, supporting women to engage more in natural resource management decision-making and/or alternative income-generating activities, and building men's support for family planning by linking discussions about food security concerns with reproductive rights.

Is it appropriate for my organisation to develop a PHE partnership?

Once you've self-assessed your organisational capacity for PHE partnerships (see chapter 2) and engaged with communities to gain an understanding of PHE-related challenges in your context (see chapter 4), then you'll be able to make an informed decision about whether it's appropriate to try to develop a PHE partnership or pursue an in-house implementation model.

Start by reviewing the above table (How can PHE initiatives be implemented?) to remind yourself of the strengths / advantages and challenges / disadvantages associated with different institutional arrangements. You may like to think through specific "pros" and "cons" of each option for your organisation, and brainstorm potential "fixes" to the "cons" (i.e. potential ways of overcoming the challenges). You may also like to talk through the following discussion points with your colleagues, bearing in mind the type of community needs that you're aiming to address:

- Would the needs of communities in our context be addressed by a PHE approach?
- Is there adequate organisational buy-in for working in this way?
- What skills and capacity do we already have for implementing a PHE initiative? What are the gaps that need filling? *(Refer to your completed organisational capacity development plan in chapter 2.)*
- Would we be open to hiring staff with technical expertise outside of our organisation's sector? *(If no - a PHE partnership would probably be most appropriate. If yes - in-house implementation could be possible.)*
- Do we have funds available that would allow us to expand the scope of our activities outside of our organisation's sector? *(If no - a PHE partnership leveraging the already funded and complementary activities of another organisation would probably be most appropriate. If yes - in-house implementation should be possible.)*
- Would we be willing to put systems in place to ensure strong coordination with a partner? *(If yes - a PHE partnership should be feasible.)*
- Are there organisations with complementary skills and objectives working in our area? *(If yes - a PHE partnership should be feasible.)*

What are the benefits of PHE initiatives for communities?

PHE initiatives increase access to basic health services and empower people to make their own family planning choices, while equipping them with the skills they need to manage their natural resources sustainably and diversify their livelihoods.

Community member testimony from the Velondriake locally managed marine area in southwest Madagascar, where Blue Ventures is implementing a PHE initiative:

Irene was in her final year of secondary school when she had her son, now four years old. She didn't manage to take her school exit exams then, and was left feeling like her efforts had been quite futile. She decided to start using family planning after the birth of her son, choosing injections (depo-provera) offered by the community health agent in her village.

Once Irene took control of her reproductive health, she found that her business ideas thrived, her confidence grew and she became able to provide for her son. To earn money, she farms seaweed and sea cucumbers through a community-based aquaculture initiative.

Photo credit: Garth Cripps

Having experienced the benefits of family planning herself, Irene is dedicated to encouraging other women in her village to know their options and exercise their reproductive rights. Women's groups and marine resource management committees in the region are actively discussing health issues and working to increase women's involvement in fisheries management, with support from Blue Ventures' PHE team.

Recognising that "people don't live their lives in sectors / silos", PHE initiatives respond to challenges as communities experience them rather than dealing with public health or natural resource management as separate and unrelated issues. PHE initiatives are designed to reflect the ways in which challenges faced by people and the environment are connected, and often compound each other. PHE initiatives break such vicious cycles by working simultaneously to improve the health of ecosystems (both marine and terrestrial) as well as the livelihoods and the health of the communities who depend on them.

Couples are enabled to space their births and attain their desired family sizes, thereby improving food security, allowing women to play a more active role in natural resource management and/or alternative income-generating activities, and bolstering local biodiversity conservation efforts.

What are the benefits of a PHE approach for environmental organisations?

Environmental organisations sometimes struggle to engage communities in natural resource management efforts, particularly when such initiatives seem removed from more urgent and/or higher priority concerns such as accessing health services.

PHE partnerships enable environmental organisations to address unmet health and family planning needs, thereby strengthening community engagement in natural resource management and bolstering local biodiversity conservation efforts.

- Responding to the needs of your partner communities in a holistic way using a PHE approach can build their trust in your organisation and strengthen their engagement in conservation initiatives.

- The immediacy of health service benefits may be particularly helpful in bolstering long-term community support for the relatively "slower-burn" progress of natural resource management efforts.
- Increasing access to basic health services will improve the health of your partner communities, which can enable them to engage more in conservation initiatives.
- Increasing access to voluntary family planning services will enable couples to space their births and attain their desired family sizes, which can give women in particular more time to engage in natural resource management and/or alternative income-generating activities.
- Increasing access to basic health information and services can also help to reduce child mortality, which in turn can lead to changes in fertility preferences (when more children survive to adulthood, couples may choose to have fewer children).
- In areas where unmet family planning needs are leading to fertility rates that are higher than desired by local women and their partners, increasing access to voluntary family planning services and/or removing barriers to uptake of these services within a reproductive rights-based framework may result in a decline in fertility rates over time, thereby reducing undue demands on finite or slow-to-replenish natural resources and/or bolstering local biodiversity conservation efforts. Note: such fertility decline is never an objective of PHE initiatives, but it is a possible secondary effect (see Does PHE have anything to do with population control? later in this chapter).
- By exploring and addressing unmet health needs, environmental organisations can develop a more complete understanding of community situations that can aid the planning and implementation of natural resource management initiatives.

Tiana Rahagalala of the Wildlife Conservation Society (WCS) describes the benefits of their PHE partnership with Marie Stopes Madagascar (MSM):

"Our collaboration with the District Health Office in Maroantsetra and Marie Stopes Madagascar (MSM) is allowing us to ensure that all communities in the MaMaBaie (Makira, Masoala and Baie d'Antongil) terrestrial and marine conservation area have full access to voluntary family planning services. We're also supporting local community health agents to facilitate discussions about the links between health and environmental issues. Now women are able to make their own family planning choices and are becoming more engaged in natural resource management."

Results observed in the Velondriake locally managed marine area of southwest Madagascar, where Blue Ventures has been implementing a PHE initiative since 2007:

- *Proportion of sexually active women of reproductive age (15-49 years) using contraception increased more than fivefold from 10% in 2007 to 55% in 2013 (2016 data forthcoming)*
- *General fertility rate (number of live births per 1,000 women of reproductive age in the last 12 months) declined by 40% between 2007 and 2013*
- *Proportion of female representatives within the Velondriake general assembly (responsible for governing the locally managed marine area) increased from 13% to 38% at the most recent community elections in 2016*

What are the benefits of a PHE approach for health organisations?

Health organisations can face significant challenges in reaching isolated communities, and PHE partnerships offer a way of overcoming these difficulties. PHE initiatives generally engage isolated rural communities living in areas of high biodiversity and/or natural resource dependence, which tend to be under-served zones where environmental organisations are already working to support community-based natural resource management.

- Collaborating with environmental organisations that have well-established operational infrastructure can enable you to reach isolated populations more easily - for example, by using their transport for your outreach staff or supply chains.
- Collaborating with environmental organisations that have well-established community relations can support greater uptake of your health services than in areas where you don't have a locally-based partner to work with - for example, by having them integrate health promotion into their existing and ongoing community outreach activities, by having them engage men in discussions about family planning at natural resource management meetings, etc.
- PHE partnerships can also allow you to expand the scope of your work to include nutrition, food security and livelihood sustainability for the more effective achievement of your health objectives.

Eugène Andriamasy of Marie Stopes Madagascar (MSM) describes the benefits of their PHE partnerships with environmental organisations in various under-served areas of Madagascar:

"Partnering with environmental organisations including the Duke Lemur Center, the Madagascar Fauna & Flora Group (MFG) and Blue Ventures is enabling us to expand the coverage of our services to reach some of Madagascar's most isolated communities with significant unmet health needs. For example, recently one of our mobile outreach teams travelled by boat with Blue Ventures to some very remote coastal communities (inaccessible by our 4x4 vehicles during the rainy season) where they were able to offer a variety of long-acting contraceptives. Community health agents supported by Blue Ventures had informed their communities about these services in advance of our visit, dispelling common misconceptions about these methods so the demand was noticeably higher than in similarly isolated communities where MSM works independently."

Evidence suggests that PHE is more cost-effective than single-sector approaches

A quasi-experimental study conducted by the PATH Foundation in the Philippines compared the results of three different interventions – an integrated PHE programme (called "Integrated Population and Coastal Resource Management" or IPOPCORM), a reproductive health programme and a coastal resource management programme – and found that integrating reproductive health services with coastal resource management efforts generated better results than the single-sector interventions in terms of indicators including contraception use, food security and improvements to coral reef and mangrove health.

Young adults – especially young men – participating in the integrated PHE/IPOPCORM programme were more likely to use contraception than in the site where the stand-alone reproductive health intervention was delivered, while coral reef and mangrove health increased more at the integrated PHE/IPOPCORM programme site than in the site where the stand-alone coastal resource management intervention was delivered.

Although the integrated PHE/IPOPCORM programme cost more to implement than either of the single-sector interventions, the combined cost of implementing the two single-sector interventions was considerably greater than the cost of implementing the integrated PHE/IPOPCORM programme. When its cost-efficiency was viewed together with its greater impacts, the study concluded that the integrated PHE/IPOPCORM programme was the most cost-effective approach.

Summarised from Castro & D'Agnes, 2008 - Reproductive Health and Integrated Coastal Management in the Philippines - ECSP Focus, Issue 11

What are the challenges of implementing PHE initiatives?

PHE implementation often entails organisations from different sectors working together, aligning work plans and coordinating activities at the community level in order to deliver fully integrated initiatives. This requires organisations and their staff to develop the competencies needed for cross-sector working, and to learn enough about each other's work in order to be able to collaborate effectively. This guide has therefore been designed to accompany the staff of both environmental and health organisations through the process of developing such competencies, with the aim of unlocking the benefits of PHE partnerships for your organisation and the communities with whom you work!

Does PHE have anything to do with population control?

A common misconception about the PHE approach is that it aims to promote the reduction of fertility rates in support of environmental goals. This is **not** the case.

PHE initiatives respond directly to the needs and priorities of communities, as identified and expressed by communities themselves. When such priorities include addressing unmet family planning and other health needs alongside building local capacity for natural resource management, a PHE approach may be appropriate.

PHE initiatives increase access to voluntary family planning services, **without any targets** for fertility decline. PHE initiatives simply aim to uphold the reproductive rights of all individuals to choose freely the number and spacing of their children, **without coercion or discrimination**. That is to say: PHE initiatives can aim to reduce or eliminate unmet family planning needs (women wanting to space or limit their births but not using contraception) by ensuring full access to voluntary services and removing any barriers to uptake (such as lack of information about different options), but it's not appropriate to set targets for contraceptive uptake as this depends entirely upon the personal choices made freely by individuals (in line with their reproductive rights outlined above).

PHE initiatives funded by USAID are legally obliged not to use any incentives or targets relating to number of family planning "acceptors" or number of births, as per the Tiahrt Amendment of 1999 in support of voluntarism and informed choice, since any such incentives or targets could risk encouraging coercive practices.

Family planning's troubled relationship with population: a historical perspective

In the late 18th century, economist Robert Malthus observed that human population was growing faster than agricultural production. He predicted that this would eventually lead to an environmental crisis, triggering widespread disease and death.

Malthusian concerns about the limits to population growth have underpinned some coercive family planning campaigns over the years, including forced abortions and sterilisation camps in countries including China and India. More recently though, Malthus's argument about the simple relationship between population growth and resource availability has been complicated and challenged by various developments, including great boosts to agricultural productivity associated with the "Green Revolution".

At the International Conference on Population and Development in Cairo in 1994, an important shift took place. Coercive family planning campaigns were denounced as examples of how women's bodies and rights were being violated in pursuit of national economic development, and the relevance of arguments about the ecological limits to population growth for the family planning movement was hotly contested. Countries at the conference agreed that governments have a responsibility to address the reproductive needs and rights of individuals, rather than strive to achieve any demographic targets. The health sector urged environmentalists to stop associating family planning campaigns with population control.

More than two decades after the Cairo conference, such commitments to reproductive rights are as strong as ever. At the same time though, reproductive rights advocates are acknowledging that sustainability arguments may be useful for advancing international support for family planning. In country after country where women and their partners are empowered to make their own family planning choices, fertility rates are declining. The health sector now invites environmentalists to address unmet family planning needs within natural resource management efforts, while respecting the rights of all individuals to choose freely the number and spacing of their births.

Adapted from WWF's PHE Manual: "Healthy People, Healthy Ecosystems: A Manual on Integrating Health and Family Planning into Conservation Projects" (2008)

Effective PHE partnerships require both environmental and health organisation to have a strong understanding of and commitment to human rights including reproductive rights, and it's important that organisations developing PHE partnerships communicate clearly the rationale for and aims of their initiatives to funders, communities and other stakeholders in order to avoid any misconceptions about population control.

How does PHE relate to national and international policy goals including climate change resilience and sustainable development agendas?

Cross-sectoral approaches such as PHE are explicitly promoted in the Libreville Declaration on Health and Environment in Africa, with 52 signatory countries including Madagascar. PHE initiatives also contribute directly to the achievement of several of the new Global Goals for Sustainable Development, and work to build social and ecological resilience to climate change.

PHE's contribution to the Global Goals for Sustainable Development:

1. No Poverty *- PHE initiatives support rural communities to diversify their livelihoods.*

2. Zero Hunger *- PHE initiatives improve food security and nutrition by advancing community-based management of natural resources (e.g. fisheries) and supporting the development of alternative income-generating activities that can be used to purchase food.*

3. Good Health & Well-Being *- PHE initiatives increase access to health information and services.*

5. Gender Equality *- PHE initiatives empower women to take control of their reproductive health and participate more actively in income-generating activities and natural resource management while encouraging men to become more involved in family health.*

6. Clean Water & Sanitation *- PHE initiatives may include measures to improve water, sanitation and hygiene.*

13. Climate Action *- PHE initiatives build social and ecological resilience to climate change by increasing access to family planning services, supporting diversified livelihoods and improving ecosystem health.*

14. Life Below Water *- PHE initiatives in coastal areas encompass community-based marine management efforts and advance the participation of women in these efforts.*

15. Life On Land *- PHE initiatives in terrestrial areas encompass community-based forest management efforts and advance the participation of women in these efforts.*

Photo credit: Laura Robson

2. Assessing and developing organisational capacity for PHE partnerships

By the end of this chapter you should:	This chapter may be of particular relevance to:
▰ Have a picture of your organisation's existing capacity for PHE partnerships (based on your organisational values, skills and knowledge) ▰ Have a plan for developing your organisation's capacity for PHE partnerships	▰ Managers of environmental organisations ▰ Managers of health organisations

Before proceeding any further through this guide, please take a moment to self-assess your existing organisational capacity for PHE partnerships using the following questionnaire. Note that the questionnaire is simply intended to be used as a prompt for facilitating reflection on your organisational attributes and expertise, so it's quite rudimentary. This exercise should allow you to identify some capacity development priorities, and then focus on the chapters of this PHE partnerships guide that are most pertinent to your organisation's needs.

Would you like more support with this process? Blue Ventures can facilitate organisational capacity self-assessment and reflection sessions. To find out more please contact pheinfo@blueventures.org.

Organisational capacity and attributes self-assessment questionnaire

Values

Read these statements and give your organisation an honest score from 1 to 3 where 1 = no resonance with your organisational culture, 2 = some resonance with your organisational culture, 3 = full resonance with your organisational culture.

1. Listening and responding to communities

In my/our organisation...

a) ... organisational priorities reflect community priorities. a) Score:

b) ... communities are treated as experts with understanding and skills to contribute. b) Score:

c) ... grants and work plans are responsive to community needs. c) Score:

Total score for this section:

Average score for this section (total score / 3):

2. Upholding reproductive rights

In my/our organisation…

a) ... all staff believe that couples and individuals should be able to choose freely and responsibly the number, spacing and timing of their births without coercion or discrimination. a) Score:

b) ... all staff believe that equal relationships between men and women in matters of reproduction are

important, and that this requires mutual respect, consent and shared responsibility for sexual behaviour and its consequences. b) Score:

c) ... no staff are motivated to provide family planning services due to concerns about population growth. c) Score:

Total score for this section:

Average score for this section (total score / 3):

3. Working with courage and humility

In my/our organisation...

a) ... we're prepared to "think outside of the box" and experiment with new approaches including working across sectors if appropriate. a) Score:

b) ... we collaborate with partners in a respectful and transparent way. b) Score:

c) ... we're not afraid to be self-critical and change our approach if something doesn't work. c) Score:

Total score for this section:

Average score for this section (total score / 3):

Skills

Read these statements and give your organisation an honest score from 1 to 3 where 1 = no experience, 2 = some experience, 3 = sufficient experience to be able to work effectively.

4. Building effective cross-sector partnerships

a) Exploring a partnership based on shared objectives and complementary expertise. a) Score:

b) Formalising a partnership with clearly defined roles and responsibilities. b) Score:

c) Implementing a partnership with activities fully integrated across different sectors. c) Score:

Total score for this section:

Average score for this section (total score / 3):

5. Fundraising for PHE partnerships

a) Communicating the benefits of cross-sector initiatives (vs. single-sector initiatives) to funders. a) Score:

b) Fundraising for sector-specific activities to be implemented as an integrated programme. b) Score:

c) Fundraising for an integrated cross-sector programme. c) Score:

Total score for this section:

Average score for this section (total score / 3):

6. Integrated programme management

a) Coordinating activities and budgets across workstreams. a) Score:

b) Integrating health and environmental topics within community outreach activities. b) Score:

c) Cross-training staff to work in an interdisciplinary way. c) Score:

Total score for this section:

Average score for this section (total score / 3):

7. Monitoring and evaluation of PHE initiatives

a) Developing a PHE programme theory (or theory of change). a) Score:

b) Monitoring health outcomes e.g. using service delivery records (number and type of contraceptives distributed) to calculate couple years of protection provided and estimated number of unintended pregnancies averted. b) Score:

c) Monitoring environmental and cross-cutting outcomes e.g. community-based natural resource management plans in place, women's participation in natural resource management meetings, household livelihood diversity, household food security, etc. c) Score:

d) Capturing most significant change stories or testimonies from community members. d) Score:

Total score for this section:

Average score for this section (total score / 4):

8. External communications about PHE partnerships

a) Communicating the connections between unmet family planning needs, food insecurity and environmental degradation. a) Score:

b) Communicating the benefits of increasing access to voluntary family planning services and upholding reproductive rights. b) Score:

c) Communicating the "added-value" benefits of PHE as a holistic cross-sector approach. c) Score:

Total score for this section:

Average score for this section (total score / 3):

Knowledge

You can either try to answer the following questions as a team and then score yourselves compared to the model answers that follow, or you can just give yourselves a score based on the expertise that you know you have within your organisation currently: 1 = no knowledge, 2 = some knowledge, 3 = sufficient knowledge to be able to teach others.

9. Community-based natural resource management

a) What are the key general objectives of community-based natural resource management?

a) Score:

b) What is the main governance tool that can be used for community-based management in your country of operation? b) Score:

c) What is the main legal framework in place for supporting community-based management in your country of operation? c) Score:

Total score for this section:

Average score for this section (total score / 3):

10. Family planning

a) What is contraception?

a) Score:

b) What are some of the benefits of family planning?

b) Score:

c) List as many contraception methods as you know:

c) Score:

d) State the duration of protection they offer:

d) Score:

e) Rank them in approximate order of effectiveness:

e) Score:

f) List some possible negative effects of hormonal contraception methods:

f) Score:

Total score for this section:

Average score for this section (total score / 6):

11. Health service delivery

a) Give an example of community-based health service delivery:

a) Score:

b) Give an example of mobile health service delivery:

b) Score:

c) Give an example of facility-based health service delivery:

c) Score:

Total score for this section:

Average score for this section (total score / 3):

12. Health-promoting behaviours

Give an example of a behaviour you could promote to...

a) ... prevent transmission of STIs/HIV:

a) Score:

b) ... protect against malaria:

b) Score:

c) ... prevent diarrhoea:

c) Score:

d) ... prevent and/or treat dehydration relating to diarrhoea:

d) Score:

e) ... improve pregnancy outcomes:

e) Score:

f) ... support premature babies or those with low birth weight:

f) Score:

g) ... enhance newborn development:

g) Score:

h) ... improve child survival (in relation to common illnesses):

h) Score:

Total score for this section:

Average score for this section (total score / 8):

13. Behaviour change approaches

a) What factors help determine behaviours?

a) Score:

b) Is information dissemination sufficient to change behaviour?

b) Score:

c) Which approaches are effective for supporting critical thinking and behaviour change?

c) Score:

Total score for this section:

Average score for this section (total score / 3):

14. PHE linkages and messages:

a) What are some key PHE linkages that you could discuss with communities?

a) Score:

b) What are some umbrella themes that you could use to reinforce key PHE linkages?

b) Score:

c) How would you describe the social and environmental benefits of couples spacing their births and attaining their desired family sizes?

c) Score:

Total score for this section:

Average score for this section (total score / 3):

Model answers for knowledge questions

Compare your answers to the model answers below and give yourself a fair score from 1 to 3 where 1 = no knowledge, 2 = some knowledge, 3 = sufficient knowledge to be able to teach others.

9. Community-based natural resource management

a) Ensure that natural resources are available for livelihoods, food security and nutrition; put communities in charge of management efforts to ensure that management plans are adapted to their needs and supported locally; conserve biodiversity and safeguard ecosystem health.

b) In Madagascar: dina (customary law) created and enforced by local communities.

c) In Madagascar: GELOSE (gestion locale sécurisée) is a policy that transfers natural resource management rights from central government to local communities.

10. Family planning

a) A woman gets pregnant if a man's sperm reaches and fertilises one of her eggs. Contraception (literally "against conception") tries to stop this happening by keeping the egg and sperm apart (for example, by using a barrier), by stopping the release of eggs or by stopping a fertilised egg from implanting in the womb (for example, by using synthetic hormones). Many couples choose to use contraception in order to prevent pregnancy and/or to plan their families (for example, to space their births).

b) Family planning can: prevent pregnancy-related health risks for women; prevent closely spaced pregnancies and associated health risks for women and babies; prevent unsafe abortions; reduce maternal and child mortality

(by around 25% or more in low-resource settings); allow girls and women to pursue educational and income-generating opportunities; allow parents to invest more in each child (e.g. schooling, nutrition and medical care).

c) Male condoms, female condoms, combined oral contraceptive pills, progestogen-only pills, progestogen injections, hormonal implants, intra-uterine devices, vasectomy (male sterilisation), tubal ligation (female sterilisation), withdrawal (coitus interruptus), standard days method, lactational amenorrhoea method, sympto-thermal fertility awareness method, diaphragms

d) Condom = single act of sexual intercourse, pill pack = one month of protection, injection = twelve weeks of protection, implant = up to three years of protection (can be removed earlier), intra-uterine device = up to ten years of protection (can be removed earlier), tubal ligation = permanent, vasectomy = permanent, withdrawal = each act of sexual intercourse, standard days method = ongoing, lactational amenorrhoea method = up to six months, sympto-thermal fertility awareness method = ongoing, diaphragm = each act of sexual intercourse (reusable)

e) Typical use failure rates (% of couples who would get pregnant if using this method for one year - taking into account when users fail to use a method consistently or correctly): implant = 0.05%, vasectomy = 0.15%, tubal ligation = 0.5%, copper intra-uterine devices = 0.8%, sympto-thermal fertility awareness method = 1.8%, lactational amenorrhoea method = 2% (perfect use), depo-provera injections = 6%, pills = 9%, standard days method = 12%, diaphragms = 12%, male condoms = 18%, female condoms = 21%, withdrawal = 22%

f) Possible negative effects of hormonal contraception methods include nausea, breast tenderness, mood changes, depression, headaches, weight gain, decreased sex drive, irregular / breakthrough / prolonged bleeding, heavier and more painful periods with intra-uterine devices, it can take several months for fertility and menstrual periods to return after injections. In resource-poor settings where PHE initiatives are implemented, the risks of unintended pregnancy are much higher than in areas with good healthcare and this impacts upon the risk-benefit ratio of contraceptive use.

11. Health service delivery

a) In Madagascar: community health agents or Agents Communautaires (ACs).

b) In Madagascar: Marie Stopes Madagascar outreach teams, Marie Stopes ladies, etc.

c) In Madagascar: Centres de Santé de Base (CSBs), Blue Star, Top Réseau, etc.

12. Health-promoting behaviours

a) Condom use, testing and treatment

b) Sleeping under insecticide-treated mosquito nets, wearing protective clothing, covering water sources near the home

c) Using water purifying solution to treat drinking water, handwashing with soap or ash at critical times (after defecating and before preparing / eating food)

d) Administering oral rehydration solution

e) Attending antenatal check ups and giving birth with a skilled attendant where possible

f) Prolonged skin-to-skin contact between mother and baby (often known as "kangaroo care")

g) Exclusive breastfeeding for six months following birth (no other liquids or solids given during this time)

h) Early and formal care-seeking for treatment of common childhood illnesses

13. Behaviour change approaches

a) Knowledge, attitudes, social norms and identities, social meanings and values, wider structural factors like gender relations, access to certain products

b) Most often no! Knowledge is generally necessary but not sufficient for behaviour change to occur.

c) Community meetings with time for individual testimonies and dialogue, facilitated small group discussions perhaps using storytelling techniques, interactive theatre workshops modelling and exploring the consequences of different behaviours, etc.

14. PHE linkages and messages

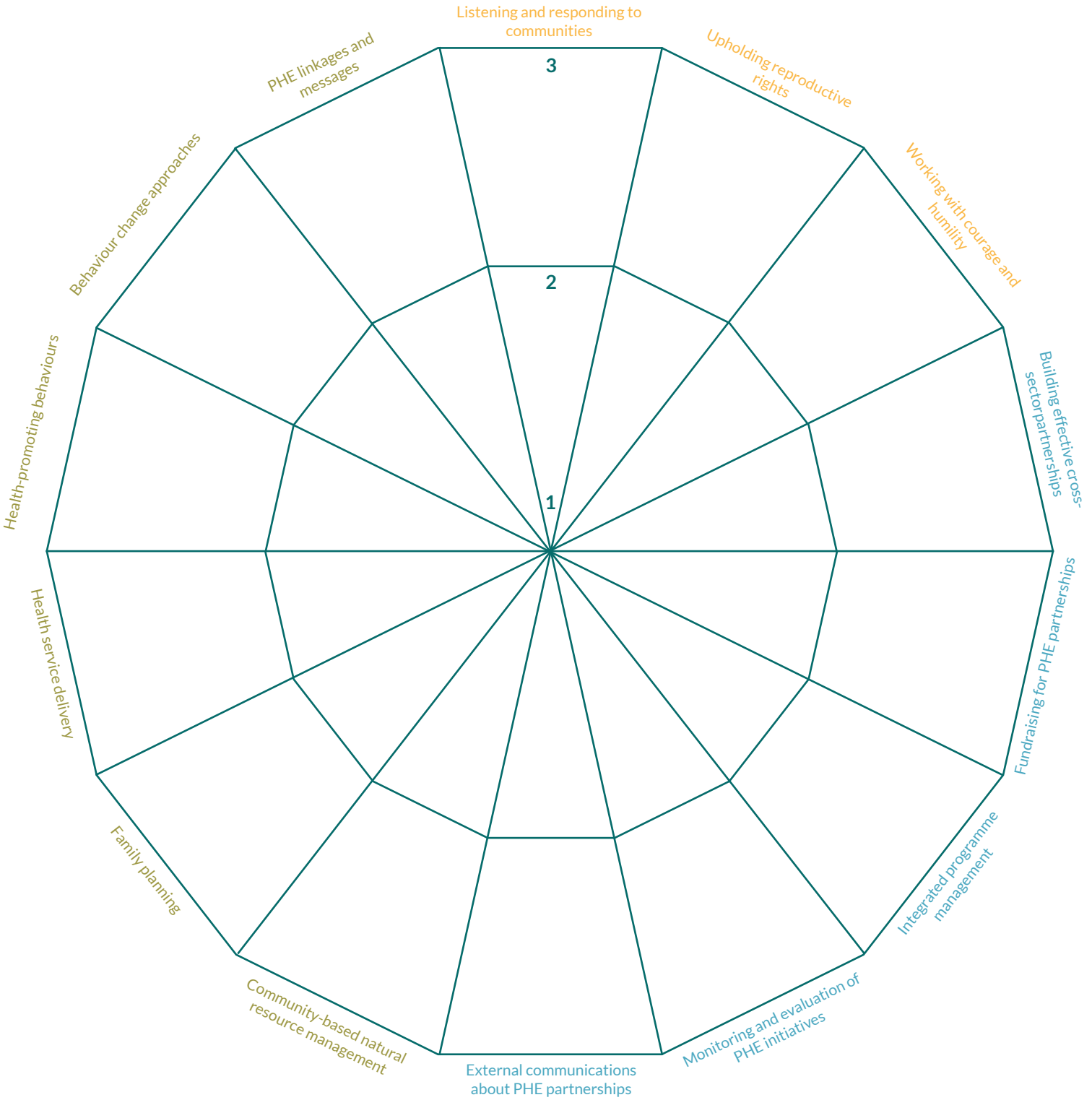
a) Connections between family planning decisions and household food security, family planning decisions and the sustainability of natural resource management efforts, family planning decisions and women's engagement in natural resource management efforts, community health and community engagement in natural resource management efforts, etc.

b) Linking reproductive rights and natural resource management rights, promoting birth spacing alongside livelihood diversification and sustainable natural resource management, etc.

c) When couples are able to space their births and attain their desired family sizes, they can generally provide better for their children (investing more in each child's education and making more food available per child). Family planning can also reduce women's childcare responsibilities, thus giving them more time to engage in alternative income-generating activities and/or natural resource management. When couples don't have access to contraceptive options they might end up having more children than they would choose, and this can put undue pressure on natural resources; giving couples access to voluntary family planning services can enable them to choose freely the number and spacing of their births, which can bolster local natural resource management efforts.

Organisational capacity and attributes self-assessment map

Mark an "X" in each segment to correspond with your average overall score for that value / skill / knowledge where 1 = inner ring, 2 = middle ring, 3 = outer ring. Note that the average overall score for each segment might sit somewhere between the rings.



This provides a visual representation of your organisational capacity and attributes for PHE partnerships that can be used to develop a tailored organisational PHE capacity development plan. The aim would be to pull all of the "X"s to the outer ring. Training and mentoring may be appropriate in segments where existing capacity is identified as being limited while accessing information and resources may be sufficient in segments where existing capacity is identified as being moderate or high.

Organisational capacity development planning template

Having completed a self-assessment of your organisational capacity and attributes for PHE partnerships, you may now wish to use the template below to map out how you plan to address your capacity development priorities.

Would you like more support with this process? Blue Ventures can facilitate organisational capacity development planning sessions and offers tailored follow up support packages. To find out more please contact pheinfo@blueventures.org.

	Initial capacity assessment score *(out of 3)*	Importance ranking *(high / medium / low)*	Information & resources *(tick if desired)* Readily available through the Madagascar PHE Network	Training sessions *(tick if desired)* Possible through the Madagascar PHE Network and/or BV support package	Tailored mentoring & quality assurance *(tick if desired)* BV support package available	Learning exchanges *(tick if desired)* Possible through the Madagascar PHE Network	Target date for advanced capacity to be developed *(month and year)*
Values							
Listening and responding to communities							
Upholding reproductive rights							
Working with courage and humility							
Skills							
Building effective cross-sector partnerships							
Fundraising for PHE partnerships							
Integrated programme management							
Monitoring and evaluation of PHE initiatives							
External communications about PHE partnerships							
Knowledge							
Community-based natural resource management							
Family planning							
Health service delivery							
Health-promoting behaviours							
Behaviour change approaches							
PHE linkages and messages							

3. Organisational values and attributes

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Have an understanding of your organisational culture ▪ Know which kind of organisational values may be pertinent for PHE partnerships ▪ Know how desired organisational values can be nurtured	▪ Managers of environmental organisations

Although certain skills and knowledge are needed to implement effective PHE partnerships and initiatives, organisational culture is equally if not more important because PHE is such a community-driven and rights-based approach. This can mean that sometimes organisations may need to work on cultivating organisational values appropriate for PHE.

What is organisational culture?

Organisational culture is a system of shared assumptions, motivations, beliefs and values that shapes how people behave within an organisation. Organisations are as unique as the people who constitute them, which explains why different organisations have different organisational cultures.

How to understand my organisational culture?

You can uncover key elements of your organisational culture by asking yourself and/or your colleagues a few questions. For example:

- How would you describe the character of your organisation in a few words?
- What motivates people in your organisation?
- Who guides your work?
- How do staff members relate to each other within your organisation?
- How would you describe your organisation's main style of working?
- How do people learn and adapt within your organisation?

Why is organisational culture important?

Two organisations may have similar missions and strategies but if they have different organisational cultures then they're likely to approach developing plans, implementing activities and interacting with communities or partners quite differently. Certain organisational values can be particularly conducive for PHE initiatives, so it may be worth trying to cultivate or maintain such values within your organisation.

Which kind of organisational values are pertinent for PHE partnerships?

No two organisations are the same, and PHE initiatives can be implemented effectively by a range of organisations. An important step in developing a PHE initiative is to take the time to explore your organisational values and attributes, ideally as a team, and to discuss which values will be most important for supporting your PHE work. Our experience suggests that the following organisational values may

be among those pertinent for the implementation of PHE partnerships:

Listening and responding to communities

Conservation and development professionals typically build up specialised expertise and work in single-sector silos, but focusing oning health or environmental problems in isolation is like looking at the world with tunnel vision or blinkers on. Organisations that are truly committed to listening and responding to communities are prepared to learn about (and seek to respond to) all types of community needs, even if not directly related to their specialisation; their work is guided primarily by the perspectives of communities. This kind of openness is vital for developing PHE partnerships that are fully responsive to the interconnected challenges faced by communities.

Upholding human rights

As outlined in chapter 1 (Does PHE have anything to do with population control?), PHE initiatives uphold the reproductive rights of all individuals to choose freely and responsibly the number, spacing and timing of their births without coercion or discrimination. A commitment to reproductive rights includes the belief that equal relationships between men and women in matters of reproduction are important, and that this requires mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

Blue Ventures' experience:

"We started working in southwest Madagascar as a marine research group, surveying coral reefs. With several scuba divers on site at any time, we employed expedition medics who were responsible for ensuring the health of our volunteers. However, soon the medics became aware of pressing community health needs as local women were coming to them asking for access to family planning options and health services.

In this way, our unconventional journey in marine conservation began through listening. We learned that people in Velondriake, Madagascar's first locally managed marine area, thought that fish stocks would collapse without increased access to family planning. We also saw that, as an organisation working in these isolated communities, we were ideally positioned to address to this critical unmet need with various health partners.

Although we viewed ourselves as a marine conservation organisation, our commitment to listening and responding to communities led us to incorporate efforts to increase access to family planning and other health services into community-based marine management initiatives. Today, our PHE programme serves more than 25,000 people across three sites along Madagascar's western coastline.

Recognising that this commitment to putting the needs and priorities of communities first has underpinned and shaped the evolution of our work over the past decade, we have articulated the following organisational value which continues to guide us today: Above all, we listen to community needs, responding in a sensitive and pragmatic way for lasting benefits."

Because of the family planning sector's troubled relationship with population control advocates, organisations implementing PHE initiatives should think carefully about their motivations for increasing access to family planning services and ensure that all staff understand the importance of upholding reproductive rights. This commitment to upholding reproductive rights should be communicated to and shared by partners and funders, so that all stakeholders are aligned in working towards ensuring full access to voluntary family planning services and free choice regarding contraception use.

Alongside a commitment to reproductive rights, PHE initiatives also typically uphold the rights of communities to manage their natural resources by advancing local capacity for natural resource management and advocating for supportive legal frameworks as appropriate.

Blue Ventures' experience:

"As a marine conservation organisation with environmental objectives, we felt that it was important to make explicit our commitment to reproductive rights when we started collaborating with health partners to increase access to family planning services. The community health component of our PHE programme is therefore called Safidy, which means "the freedom to choose" in Malagasy. This theme of free choice permeates all of our community outreach and sends a strong message to our partners that although we're an environmental organisation, our community health work is motivated by wanting to ensure that all individuals have access to comprehensive information and a full range of methods that they can choose freely to use to make their own family planning decisions."

PHE can therefore be thought of as a dual human rights-based approach (encompassing reproductive rights and natural resource management rights) with a consistently community-centred ethos, which may contrast with more top-down conservation efforts. Environmental organisations that are interested in developing PHE partnerships yet usually work in a more top-down ways may like to consider whether it would be appropriate to change or adapt their ways of engaging with communities, particularly in light of potential synergies that could be achieved through more community-based work.

Working with courage and humility

Linked with the organisational value of listening and responding to communities, the PHE approach generally requires organisations to work with courage and step outside of their comfort zones to address priority community needs. PHE initiatives also tend to work best when organisations develop and facilitate them with humility; believing in and treating communities as experts with understanding and skills to contribute, and collaborating with partners in a respectful and transparent way.

Blue Ventures' experience:

"Our journey towards developing a PHE initiative was characterised initially by doubts about whether we could respond to what local communities were asking us to do (provide access to family planning options and health services). Different staff within our organisation held varying opinions on this dilemma. Some felt that it was outside of the scope of our mission. Others recognised the connections between human and ecosystem health, and saw that it was important to leverage our position to address these priority needs expressed by local communities. After some internal discussion and debate, the bold decision was made to pursue this work. Of course we recognised that we couldn't do this alone, so we reached out to health partners in the area to draw on their expertise and explore opportunities for collaboration."

Photo credit: Garth Cripps

How to nurture desired organisational values?

Nurturing desired organisational values is an important and ongoing process. It can seem quite intangible so here are some practical tips for supporting staff members to live and breathe desired organisational values:

- Convene a group of staff members from across your organisation to reflect on your organisational values and put them into words
- When recruiting new employees, include these values in your job descriptions, and try to assess the

motivations and values of candidates (for example, by getting them to talk through how they would behave in different scenarios) in addition to their technical skills and experience

- Develop on-boarding processes for new employees that instill a deep understanding of and commitment to your organisational values (for example, by having them shadow existing staff members who model organisational values well)
- Craft performance planning and review frameworks to encourage and reward behaviour that's coherent with desired organisational values
- Create opportunities for staff members to evaluate their team's work in relation to desired organisational values and/or flag occasions where desired organisational values risk being compromised

Photo credit: Garth Cripps

- Ensure that working spaces and conditions enable and support the enactment of desired organisational values
- Recognise that the above steps can only nurture desired organisational values if your leadership team's words and actions are in tune with these values every single day

4. Facilitating community consultations

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Understand why it can be helpful to facilitate community consultations before designing a PHE initiative or establishing a PHE partnership ▪ Know what type of information may be needed and how it can be collected ▪ Be able to review the information that you have already and then decide how to gather any further information that's needed ▪ Know how to organise and facilitate an effective focus group ▪ Know what kind of questions you could use in focus groups ▪ Know how to engage key informants in a community consultation ▪ Understand that there are rapid and resource-light ways of facilitating a community consultation or involving communities in the design of a PHE initiative	▪ Managers and community-based staff of environmental organisations

Why facilitate a community consultation?

Before designing a PHE initiative or establishing a PHE partnership, it's imperative to get an understanding of community needs and capacities in your context so that you can tailor your approach and the PHE components as appropriate. In fact, a community consultation should really form an integral part of the planning process as you listen to community perspectives and identify ways forward together.

What type of information may be needed and how can it be collected?

Photo credit: Brian Jones

The list on the next page is just suggestive; all of this information is not necessarily required and your organisation may have additional suggestions so think carefully about what exactly you need to gather in your context! Note that you may have much of it already and/or be able to gather it quite easily and quickly from informal conversations with community members during your day-to-day work.

Type of information	Most appropriate collection method
Community strengths, capacities and problem-solving histories	➡ Focus groups or conversations with community members ➡ Conversations with key informants
Community perceptions of priority challenges	➡ Focus groups or conversations with community members ➡ Conversations with key informants
Community perceptions of connections between different priority challenges (health and natural resource management in particular)	➡ Focus groups or conversations with community members ➡ Conversations with key informants
Local natural resource management regimes (and gender roles in these)	➡ Focus groups or conversations with community members ➡ Conversations with key informants
Local livelihood activities (and gender roles in these)	➡ Focus groups or conversations with community members ➡ Conversations with key informants
Key community health problems	➡ Focus groups or conversations with community members ➡ Conversations with key informants (including local or regional health service providers) - especially because in areas with limited health education, the information that communities provide may not reflect the full extent of their unmet health needs ➡ Health service data can also be useful for cross-checking qualitative data if available / obtainable
Current prevention and treatment of health problems	➡ Focus groups or conversations with community members ➡ Conversations with key informants (including local or regional health service providers)
Current access to and uptake of health information and services	➡ Focus groups or conversations with community members ➡ Conversations with key informants (including local or regional health service providers) ➡ Health service delivery data + census data (to calculate % of population accessing services) if available / obtainable and a quantitative indicator is deemed necessary for baseline ➡ Social surveys (to assess % of population accessing services) if health service delivery data + census data are unavailable / unobtainable and a quantitative indicator is deemed necessary for baseline
Desired access to currently unavailable health information and services	➡ Focus groups or conversations with community members ➡ Conversations with key informants ➡ Social surveys (to assess % of population with unmet needs) can also be conducted if your organisational capacity is adequate and a quantitative indicator is deemed necessary for baseline
Family planning knowledge - different methods and side effects	➡ Focus groups or conversations with community members ➡ Conversations with key informants ➡ Social surveys (to assess % of population with certain knowledge) can also be conducted if your organisational capacity is adequate and a quantitative indicator is deemed necessary for baseline - generally focus groups will suffice
Family planning attitudes - including fertility preferences and decision-making dynamics	➡ Focus groups or conversations with community members ➡ Conversations with key informants ➡ Social surveys (to assess % of population with certain attitudes) can also be conducted if your organisational capacity is adequate and a quantitative indicator is deemed necessary for baseline - generally focus groups will suffice
Family planning practices - contraception use	➡ Focus groups or conversations with community members ➡ Conversations with key informants ➡ Health service delivery data + census data (to calculate % of women of reproductive age using contraception) for baseline ➡ Social surveys (to assess % of women of reproductive age using contraception / with unmet family planning needs) if health service delivery data + census data are unavailable / unobtainable for baseline

A community consultation should never be about extracting information and using it to plan a project without further community input. It's important to have a two-way conversation involving community members in the process of designing a locally tailored PHE initiative! This should maximise local ownership from the beginning and build on the existing strengths of community members. Note that some consultations may indicate that a PHE initiative isn't feasible or ideal for a particular situation but, whether consultations result in a PHE initiative or not, it's always important to ensure that results of consultations are reported back to communities.

First step - review existing information

Begin by reviewing any relevant information about PHE challenges in the local context that you've already collected / have access to / can request from partners. This could include conversations with community members or social surveys or focus groups conducted by your organisation or partners in the past, service delivery data from local health service providers, and census data from local authorities. These can help you to build up a picture of community needs in the area where you work, possibly including the proportion of the local population using certain health services (if you're able to cross-check health service user numbers with population numbers).

Next step - decide how to gather any further information needed

Now think about what (if any) additional information you need in order to be able to develop a locally appropriate PHE initiative (see the table on the previous page for a guide), and how you'd like communities to participate in this process. Ideally it should be a collaborative effort, surfacing challenges and possible solutions through conversations with community members who are themselves experts of their own situations.

Although conducting social surveys may be appropriate for gaining an overview of community needs and establishing quantitative baselines from which to monitor the results of your PHE initiative, informal conversations and/or focus groups are likely to be much more effective for gathering in-depth community perspectives of the connections between various PHE challenges in the local context and of health needs in particular. They are also less costly and logistically challenging than social surveys to organise, and allow for valuable two-way dialogue with community members.

What is a focus group?

A focus group is a semi-structured group interview / facilitated discussion during which people are asked about their opinions and experiences, which may or may not be representative of the general population. Focus groups are a form of qualitative research, with open-ended questions that can be used to develop an in-depth understanding of various issues. They're an excellent stand-alone research tool, and may also be used alongside more quantitative data collection methods such as social surveys.

How to organise an effective focus group?

Unlike with social surveys, you're not trying to get a representative sample of the community so purposive or convenience sampling of small numbers of people is fine but it's important to remember this as you analyse and apply the results. You'll probably want to consider perspectives among different subsets of the community in order to build up a picture of the situation from various angles (for example, different genders and ages).

You should explain to all prospective participants the aim of the focus group (i.e. to understand community strengths, priorities and needs in order to explore how we might work together to improve the health of people and the environment in the local area), check that they understand this, indicate how long the focus group discussion is likely to last, and ask for their verbal consent to participate. It's also important to clarify that there are no right or wrong answers, and that the facilitator is not looking for any set responses. You may need permission from local authorities or village leaders to convene these focus groups, especially if you're not already working in the area and/or will be asking personal or health-related questions, so check with them before doing anything if in any doubt.

Think about where would be best to facilitate your focus groups, ideally in a quiet and informal place where people feel comfortable to share openly yet will not be disturbed or overlooked by others.

How to facilitate a focus group?

Focus groups are generally convened with 6-10 people.

You should probably arrange your focus groups into similar ages and genders (e.g. young women, young men, older women, older men) as this is likely to create the most comfortable environment for open discussion and maximum disclosure among participants. In some places this may be vital for ensuring that participants can speak freely, especially about sensitive health topics. Another advantage of this approach is that you can easily compare viewpoints across demographic groups.

Alternatively you may like to consider bringing together people of different ages and genders within the same focus groups to stimulate debates among diverse viewpoints. However, even with proactive facilitation it can be difficult to mitigate power differences between participants so this approach is generally not recommended.

Ideally you need two people to facilitate a focus group. One person acts as the facilitator and leads the focus group participants through a discussion loosely structured around a topic guide or sample questions; the aim is to generate free-flowing exchanges among participants and explore a diversity of views. The second person acts as the note-taker and writes down all points shared as well as contextual observations; they may also take photos of the outcomes of participatory ranking and mapping exercises as appropriate. It can be helpful to audio-record the focus groups in order to have a complete record of everything, and to be able to cross-check the note-taker's records. (Always ask participants' permission before recording.)

Start the focus group by restating its purpose, and establishing some ground rules (e.g. everyone's opinions are important, there are no right or wrong answers, let's listen to each other and allow everybody time to speak, agree on confidentiality parameters, etc). Then give participants a brief overview of the structure of the discussions that will follow (e.g. we'll start by exploring the strengths of this community then various challenges you face and there'll be time to ask us questions at the end), before asking each person to introduce themselves briefly and perhaps doing a quick icebreaker.


Photo credit: Brian Jones

It's imperative to properly brief and train anyone who will be acting as a focus group facilitator and/or note-taker. You can find further resources for focus group facilitators in Annex I.

Possible focus group topics / questions

*These are suggestions and are **not** all required (nor all possible to cover in one session); please exercise your own judgement and choose which ones you need to use as appropriate in your context, bearing in mind all of the information that you already have access to!*

- What sort of activities do people undertake in this community? What are the good things about living in this community? What are the strengths of this community?[1]
- When you face a challenge as a community (or as individuals / households / families) how do you respond? Have people here come together in the past to solve a problem? If yes - how?[1]
- What are the greatest challenges faced by this community?
  - Invite an open discussion then probe about natural resource management, income generation, food security, health, education, gender relations, etc. as relevant.
  - Ask people to rank challenges according to importance.[2]
  - Ask people to explain any connections they see between different challenges.[2] Probe perceptions of connections between community health, family planning and natural resource management in particular.
- How are natural resources used and managed in your community? Who makes the decisions?[3]
  - Do women have a say? If no - why not (what are the barriers to them participating)?
  - What are some examples of how people within your community or outside of your community respect or disrespect natural resource management rules? If rules are disrespected - what are the reasons for this and what are the consequences (e.g. are sanctions generally enforced)?
- What do people in your community do to generate income, secure food and support their families?[3]
  - How are the roles of men and women similar and/or different within this community? Do they vary across younger and older generations? If yes - why do you think that might be?
- **What are the greatest health problems facing your community / families?**
  - Ask people to rank problems according to frequency and/or severity.[4]
  - Which sub-groups within the community are most affected by these health problems (if relevant)?
  - **What do you do to try to prevent these health problems (if anything)?**
  - **What kind of treatments do you seek for these health problems (if any), from where and why?**[5]
  - What impact do these health problems have on other aspects of your lives e.g. livelihoods, education, etc?
- **What health information and services do you currently have access to / use?**
  - **Probe specific themes (e.g. family planning, sexual health, maternal health, child health, water, sanitation, hygiene, nutrition, etc.) if necessary.**
  - **Which kind of service providers (e.g. public / private / mobile / informal / traditional)? Where are these located? Do they charge for their services?**
  - **Are there any barriers to access / uptake? Probe about distance, cost, lack of information, partner support, staffing, availability of stock, quality of care, etc. as relevant.**

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1 We recommend starting by asking communities to reflect on their strengths and existing capacities rather than jumping straight into their needs and problems - as per the Asset-Based Community Development approach.

2 You could illustrate different challenges on pieces of paper (e.g. fish for food security, red cross for health, etc.) and ask people to get involved arranging them along a ladder (ranking exercise) or within a web (connections exercise) traced onto the ground - as per the Participatory Rural Appraisal approach.

3 You may or may not like to include these topics / questions depending on if you're wanting to keep things broad or focus mostly on health. We normally recommend starting with some questions about natural resources and livelihoods before moving onto more sensitive health topics but the previous topics / questions above should serve as a good introduction anyway so you could leave out these topics / questions if you already have this information from elsewhere.

4 You could illustrate different challenges on pieces of paper (e.g. latrine for diarrhoea, mosquito for malaria, etc.) and ask people to get involved ranking them along a ladder - the discussions and debates about the health problems that ensue are likely to be as interesting as the ladder that they end up producing.

5 You could map out typical treatment pathways using pieces of paper illustrating different service providers (e.g. building for clinic, person with briefcase for community health agent, etc.) and health problems (as above).

- What health information and services are not available here that you most need / want?
  - What do you think is most needed in order to change this situation?
  - Do you have any ideas about how we could work with you to change this situation?[6]
- **What do you know about family planning?**
  - **Probe about different contraception methods (e.g. condoms, pills, injections, implants, intra-uterine devices, natural methods, etc.) and side effects.**
  - Where does your knowledge about family planning come from? Who do you discuss family planning with?
- What do you think about family planning?
  - Probe about different views held by men / women / young people / leaders within the community.
  - How do you decide when to have children and how many children to have? Who makes the decision?
  - **Do many couples / young people in this community use family planning? Why / why not? What are the reasons for people not using family planning in this community if they would like to?[7]**
- Is there anything else you'd like to share that we haven't covered?
- Do you have any questions for us?
- Feedback on next steps so that they know what to expect.

6 Following the first footnote on the previous page - trying to build on existing community strengths and capacities. Include this only if you are prepared to be able to help address this in tangible ways fairly quickly in order to ensure that no expectations are created that can't be met.

7 You may like to probe common barriers to family planning use here - e.g. do men support their partners to use family planning and if not then why not, do women experience any negative effects from using hormonal methods and if yes then what do they do in response (e.g. persevere, use inconsistently, stop using, switch methods, etc)?

It can be helpful to pilot your chosen topics and questions with one or two groups to check that the wording is clear and you're getting relevant information. You can then make any necessary adaptations before facilitating them with the remaining groups.

Engaging key informants

In addition to informal conversations or focus groups with community members, you may also like to speak with key informants (e.g. village leaders, religious leaders, formal health service providers, traditional health service providers, natural resource management committee members, women's association members, etc) if not already included and engaged. Depending on the situation, you could approach such conversations as informal semi-structured interviews or as two-way discussions exploring their perspectives of PHE challenges in the local context and potential opportunities for collaboration. The latter approach is almost certainly most appropriate for meetings with Ministry of Health officials as you seek to build horizontal relationships with them.


Photo credit: SEED Madagascar

In thinking about whether to conduct focus groups with community members or speak with key informants first, there are advantages and disadvantages to either order. On the one hand, it may be preferable to facilitate community focus groups first and then feed some of the general themes from these into your conversations with key informants. On the other hand, it may be useful to speak with key informants first in order to refine the topics you choose for the community focus groups. You may also need to consider local protocol regarding this. In practice, an iterative approach is likely to be most appropriate, including ongoing conversations with key informants throughout the planning process to ensure that they're fully engaged and supportive of the work you're planning.

Final steps - feedback and planning

As you complete your community focus groups and conversations with key informants (and obtain appropriate health service delivery data + census data / social survey data[1] as appropriate), you should review the most salient themes emerging from the community consultations. If you're an environmental organisation working in a remote area, these themes are likely to include limited access to health information and services. If this is the case, next steps may entail identifying potential partner health organisations or health service providers with whom you could discuss and explore opportunities for collaboration once local grassroots options for increasing access to health information and services have been exhausted. Thorough mapping of partners and existing programmes in the area may be required; often this can be achieved through desk-based research followed by preliminary partnership exploration meetings as detailed in chapter 5.

Your in-depth understanding of the local context should now enable you to develop a PHE initiative closely tailored to community needs, and sensitive to community attitudes around gender and family planning. Your overview of local health problems should allow you to identify some key health-enhancing behaviours that you might like to promote, such as condom use for HIV prevention or exclusive breastfeeding for newborn development. Your assessment of family planning knowledge and attitudes as well as community perceptions of the connections between health and natural resource management challenges should enable you to design a fully integrated programme of community outreach, ideally led by local community champions (of reproductive rights, gender equality and environmental conservation) identified during the community focus groups.

SEED Madagascar conducts a community consultation to understand PHE challenges and unmet needs in rural southeast Madagascar:

SEED Madagascar recently completed an extensive PHE community consultation in the rural commune of Mahatalaky; a remote part of the Anosy region in southeast Madagascar. Aimed at developing a comprehensive understanding of the interlinked challenges faced by isolated communities in this commune, the consultation consisted of meetings with community groups and key informants, as well as focus groups with youth, men, women and elders, and one-to-one interviews. These captured community behaviours, practices and perceptions, highlighting connections between health outcomes, livelihood options and the accessibility of natural resources. The consultation identified a range of unmet community needs, as well as potential opportunities for bringing together regional actors and leveraging existing community structures in order to address these unmet needs.

Key issues raised by the consultation included reliance on traditional health service providers, limited capacity of community health agents, lack of access to accurate health information, lack of partner support for family planning, reliance on limited natural resources for food and livelihoods, insecure land tenure, lack of training and inputs for alternative livelihoods, and non-compliance with local natural resource management rules. SEED is now preparing a holistic PHE initiative in order to address these issues. This initiative seeks to include the facilitation and development of PHE partnerships among health and environmental actors in the Anosy region, training and support for community health agents, the creation of community forums for advancing local environmental and health initiatives, and training for SEED staff in integrated PHE community outreach.

1 *You can find guidance about social surveys in chapter 8 and Annex II.*

It's vital to maintain community engagement throughout this planning stage, feeding back the themes emerging from the consultations and then brainstorming potential solutions together; building on community strengths, and bringing in partner organisations with additional expertise as required.

The Duke Lemur Center's SAVA Conservation initiative reaches out to discuss collaboration opportunities with Marie Stopes Madagascar (MSM) following informal identification of unmet family planning needs in northeast Madagascar:

Based on an understanding of community challenges including lack of access to family planning services developed through their day-to-day work in and around Marojejy National Park in northeast Madagascar, the Duke Lemur Center's SAVA Conservation team seized the opportunity to connect with Marie Stopes Madagascar (MSM) via Blue Ventures in 2013. This resulted in the creation of a PHE partnership, bringing family planning services to women and their partners in some of the most isolated communities in the region, and complementing ongoing local environmental initiatives.

Photo credit: Inaki Relanzon

What if my organisation doesn't have the time and resources to facilitate a community consultation? Can we still develop a PHE initiative?

Absolutely! In fact many organisations supporting community-based initiatives build up a strong understanding of community priorities and unmet needs in the course of their day-to-day work. Others may have access to information through government sources or partners. In these cases a full-blown community consultation may not be necessary! You may be able to proceed directly to developing a strategy for addressing already identified community priorities and unmet needs. (Remember also that it'll be important to keep revisiting existing information and community priorities and unmet needs throughout the implementation process as well.)

Feeling like you need to facilitate a full-blown community consultation but you don't have the time or resources to do this shouldn't be a barrier to developing a PHE initiative. What information do you already have and what information do you think you need to gather in order to proceed? Remember that community consultations can be facilitated in various ways - ranging from a few informal conversations to a series of focus groups - depending on your capacity and preferences. So you could try to incorporate conversations with community members into your day-to-day work or explore whether a partner organisation would have the capacity to do a more in-depth community consultation in the area.

Would you like more support with this process? Blue Ventures can assist you with the development of a community consultation plan including providing bespoke advice on focus group questions as well as analysis of findings and next steps. To find out more please contact pheinfo@blueventures.org.

5. Building effective PHE partnerships

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know some key characteristics of effective PHE partnerships ▪ Know how effective PHE partnerships can be established ▪ Understand why it can be helpful to think of a Memorandum of Understanding (MoU) as an outcome of the partnership building process once all of the groundwork for a respectful and productive working relationship has been laid ▪ Know what a PHE partnership MoU should include ▪ Know what to do if things go wrong with your partner(s)	▪ Managers of environmental organisations ▪ Managers of health organisations

What is a partnership?

In the context of PHE, a partnership can be defined as a cooperative relationship between autonomous organisations working across sectors (combining expertise and services / activities) to deliver an integrated PHE initiative.

What are some key characteristics of effective PHE partnerships?

- Common purpose
- Compatible (ideally shared) values - *e.g. around reproductive rights and community leadership*
- Clearly defined objectives, roles and responsibilities designed to address expressed community needs - *these may be outlined in a Memorandum of Understanding along with details of any funding or operational resources to be shared*
- Strong commitment to building a long-term relationship
- Appreciation of each other's complementary expertise and basic understanding of each other's sectors
- Balance of power
- Jointly agreed partnership principles - *for example:*
  - Mutual respect and trust
  - Transparency and accountability coupled with open lines of communication for feedback and data sharing - *this may include building in periodic reviews of the partnership in order to identify any issues and areas for improvement*
  - Commitment to learning, flexibility and adaptation

How can effective PHE partnerships be developed?

If you're interested in developing a PHE partnership in a region where you're already working or wish to reach, you should start by identifying potential partners that you could approach who also work in that region. If you're an environmental organisation then you'll probably be looking for health organisations to partner with and if you're a health organisation then you'll probably be looking for environmental organisations to partner with, in order to develop an integrated PHE initiative together.

Preliminary things to look for in potential partners include complementary expertise, compatible values, an understanding of the value of cross-sector working and geographical overlap / presence in the region where you're hoping to develop a PHE initiative. Once identified, you should reach out to these potential partners and suggest a meeting to discuss opportunities for collaboration. In this first contact, you could mention a little about your organisation's scope of work and the value that you believe you could add to their organisation's work by developing a cross-sector partnership (see chapter 1 - What are the benefits of a PHE approach for environmental / health organisations? - for ideas).

Suggested topic guide for your initial meeting(s):

- Personal introductions
  - Names and roles
- Organisational introductions
  - Mission and expertise
  - Objectives and key activities
  - Approach and values
  - Brief overview / history of community engagement in the region
- Identification of compatibility / overlap in terms of values and objectives
- Identification of complementarity / potential synergies in terms of expertise and activities
- Exploration of opportunities for collaboration
  - Increasing the reach of family planning and other health services in the region
  - Integrating community health promotion into ongoing environmental community outreach work
  - Expanding the scope of community health promotion to include food security and livelihood sustainability
  - Training community health agents to facilitate discussions about the links between family planning, community health, natural resource management and ecosystem health
  - Engaging men more in family planning discussions and women more in natural resource management decision-making
- Discussion of broad partnership principles - clarifying expectations regarding:
  - Potential roles and responsibilities
  - Level of coordination / integration of activities
  - Accountability, data sharing and communication
  - Likely formality and duration of collaboration
- Agreement on next steps
  - Reviewing guidance about PHE partnerships (such as this guide)
  - Consulting communities (see chapter 4)
  - Seeking approval and/or buy-in from colleagues (including senior management as necessary)
  - Drafting a Memorandum of Understanding
  - Scheduling a follow up meeting for more detailed planning


Photo credit: Lemur Conservation Foundation

What is a Memorandum of Understanding and is it necessary for an effective PHE partnership?

A Memorandum of Understanding or MoU is a formal agreement between two or more organisations, often used to establish official partnerships. MoUs are not legally binding, but they carry a degree of seriousness and mutual respect, demonstrate a level of commitment to the partnership and provide clarity on what will be done. They express a convergence of objectives between signatories, and typically outline an intended collaborative course of action.

You don't need to sign an MoU in order to operationalise an effective PHE partnership, but it can be helpful in ensuring a shared understanding of how the collaboration is expected to work and it can also be used as a reference point during periodic reviews of how the partnership is progressing.

Collaboration with ministries

PHE partnerships generally entail collaboration between environmental and health organisations, however, such initiatives should also align closely with ministry frameworks and contribute to the achievement of ministry priorities. It can therefore be helpful to draw up a simple Terms of Reference or ToR to be approved by relevant ministries, detailing the scope of work of your PHE partnership (key objectives, activities, partners and alignments with national policies) in order to facilitate productive relationships with such ministries. The ministries should typically respond with a signed letter endorsing the ToR, and provide you with the contact details of designated focal points who will work with your organisation moving forward.

Avoiding a common pitfall! It's tempting to focus on drafting and signing an MoU, but this alone will not guarantee an effective PHE partnership. Instead, it can be helpful to think of an MoU as an outcome of the partnership building process, once all of the groundwork for a respectful and productive working relationship has been laid. This process includes sharing information with and requesting input from all relevant managers and staff, then listening to and addressing any of their concerns about the partnership, thereby ensuring strong commitment and buy-in from all involved.

What should a PHE partnership MoU include?

- Name of the contact person for each organisation
- Purpose of the partnership
- Intervention zone
- Key activities to be undertaken
- Roles and responsibilities of each organisation
- Timeline / completion dates for activities if relevant
- Important shared values - *e.g. upholding reproductive rights*
- Funding arrangements
- Sharing of operational resources - *e.g. transport / equipment*
- Sharing of data - *e.g. service delivery / community outreach data*
- Periodic reviews
- Duration of engagement

Please see Annex III for a full PHE partnership MoU template.

What to do if things go wrong with your partner(s)?

The chances of things going wrong should be minimised by following the above guidance about how to create a solid foundation for an effective PHE partnership; building strong commitment to a common purpose and shared values among all staff involved, and documenting your collective understanding of how the partnership will operate in an MoU.

However, if things don't go according to plan you should start by reviewing and clarifying your expectations of the partnership; specifically its purpose, and your respective roles and responsibilities. If one or both of you are unable to fulfil your commitment to the partnership, you should openly discuss the reasons for this and seek to identify appropriate solutions together. This may involve modifying the terms / scope / scale of the partnership, or bringing in other partners with complementary expertise. It's best to raise and address any concerns as soon as they arise in order to deal with them effectively and efficiently.


Photo credit: Garth Cripps

Marie Stopes Madagascar (MSM) works with Blue Ventures to ensure a consistent delivery of long-acting reversible contraceptives (LARCs) in remote southwest Madagascar:

Blue Ventures has been partnering with MSM in the Velondriake locally managed marine area of southwest Madagascar since 2010, with the aim of making LARCs available to women on a quarterly basis. Initially these methods were offered by MSM's mobile outreach team, comprising three or four medical professionals travelling in a 4x4 vehicle. However, this team serves a large area and has a busy schedule which is subject to change, making it difficult to ensure a consistent quarterly cycle of LARC provision, check-ups and removals for women in Velondriake. Blue Ventures therefore discussed alternative service delivery options with MSM, which resulted in a new partnership with a "Marie Stopes lady" (nurse trained and supported by MSM to offer LARCs), who is based in the regional capital of Toliara. Blue Ventures agreed to arrange for her transport and accommodation in the Velondriake area on a quarterly basis, enabling her to visit five villages each time. The mobile outreach team also continues to visit as their schedule allows, and thus a consistent delivery of LARCs has been achieved in Velondriake.

6. Resourcing PHE partnerships

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Understand that it may not be necessary to raise dedicated funds in order to operationalise a PHE partnership ▪ Know the benefits and challenges associated with combining single-sector grants or seeking cross-sector grants ▪ Know how to frame your PHE initiative as a solution that addresses key concerns held by a funder	▪ Managers and fundraising staff of environmental organisations ▪ Managers and fundraising staff of health organisations

Is it necessary to raise dedicated funds in order to operationalise a PHE partnership?

No, in fact often it's not necessary! Your first step should be to draw up a rough work plan with your partner(s), then see what funding each of you already has secured or available for these activities. In many cases it won't be necessary to raise funds specifically for the PHE partnership, as often such partnerships can be operationalised by combining already funded activities.

In these cases, it may simply be helpful to communicate the "added-value" benefits of the PHE partnership to your respective funders so that they can see how the PHE partnership is contributing to the achievement of the objectives in which they're interested. For example, environmental funders may be pleased to hear that working with a health partner is allowing you to increase access to voluntary family planning services, thereby enabling women to engage more in natural resource management initiatives and enabling couples to attain their desired family sizes, thus bolstering local natural resource management efforts. Meanwhile, health funders may be pleased to hear that working with an environmental partner is allowing you to reach under-served communities and engage men in discussions about family health, thereby increasing your reach and building support for uptake of your services.

Madagascar Fauna & Flora Group (MFG) partners with Marie Stopes Madagascar (MSM) without dedicated funds:

MFG has been collaborating with MSM since 2015 in order to increase access to family planning services for isolated communities around the Betampona Natural Reserve in east Madagascar. MSM's mobile outreach team now visit every few months to offer long-acting reversible contraceptives while MFG's environmental outreach staff incorporate basic health information and messages into their community work. MSM already had funding secured for its mobile outreach team to operate in this region (although they weren't previously reaching these particular communities) and MFG already had funding secured for its community conservation activities around the Betampona Natural Reserve so this complementary PHE partnership was rapidly established simply by coordinating and integrating their already funded activities.

Photo credit: MFG

If dedicated funds are needed to operationalise a PHE partnership, how can these be secured?

There are two main approaches to securing grant funding for a PHE partnership: fundraising for single-sector activities to be implemented together as an integrated initiative (i.e. combining single-sector grants from single-sector funders), or fundraising for an integrated cross-sector initiative from the outset (i.e. seeking a cross-sector grant from a cross-sector funders). Some of the advantages and disadvantages to these different approaches are detailed below:

Approach	Advantages / strengths	Disadvantages / challenges
Combining single-sector grants	▪ Often easier to find funders wanting to support single-sector work than cross-sector work ▪ Single-sector grants allow partners more autonomy in managing their respective funds / reduce the need for a shared accounting system ▪ Single-sector grant applications can be strengthened by explaining how the PHE partnership (/ linked activities funded separately) will contribute to the achievement of the objectives in which the funder is interested ▪ Single-sector grant applications can leverage funds already secured for complementary single-sector activities (i.e. cost-sharing)	▪ Can be difficult to align grant start / end dates ▪ Can be difficult to account for shared expenditure (e.g. splitting receipts across grants for shared transport or equipment if necessary)
Seeking a cross-sector grant	▪ Shared work plan and budget enable streamlined programme and financial management ▪ May encourage closer / stronger coordination of PHE components	▪ Often difficult to find funders willing to fund cross-sector work ▪ May need to set up a shared accounting system or sub-granting arrangement

Some top tips for PHE grant proposals

- Try to find funders willing to support cross-sector work (although it's often more feasible to expect to have to combine single-sector grants)[1]
- Research the funder's thematic priorities
- Frame your integrated PHE initiative as a solution that addresses key concerns held by the funder - for example, you could emphasise the programme's health or environmental goals more strongly if the funder is particularly interested in one or the other sector, without changing the overall focus of your integrated PHE initiative
  - For example, if approaching a health funder you could say that this cross-sector initiative aims to improve community health outcomes by increasing access to family planning and health services, as well as advancing nutrition and food security through support for livelihood diversification and sustainable natural resource management.
  - For example, for the same initiative approaching an environmental funder you could say that this cross-sector initiative aims to conserve priority ecosystems by supporting community-based natural resource management efforts, with complementary support for livelihood diversification and access to family planning services (as lack of alternative livelihood options and unmet family planning needs threaten to restrict and undermine the viability of community-based natural resource management efforts).


Photo credit: Garth Cripps

1 Funders that have / are currently supporting PHE partnerships and programmes include: USAID, The David and Lucile Packard Foundation, The William and Flora Hewlett Foundation, The John D. and Catherine T. MacArthur Foundation, The Leona M. and Harry B. Helmsley Charitable Trust, The Segal Family Foundation, Comic Relief, Amplify Change, UNFPA.

- Present evidence of PHE issues in the target intervention zone - unmet family planning needs, other health indicators, measures of environmental degradation, etc. - and relevant insights from your community consultation
- Clearly describe your PHE approach / components and how each of these activities is vital for achieving the objectives in which the funder is interested[2]
- Present evidence of the effectiveness of PHE programmes - for example, reference studies (such as IPOPCORM detailed in chapter 1 - Evidence suggests that PHE is more cost-effective than single-sector approaches) demonstrating that PHE programmes generate better outcomes than single-sector interventions
- Make sure that your commitment to reproductive rights is stated clearly

2 *For example, addressing unmet family planning needs should increase women's engagement in natural resource management and boost the sustainability of local conservation efforts, while support for community-based natural resource management should increase livelihood sustainability and improve food security thereby impacting positively on nutrition and community health outcomes.*

7. Managing PHE partnerships and cross-training staff

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know some different ways of structuring and managing teams for PHE implementation ▪ Know how to coordinate activities and budgets across workstreams ▪ Know how to balance the need for high levels of collaboration with staff autonomy ▪ Understand why it's important to cross-train staff ▪ Know how to facilitate the exchange of technical knowledge among staff	▪ Managers of environmental organisations ▪ Managers of health organisations

What are some different ways of structuring and managing teams for PHE implementation?

There are various ways of structuring and managing teams for PHE implementation, with the following three possible team structures corresponding to the three institutional arrangements outlined in chapter 1 (How can PHE initiatives be implemented?):

Institutional arrangement	Partnership between environmental and health organisations	Sector-specific teams working within the same organisation	Interdisciplinary team working within the same organisation
Possible team structure	2 key contacts (*typically head office-based partnerships coordinators or regional managers - responsible for ensuring the full contribution of their respective staff to the PHE partnership*)	1 site manager (*responsible for overseeing site logistics and ensuring adequate coordination among sector-specific teams*)	1 site / integrated programme manager
	2 programme managers (*these may be the same people as the key contacts*)	2 (or more) programme managers (*one of these may be the same person as the site manager*)	
	Community-based staff with sector-specific responsibilities	Community-based staff with sector-specific responsibilities	Community-based staff with cross-sector responsibilities

In deciding how to structure and manage teams for PHE implementation, you'll of course need to take into account how your organisation already organises its teams and lines of responsibilities but also bear in mind that PHE implementation may require more collaborative or integrated set-ups as outlined above.

In the case of a partnership between an environmental organisation and a health organisation, the above structure is simply one possible example and each organisation may structure their teams differently.

When partners are committed to a long-term collaboration and deeper integration of activities, it may be desirable to jointly recruit a dedicated manager responsible for ensuring close coordination among partners; where this person is located and how they are managed should be determined collectively by all partners.

The Wildlife Conservation Society (WCS) partners with Marie Stopes Madagascar (MSM):

WCS is collaborating with MSM in the MaMaBaie (Makira, Masoala and Baie d'Antongil) terrestrial and marine conservation area in northeast Madagascar to implement PHE activities. These include having MSM's mobile outreach team offer long-acting reversible contraceptives to isolated communities in the area, and training community health agents to facilitate discussions about the links between family planning and natural resource management.

Key contacts based in the capital city of Antananarivo *- responsible for initiating and outlining the terms of the partnership, connecting their respective programme managers and sharing service delivery data as appropriate*

Managers based in the regional towns of Tamatave / Maroantsetra *- responsible for coordinating the practical details of the collaboration and ensuring that community-based staff understand the purpose of the PHE partnership*

Community-based staff with sector-specific responsibilities *- responsible for delivering their services or implementing their activities as part of the PHE partnership*

Blue Ventures develops a more integrated team structure for its PHE initiative in Belo sur Mer

Blue Ventures is implementing a small PHE initiative in Belo sur Mer and surrounding villages on the west coast of Madagascar. The institutional arrangement here is sector-specific teams working within the same organisation (we also partner with health organisations including JSI Mahefa Miaraka and MSM but we're leaving these out for the purposes of this example).

Site manager *- responsible for overseeing site logistics, coordinating community outreach activities and budgets, facilitating cross-training among staff, ensuring achievement of grant objectives, liaising with partners, etc.*

Programme managers *- one manager is responsible for the development and implementation of conservation initiatives including mangrove fisheries management and aquaculture, and the other manager is responsible for the development and implementation of community health initiatives including family planning, child health and WASH promotion*

Community-based staff with sector-specific responsibilities *- one staff member is responsible for fisheries management outreach, one staff member is responsible for aquaculture support, and one staff member is responsible for community health outreach and support - although all are cross-trained in order to be able to work across sectors*

Previously we didn't have a dedicated site manager in Belo sur Mer, so we relied on two programme managers working closely together to harmonise their activities and budgets. As our PHE initiative developed, we decided that having a dedicated site manager would facilitate greater integration and smoother coordination. Based on our positive experience of this team structure to date, we would recommend it for relatively small sites where tight integration is desired and where it's reasonable to expect a single site manager to be able to oversee everything.

How to coordinate activities and budgets across workstreams?

In order to manage your PHE partnership effectively, you'll need to create simple systems for joint planning and information sharing among organisations. Here are some top tips:

- Create regular opportunities for teams to plan activities such as integrated community outreach (linking health and environmental topics) together - these could be monthly or quarterly planning workshops depending on the level and frequency of your collaboration
- It may be desirable to produce joint work plans taking into account any grant objectives that need to be achieved within certain timeframes
- Weekly coordination meetings at the community level can be very helpful for maximising communications among teams (both about their respective activities and any issues raised by community members) and identifying opportunities for pooling transport e.g. 4x4 vehicles or boats for community outreach missions
- Depending on the nature of your partnership, it may be appropriate to have a single combined budget that everyone can work from with different lines funded by different funders or shared among several funders

How to balance the need for high levels of collaboration with staff autonomy?

It's good to have programme managers and community-based staff clearly responsible for the delivery and quality of certain activities within integrated PHE initiatives, and for this a certain degree of autonomy is required. However, it's equally if not more important that programme managers and community-based staff work closely together to coordinate their work.

Key to achieving this balance is building trust and understanding among teams (e.g. through trust-building exercises, reflecting on the complementary strengths of different staff, cross-training sessions and frequent communications), nurturing an organisational culture that values cooperation, having systems in place that facilitate regular open communications, and ensuring that all staff can see how their work feeds into the broader PHE initiative (see chapter 8 - How to develop a programme theory?).

Collaborating proactively with colleagues and partners should be written into the performance plans of all staff, so that they can be held accountable for working in this way in addition to delivering the activities for which they're directly responsible.

Ultimate team member exercise

Participants are arranged into groups of 4-8 people and instructed to share individual strengths and positive attributes which they feel that they could contribute to the success of their group.

Each participant writes down their individual strengths and positive attributes on a piece of paper, then each group is instructed to create their "ultimate team member" by combining each individual's strengths and positive attributes into one imaginary person.


Photo credit: Jean-Philippe Palasi

This "ultimate team member" should be given a name, have a picture drawn of them on a large sheet of paper and have their different attributes labelled. The group should also write a story about this "ultimate team member", highlighting all of the things their imaginary person can do with all of their amazing characteristics.

At the end of the exercise, each group should share their "ultimate team member" with the wider group and read the accompanying story. This exercise can help co-workers to understand that they're capable of having more strengths and positive attributes as a group than they would have working solo.

Why cross-train staff?

Staff working in different sectors with different backgrounds can have different worldviews, terminologies and ways of approaching problems. There may also be a significant differences between organisational cultures across sectors. Cross-training staff so that they can understand and support each other's work is probably the most crucial factor in determining the effectiveness of cross-sector PHE partnerships.

Environmental staff must understand the health component of the PHE initiative, and health staff must understand the environment component of the PHE initiative. Much learning and communication may occur informally between teams, but it's important to develop the institutional infrastructure to ensure that this happens.

How to facilitate the exchange of technical knowledge among staff?

Here are some top tips for facilitating the exchange of technical knowledge among staff:

- Cross-training workshops covering the issues being addressed by the PHE partnership. These might include the basic principles of community-based natural resource management, reproductive rights, benefits of family planning, different contraceptive options, health-promoting behaviours, PHE linkages, etc. so that all staff are able to assist with integrated community outreach and/or even if staff are not charged with implementing different sector-specific activities, they at least understand the approach that's being taken in that sector and why. These workshops could be facilitated by managers with the contribution of relevant community-based staff. They should ideally be organised at the beginning of a partnership followed by refresher sessions at regular intervals. See Annex IV for a cross-training workshop outline.
- Community consultations facilitated jointly by environmental and health staff to learn directly from communities how the health and environmental challenges they face are interconnected.
- PHE briefing materials should be readily available for new and existing staff. A thorough introduction to key environmental and health topics (as detailed in chapters 10, 11, 12 & 13 of this guide) should be provided by relevant managers to new staff as part of their orientation - this could include one-to-one talks and discussions to ensure full understanding.

Blue Ventures' staff facilitate cross-training workshops:

Blue Ventures' staff include public health professionals, fisheries specialists, aquaculture technicians and community organisers. Bringing together such diverse talents and skills to enable interdisciplinary work isn't always straightforward; Blue Ventures has come to value inter-staff training as a great way of exchanging knowledge across sectors and making sure that all team members are able to support each other's work effectively. This means that when a fisheries specialist is holding a village meeting they can also be facilitating discussions around reproductive rights, or when a community health agent is assisting with a women's group they can also be talking about marine resource management.

Blue Ventures' community health staff have organised workshops to train their environmental colleagues in the fundamentals of their Safidy community health programme (Safidy means "the freedom to choose" in Malagasy; reflecting the organisation's long-standing commitment to reproductive rights), so that these environmental outreach workers can contribute to community health promotion efforts. In turn these environmental outreach workers have trained community health agents in the basics of marine resource management and health-environment linkages specific to their contexts, so that they can support increased women's engagement in management initiatives within their villages. These sessions have included PHE storytelling sequences, where community health agents are encouraged to narrate a story about a fictitious local family then identify overlaps between health and environmental issues within the story. This has led the community health agents to develop practical strategies for addressing such interconnected challenges in their villages, based on their own visions for healthy communities and ecosystems.

- Developing an adequate understanding of PHE and basic knowledge of different sectors should be written into the professional development plans of all staff with details of the support or resources needed to achieve this - this could include participation in cross-training workshops, shadowing colleagues working in different sectors, and time to do more background reading or opportunities to ask relevant colleagues specific questions.

8. Monitoring, evaluation and learning

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know what a programme theory is and why it's important ▪ Know how to develop a programme theory for your PHE partnership ▪ Understand the difference between monitoring and evaluation ▪ Know some top tips for fostering organisational learning ▪ Know how to develop a monitoring plan for your PHE partnership and select a few indicators based on your programme theory ▪ Know how to monitor contraception use, calculate a standardised measure for contraception use (couple years of protection) and estimate number of unintended pregnancies averted ▪ Understand why it's important **not** to set targets for contraception use or fertility changes ▪ Have some examples of family planning, health, environmental and cross-cutting indicators that you could use ▪ Know the basics of how to conduct a social survey and be aware of some important considerations to take into account first ▪ Know the basics of how to collect qualitative data including most significant change stories ▪ Know the basics of how to plan an evaluation	▪ Managers and M&E staff of environmental organisations ▪ Managers and M&E staff of health organisations

What is a programme theory?

A programme theory is a theory of how a programme is believed to work. It can be represented by a diagram illustrating how various programme activities are believed to lead to the achievement of one or more programme goal(s). It may also be known as a theory of change, a conceptual model, a conceptual framework or a results chain!

A programme theory is made up of a series of linked "if… then…" hypotheses. It fills in what can be described as the "missing middle" between what a programme does and the outcomes it produces.

A PHE programme theory often encompasses the achievement of improved ecosystem and human health resulting from anticipated changes in the knowledge, attitudes and practices of programme participants following the input of new information (through training or discussion), resources and services.

Why develop a programme theory?

Some PHE partnerships may arise quite spontaneously and informally when environmental and health organisations working in the same geographical area spot opportunities for collaboration. Soon though the need for monitoring, evaluation and learning (MEL) is likely to become clear: most organisations (and their funders) will want to measure the outcomes of their PHE partnership and understand the processes through which these outcomes are being generated.

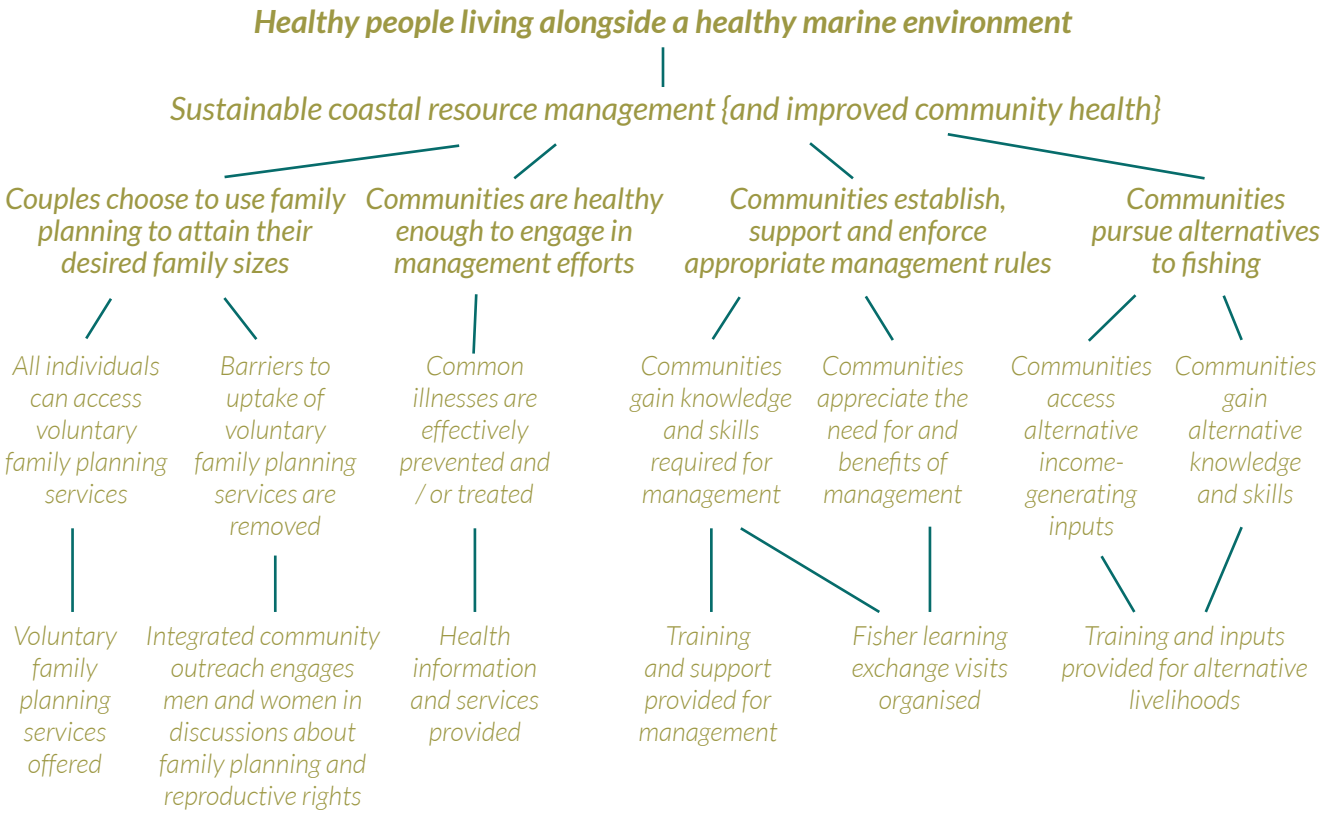
In order to decide which outcomes to measure (and how), you first need to outline the changes that you believe your PHE partnership is generating. For this, a programme theory is required. In addition to providing the foundation for the development of your monitoring plan (allowing you to identify a few key outcomes to monitor), a programme theory can also be very helpful for building a clear and shared

understanding among all staff of how their activities feed into the achievement of the overall PHE partnership goal(s).

How to develop a programme theory?

- Start by agreeing on the overall **goal** of your PHE partnership with your partner - e.g. healthy people living alongside a healthy ecosystem - identified through community consultations (see chapter 4) and outlined in your PHE partnership agreement (see chapter 5).
- Work back from this goal to identify all of the **conditions** that must be in place in order for it to be achieved - e.g. changes in existing knowledge, attitudes and practices.
- Work back from these conditions to identify all of the **programme activities** that must be in place in order for them to be achieved - e.g. input of new information (through training or discussion), resources and services.
- Check that your assumptions are valid and make any adjustments as necessary - e.g. "*if* full access to family planning services is ensured *then* family planning needs are met" may not be valid because there may be other causes of unmet family planning needs (such as lack of support from partners) in addition to inadequate access to services.

Map all of these out in a diagram, remembering that the basic format of any theory of change can be expressed as: *if* [this condition is met] *then* [this change occurs], *if* [this condition is met] *then* [this change occurs], *if* [this condition is met] *then* [this change occurs], etc. The number of linked "if... then..." hypotheses may vary depending on the nature of your PHE partnership and the degree of specificity that you use to outline your programme theory.



A highly simplified (and therefore limited) example of a PHE programme theory

Would you like more support with this process? Blue Ventures can facilitate bespoke monitoring planning workshops and provide tailored advice with regards to the development of your PHE programme theory. To find out more please contact pheinfo@blueventures.org.

Another way of producing a programme theory is to create a problem tree mapping out the root causes of the challenge that you're trying to address, then turn these negative statements into positive statements to produce a solution tree which is essentially a programme theory.

What is the difference between monitoring and evaluation?

Monitoring is the routine collection and analysis of data throughout the life of a programme, with a focus on tracking outputs (or activities) and outcomes (or changes) in order to determine if the programme is set to achieve its goals. Such data should be reviewed at different stages during the programme timeframe to ensure that learning is ongoing and implementation strategies are adapted as necessary. Monitoring data are often also used for evaluation.

Evaluation probes deeper to assess the results and effectiveness of a programme, possibly including some reflection on performance against expectations or goals, how the programme worked (the processes through which it generated changes), what went well and what could have been done differently. Evaluation should take place at appropriate intervals for the outcomes being evaluated, although often generally takes place at the "end" of a programme or funding cycle, or sometimes at a midway point.

Looking out for unintended consequences!

It's a good idea to use your PHE programme theory to inform and guide your monitoring efforts so that you can monitor those results that you hope to achieve (and avoid the burden of collecting additional unnecessary data), however, it's also very important to look out for unintended consequences or unexpected outcomes of your PHE initiative. Collection of most significant change stories (as detailed below) and/or open discussions in focus groups with community members can be an effective way of identifying any results that may have been overlooked by your PHE programme theory, and then you can decide whether it would be appropriate to incorporate these into your more formal monitoring efforts.

What about learning?

It's generally assumed that monitoring and evaluation (M&E) is how the majority of learning in an organisation takes place, but often M&E ends up focusing on results and accountability to funders. If M&E is separated from active learning, then it risks becoming a judgmental exercise.

PHE partnerships are highly complex and context-specific initiatives, and the processes through which they generate changes are not yet fully understood and may vary across different contexts. This is why it's very important to think about monitoring, evaluation *and learning* (MEL) and to create space for active learning by all programme staff, so that the PHE partnership can be managed adaptively in line with their growing understanding of what works and how in your particular context.

Top tips for fostering organisational learning

- Nurture an organisational culture that is supportive of learning - i.e. one that encourages, enables, values, rewards and uses the learning of its members both individually and collectively
- Map out the internal creation and flows of knowledge within your organisation currently - highlight rich sources and under-tapped processes of learning in order to identify possible mechanisms for ensuring that your organisation can benefit more from its own experiences
- Build learning into job descriptions - make it as an integral and legitimate part of each staff member's work responsibilities
- Strengthen interpersonal relationships and build trust so that staff don't fear negative repercussions of discussing challenges openly
- Encourage staff to approach their work with a spirit of curiosity, ask questions and listen to each other, and constructively challenge each other's assumptions - and model this behaviour yourself (e.g. request feedback from colleagues about your approaches or assumptions)

- Prioritise time for individual and collective reflection - e.g. keeping learning journals, post-mission team debriefs, reflection periods or retreats, etc.
- Welcome difficulties or apparent "failures" as opportunities for collective learning
- Surface issues and deal with them without blame
- Provide informal physical spaces where staff can meet and exchange ideas
- Include a lessons learned section in all internal documents e.g. mission reports
- Share and celebrate effective approaches
- Make sure that learning is shared among all partners e.g. through regular review meetings
- Set up action learning sets - groups of peers who meet regularly to work through challenges by reflecting on their actions and using this learning to brainstorm and plan more appropriate ways forward

Who is monitoring and evaluation for?

M&E is generally designed to meet the different needs of (and ensure accountability to) various stakeholders including community members, implementing organisations, their funders and policy makers. For example, implementing organisations might want to know how their programme is working so that they can improve its design and implementation (adaptive management), while funders might want to know if their grant is achieving its goals so that they can decide whether to keep supporting the programme. It's important to bear this in mind when developing a monitoring plan, so that the needs of all stakeholders are adequately met.

How to develop a monitoring plan?

Once you've outlined your programme theory, you can develop a monitoring plan for your PHE partnership. Start by identifying a few outputs and outcomes from your programme theory that you'd like to monitor (for yourself and/or your stakeholders including community members), and think about what kind of indicators you could use for these and what kind of data you need to collect (and if this is feasible with the resources you have). Also think about how you will use and disseminate these data: who needs what information when?

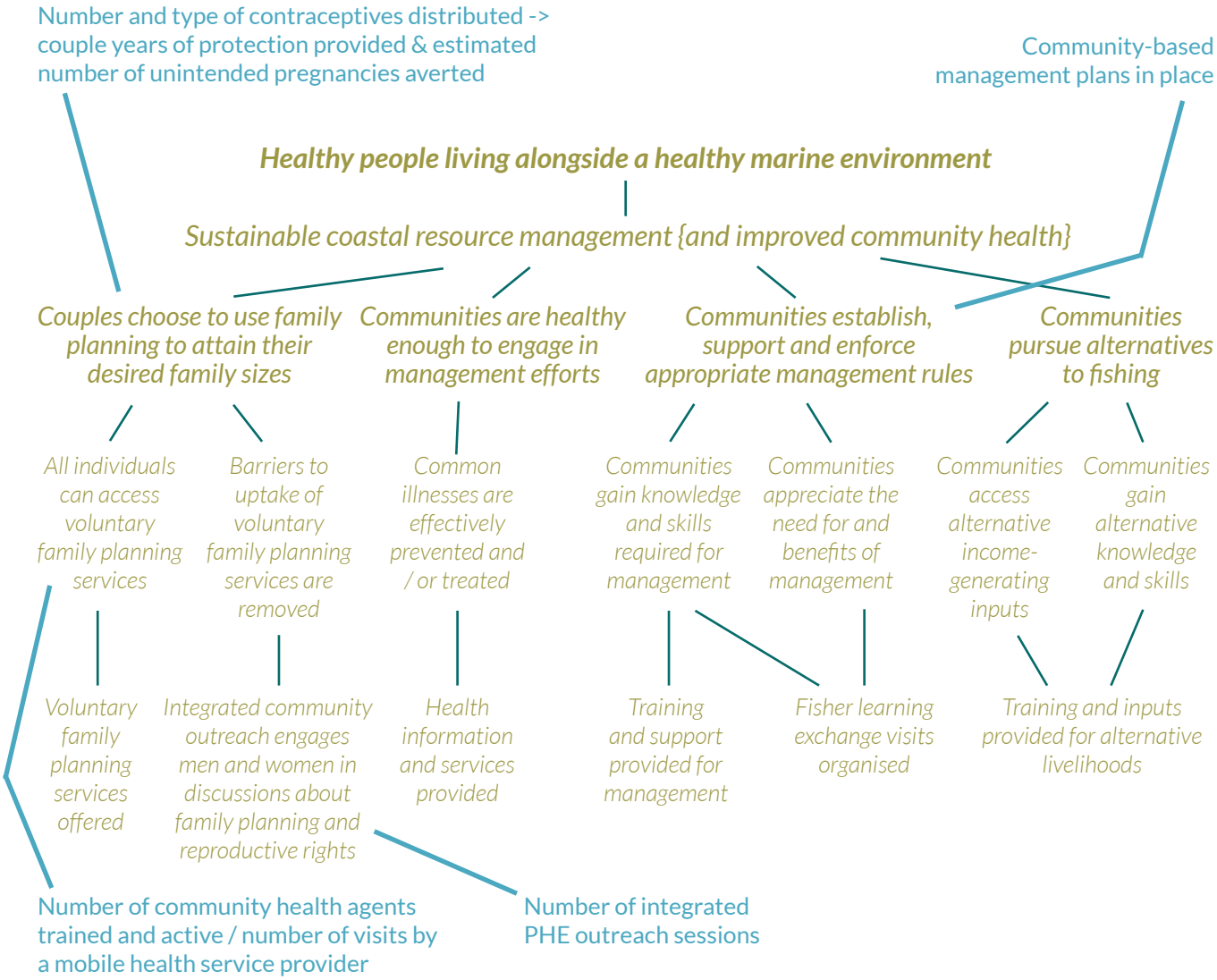
If your organisation already has a monitoring plan for its existing environmental or health activities, then you may simply need to consider whether it would be appropriate to add any indicators relating to the new health or environmental components that you're integrating through your PHE partnership (and any associated hypothesised "added-value" gender equality, food security or livelihood outcomes).

You could use the following template to develop a monitoring plan:

Anticipated output / outcome	Indicator	Data source (e.g. service delivery records, activity records, etc)	Who to collect? (which partner?)	When to collect? (e.g. annually, quarterly, monthly, etc)	How to analyse?	Resources needed to collect and analyse?	Of interest to which stakeholders?

Selecting indicators based on your programme theory

The following sections of this chapter present some indicators that you may like to consider using to monitor key anticipated outputs and outcomes of your PHE partnership. Because PHE initiatives are so multifaceted, there are lots of possible indicators to choose from and it can get quite overwhelming if you think that you have to monitor everything! This is why it can be helpful to focus closely on your own PHE programme theory and consider who needs to know what. Generally you won't monitor everything in your PHE programme theory, but rather **select a few key anticipated outputs and outcomes that are of greatest interest to you and your stakeholders** and that are feasible to measure (for example, just using service delivery records and activity records).



Possible indicators for a highly simplified (and therefore limited) example of a PHE programme theory

Would you like more support with this process? Blue Ventures can facilitate bespoke monitoring planning workshops and provide tailored advice with regards to the selection of your indicators. To find out more please contact pheinfo@blueventures.org.

A fairly standard set of indicators can be used to measure family planning and health outcomes, but environmental outcomes vary depending on the site (e.g. marine vs. terrestrial) and tend to take longer to occur. It can be challenging to identify appropriate environmental outcomes that can be measured in short time periods (1-2 years), so often environmental indicators focus on outputs.

Top tips for developing a monitoring plan

- Collaborate with your partner(s) to select a suitable set of indicators based on your programme theory, funder requirements and resource availability - **note that it may be most feasible to use service delivery records and activity records as data sources rather than conducting social surveys**
- Clarify expectations and develop consensus on data collection timelines and data quality standards with your partner(s)
- Integrated social surveys can allow analysis of possible associations between health and environmental knowledge, attitudes and practices while sharing of costs among partners - but don't underestimate the time, resources and expertise needed to conduct these properly!
- Think of monitoring as an iterative process so your plan may need to be revised periodically as your PHE programme theory evolves

Monitoring contraception use

Anticipated output / outcome	Indicator	Data source	Who to collect?	When to collect?	How to analyse?	Resources needed to collect and analyse	Of interest to which stakeholders?
Increased contraception use	Number of couple years of protection (CYPs) provided	Service delivery records: number and type of contraceptives distributed	Health partner (from community health agents / mobile outreach teams)	Monthly	Calculate CYPs using USAID-approved conversion factors	Reporting forms, etc	Community health agents, natural resource management committees, implementing organisations, funders, national PHE network, policy makers

One important thing to track within your PHE partnership is the **number and type of contraceptives distributed** as this will allow you to calculate two key indicators: number of couple years of protection provided - which is a key family planning output - and estimated number of unintended pregnancies averted (see below) - which is a key family planning outcome.

1 couple year of protection (CYP) is 1 year of protection from unintended pregnancy for 1 couple.

It's very easy to calculate CYPs from the number and type of contraceptives distributed using the following formulae:

15 pill packs = 1 CYP (divide the number of pill packs distributed by 15 to get CYPs)

4 injections = 1 CYP (divide the number of injections given by 4 to get CYPs)

1 implant = 2.5 CYPs (multiply the number of implants inserted by 2.5 to get CYPs)

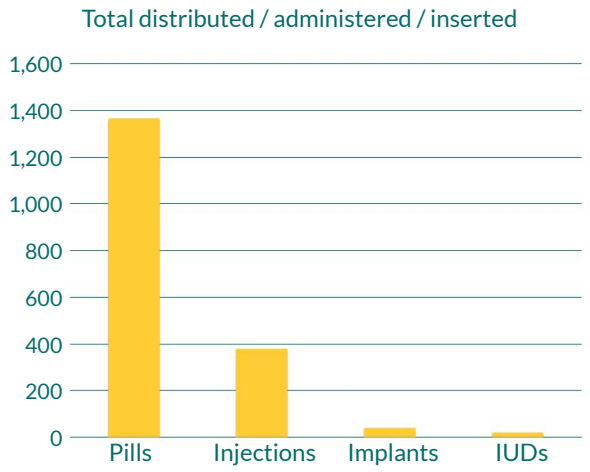
1 intra-uterine device (IUD) = 4.6 CYPs (multiply the number of IUDs inserted by 4.6 to get CYPs)

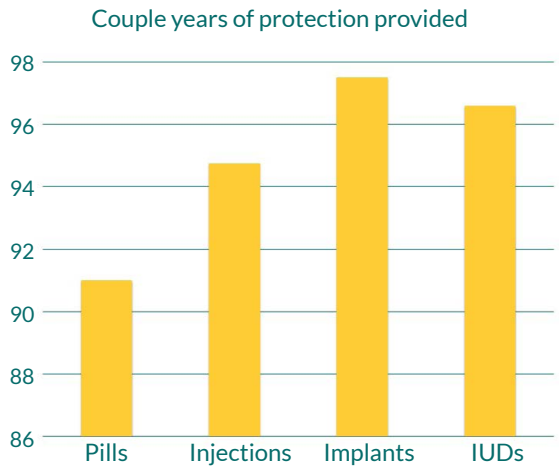
These USAID-approved CYP conversion factors take into account that some methods like pills may be used incorrectly and/or discarded, while implants and IUDs may be removed before their lifespan is realised.

Why calculate CYPs?

Different contraception methods provide different durations of protection: a pill pack provides 1 month (4 weeks) of protection, an injection provides 3 months (12 weeks) of protection, an implant can provide up to 3 years of protection (or be removed earlier if the woman so chooses), and an intra-uterine device can provide up to 10 years of protection (or be removed earlier if the woman so chooses). If you distribute 10 pills packs or fit 10 intra-uterine devices, you've actually delivered very different amounts of protection: you can't meaningfully compare distributing 10 pill packs to fitting 10 intra-uterine devices because they provide such different durations of protection. This is why calculating CYPs is so important. CYP conversion factors account for the different durations of protection provided by different contraception methods, and thereby allow you to compare like with like.

	Pills	Injections	Implants	IUDs
Total distributed / administered / inserted	1,365	379	39	21
Couple years of protection provided	91	95	98	97





Expressing the services you've delivered in terms of CYPs is a much more meaningful way of communicating the amount of contraceptive protection you've provided. After applying the relevant CYP conversion factors, you can compare the amount of contraceptive protection that you've provided across different methods. You can also communicate the total amount of contraceptive protection that you've provided - it's best to do this with reference to the total population served. For example: "More than 1,000 couple years of protection were provided in 2016 among a population of 10,000 people." (This is more impressive than if the population served was 100,000 people, for example.) Good census data are therefore vital for putting CYPs into context!


Photo credit: Garth Cripps

Monitoring unintended pregnancies averted

Anticipated output / outcome	Indicator	Data source	Who to collect?	When to collect?	How to analyse?	Resources needed to collect and analyse	Of interest to which stakeholders?
Increased spacing and/ or limiting of births	Estimated number of unintended pregnancies averted	Service delivery records: number and type of contraceptives distributed	Health partner (from community health agents / mobile outreach teams)	Monthly	Calculate using Marie Stopes International's Impact 2 Tool	Reporting forms, etc	Community health agents, natural resource management committees, implementing organisations, funders, national PHE network, policy makers

Another useful calculation that you can do with the number and type of contraceptives distributed is to estimate the number of unintended pregnancies averted by these contraceptives using Marie Stopes International's Impact 2 Tool, which is freely available to download at https://mariestopes.org/impact-2. You input the number and type of contraceptives distributed, and it calculates a variety of estimated impacts including the estimated number of unintended pregnancies averted. It's best to communicate this with reference to the total population served. For example: "More than 500 unintended pregnancies are estimated to have been averted in 2016 among a population of 20,000 people." (This is more impressive than if the population served was 200,000 people, for example.) Good census data are therefore vital for putting the estimated number of unintended pregnancies averted into context!

Detailed instructions for using MSI's Impact 2 Tool:

- Open the Excel file (it may take a moment to load), and click "enable macros"
- Click "next", and agree to terms & conditions (click "yes")
- Click on "organisation(s)" to select this mode
- Select your country from the drop-down list, select "service provision to impacts (past/future)", enter the years for which you have data, and click "next"
- Enter the number of contraceptives distributed in the years and methods for which you have data, and click "next"
- Leave the client profile data blank if you don't have this information, and click "next"
- Select "create report" (in the lower right corner of the dialogue box), and click "create report" again when prompted
- Wait for it to generate the report (this may take several minutes)
- You will now see a variety of estimated impacts including the estimated number of unintended pregnancies averted in the years for which you have data, with guidance about how to write about different impacts and what they mean / how they are estimated

Should we / can we set targets for contraception use or changes in fertility?

No!

PHE initiatives aim to uphold the reproductive rights of all individuals to choose freely the number and spacing of their births without coercion or discrimination. PHE initiatives can aim to reduce unmet family planning needs (women wanting to space or limit their births but not using contraception) by ensuring full access to voluntary family planning services and removing any barriers to uptake (for example, lack

of information about different options). However, no one involved in providing family planning services should set targets for contraception use or changes in fertility because these depend entirely upon the choices made freely by individuals in line with their reproductive rights. This is outlined in US law (Tiahrt Clause) and USAID policy.

While it's important to monitor (and report on) the number of CYPs provided and estimated number of unintended pregnancies averted, it's not appropriate to set targets for these numbers. If you wish to set explicit targets relating to your family planning work, you could aim to increase access to services and/or to reduce unmet family planning needs (as detailed immediately below).

Family planning / demographic indicators

A few examples (in addition to CYPs and estimated number of unintended pregnancies averted - as detailed above):

Anticipated output / outcome	Indicator(s)	Data source
Increased access to family planning information and services	Number of programme staff trained to provide information Number of community health agents trained and active Number of visits by a mobile outreach team Number of active service delivery points	Training and service delivery records
Increased knowledge of family planning options	Proportion of people who know at least X number of contraception methods	Individual surveys - see Annex II
Reduced unmet family planning needs	**Unmet family planning needs:** proportion of sexually active women of reproductive age (15-49 years) who report wanting to space or limit their births but are not currently using contraception plus those who are currently pregnant but wanted to wait or not get pregnant	Individual surveys - see Annex II *(multiple questions required)*
Increased contraception use	**Contraceptive prevalence rate:** proportion of women of reproductive age (15-49 years) who are currently using modern contraception (often only reported for those sexually active or in union)	Service delivery data + census data / individual surveys - see Annex II
Increased spacing and/or limiting of births	**General fertility rate:** number of live births per 1,000 women of reproductive age (15-49 years) in the last 12 months	Census data / household surveys - see Annex II

Health indicators

A few examples (in line with some of the health-promoting behaviours detailed in chapter 13):

Anticipated output / outcome	Indicator	Data source
Increased condom use	Proportion of people who report using a condom the last time they had sexual intercourse	Individual surveys - see Annex II
Increased use of mosquito nets	Proportion of households who report use of mosquito net(s) last night *(with visual check)*	Household surveys / observation - see Annex II
Increased use of water purifying solution	Proportion of households who report use of water purifying solution	Household surveys - see Annex II
Increased practice of handwashing with soap or ash	Proportion of households who report handwashing with soap or ash *(with visual check)*	Household surveys / observation - see Annex II
Increased practice of exclusive breastfeeding for six months	Proportion of mothers with a child <1 year who report having breastfed / planning to breastfeed for six months with no other liquids or solids given during this time	Individual surveys - see Annex II
Increased formal care-seeking for treatment of common childhood illnesses	Proportion of mothers with a child <5 years who report seeking formal care for treatment of diarrhoea, malaria and respiratory infections	Individual surveys - see Annex II

Environmental indicators

A few examples:

Anticipated output / outcome	Indicator	Data source
Increased community-based natural resource management (NRM)	Proportion of communities with an NRM plan / committee in place	NRM plan / committee documents
Increased participation of women and youth in NRM decision-making	Proportion of women and youth attending and speaking at NRM meetings	NRM meeting registers and records
Increased enforcement of local NRM rules	Proportion of infraction sanctions applied	NRM committee records
Increased local fisheries management efforts	Number of fishery closures held	Activity records
Increased local forest management efforts	Number of fast-growing trees planted (fuelwood alternatives)	Activity records

Cross-cutting indicators

A few examples:

Anticipated output / outcome	Indicator(s)	Data source
Increased community discussions of the links between health and environmental issues	Number of integrated PHE outreach sessions Number of occasions of health and environmental organisations addressing non-traditional groups	Activity records
Increased livelihood diversity	Average number of household income-generating / food production activities	Household surveys - see Annex II
Increased participation of women in livelihood activities	Average proportion of household income-generating / food production activities undertaken by women	Household surveys - see Annex II
Increased household dietary diversity	Average household dietary diversity score	Household surveys - see Annex II *(composite measure based on multiple questions)*
Reduced household food insecurity	Average household food insecurity access scale score	Household surveys - see Annex II *(composite measure based on multiple questions)*

Is there a single indicator that can be used to capture the "added-value" of integrated PHE initiatives for people, their health and the environment?

Unfortunately no!

PHE implementers and their funders have been searching for such an indicator for many years but with no success. The difficulty is that the supposed "added-value" of a holistic PHE approach resides in the ***interactions*** between different PHE outcomes (or indicators).

Different components of integrated PHE initiatives are believed to work together synergistically to unlock a series of positive chain reactions and feedback loops. For example, increased access to and use of contraception may be hypothesised to support increased household food security, increased household livelihood diversity and increased engagement of women in natural resource management decision-making. However, the possible connections and pathways between these different outcomes are poorly theorised and only weakly supported by anecdotal evidence.

A number of PHE implementers including Blue Ventures are therefore currently trying to develop and apply more joined-up approaches to PHE data collection, with the aim of exploring possible interactions between observed PHE outcomes (please contact pheinfo@blueventures.org to find out more). In the meantime, many organisations are using qualitative data (such as most significant change stories) alongside key quantitative data (such as the estimated number of unintended pregnancies averted) to communicate the results of their integrated PHE initiatives to their funders.

When is it appropriate to conduct a social survey?

Conducting a social survey may appear to be relatively straightforward but don't underestimate the time, resources and expertise needed to design and implement one properly!

Some data that you may wish to collect through a social survey can be collected in other ways, such as through service delivery records and activity records, in which case it's certainly worth pursuing these options first. If the data that you wish to collect is absolutely vital for understanding the outcomes or functioning of your programme, required by your stakeholders and can only be collected through a social survey, then you'll need to take various important considerations (detailed immediately below) into account when designing and implementing such a social survey.

Important considerations for conducting a social survey

If you want the results from your survey to represent the whole population in the area where you work, it's important to sample randomly across that population or else understand fully the sampling frame that you're using, the limitations of it, and why and how to apply weights to your survey data. Census data can help you to choose the size of your survey sample and select a sample that is representative of your total population (e.g. that has the appropriate proportions of men and women in it). Census data can also help you to adjust or weight your results after the survey if you find that - despite your best efforts - you did not end up with a representative sample (e.g. it's quite common in household surveys to find the final sample biased towards female and elderly respondents as these demographic groups may be more commonly at home and available to answer questions).

Another important element of survey design that's often overlooked is the questions. Common challenges that should be taken into account when designing questions include: social desirability bias (a tendency to give a certain answer because it's what is "expected" or socially desirable); agreement bias (a tendency to agree with opinion statements); questions that are filtered according to previous responses (in-depth surveyor training and/or the use of electronic data collection methods can help to ensure the correct flow of the survey); questions that are embarrassing, intrusive or rude in the local context (these can be identified and adapted through reviews with community-based programme staff and piloting / testing with community members); and questions that require respondents to incriminate themselves or jeopardise their livelihoods (these should be avoided or else can be mitigated somewhat by assurances of confidentiality). Ethical approval should be sought for all questions, and the overall survey design.

Surveyors should be trained in confidentiality, informed consent and also in the specific sampling frame and survey questions that you've chosen; such training and follow up supervision is vital because even if the sampling frame and survey questions are well designed, if poorly implemented then the data collected are unlikely to be meaningful.

Another very important point to consider is survey fatigue and length. Surveys should be kept as short as possible and should not be seen as a replacement for poor record-keeping on a day-to-day basis. Surveys demand respondents' time and goodwill to answer the questions so this imposition should be kept to a minimum. The purpose of the survey should be explained to the whole community and results should be shared back to them in a timely and accessible manner.

In sum, a social survey should not be undertaken lightly, and certainly not without careful design of the sampling frame and questions, testing of questions in the relevant context, and careful attention to ethics. In addition, one shouldn't expect too much from a survey: some indicators, such as those relating to food security, change very slowly and have many complex inputs.

How to conduct a social survey?

- Design your questions in line with the indicators detailed in your monitoring plan which should have been informed by your PHE programme theory and goals arising from community consultations
- Decide whether it will be an individual and/or household survey depending on the questions you want to ask (as some are for individuals and some are for households) and the level of detail that you need (as sometimes it may be important to differentiate between men and women while other times it may be acceptable to have an average indicator for entire households)
- Construct your sampling frame (using the best available census data / population estimates - you may actually need to start by collecting your own)
- Design a random sampling strategy (so that every *nth* individual and/or household has an equal probability of being included in your sample)
- Seek ethical approval
- Recruit and train surveyors in confidentiality, informed consent, probing skills, the specific survey that you've designed, etc.
- Conduct a small pilot - remembering that you must allow sufficient time to redesign and retest the survey or certain questions after the pilot as necessary
- Review answers - revise the wording of the questions as necessary to ensure maximum clarity and cultural acceptability
- Roll out the survey across the target area - keep monitoring responses and how the questions are being received throughout this phase
- Enter the data into a database with quality checks (usually including double entry) - although this might not be necessary if you choose to use electronic data collection methods such as tablets or smart phones
- Analyse the data (frequencies, percentages, associations between variables, etc)

Please see Annex II for some sample questions.

How to collect qualitative data?

Collecting stories from community members can be an effective way of understanding and documenting the outcomes of your PHE initiative, especially unexpected outcomes. These stories are likely to yield rich and detailed information, complementing and helping to explain quantitative data. Stories can be collected through one-off interviews or longitudinal case studies, whereby you speak with the same person or household multiple times over several months / years in order to track changes over time. Informed consent must be obtained from all respondents. If you'd like to share their stories in your external communications then you should explain what


Photo credit: Garth Cripps

this would entail and check whether they agree to this, and if so whether they'd be comfortable with their own name being used or whether they'd prefer to remain anonymous.

A systematic way of collecting and analysing stories is called the "most significant change" technique. It involves the collection of significant change stories from community members and community-based staff, which can be analysed individually to provide insights into the impacts that a programme is having in the lives of community members. An additional step is the identification of the most significant of these stories by groups of staff and stakeholders. These people sit down together, read the stories aloud, sort them into themes and have in-depth discussions about the value of the reported changes. The stories are gradually reduced in number through a systematic and transparent process; every time stories are selected, the criteria used to select them are recorded and fed back to all interested stakeholders. After this process has been used for some time, a document is produced with all of the most significant change stories and the reasons why they were selected. Where possible, these most significant change stories are triangulated with quantitative data.

Significant change stories are collected from community members and community-based staff using the following question (or a variation thereof that is appropriate locally / to the programme being evaluated):

Looking back over the last month / year, in your opinion, what was the most significant change that took place for you / your family / participants in this initiative?

In addition to this, it's very important that respondents are encouraged to report why they consider a particular change to be significant to them.

The "most significant change" technique was originally developed to address some of the challenges associated with monitoring and evaluating a complex participatory rural development programme in Bangladesh, so it's well-suited for PHE partnerships and particularly helpful for shedding light on unexpected and "added-value" outcomes of cross-sector programming as it doesn't use pre-defined indicators.

There are many other ways of capturing some of the richness and impacts of PHE initiatives using qualitative data; please contact pheinfo@blueventures.org if you'd like to know more.

How to plan and carry out an evaluation?

- Start by deciding the aims of your evaluation with your partner(s), bearing in mind your learning objectives and the needs of different stakeholders.
  - For example, you may wish to assess the (expected and unexpected) outcomes of your initiative, how these were achieved, what worked well and what could have been done differently.
  - Other questions to consider: was your programme theory valid (sound logic and assumptions met), did the initiative respond to community needs, were the activities implemented well and targeted appropriately (or could they have been more efficient), did your staff have adequate training and support?

- Next, decide who will conduct the evaluation (your staff or an external evaluator).
  - In deciding this, it's important to consider that conducting a robust evaluation of your PHE initiative may require significant expertise not found within your organisation. PHE initiatives are highly complex and therefore most amenable to mixed methods evaluation (using both quantitative and qualitative data). Different methodological approaches can be used to evaluate such data. For example, realist evaluation is one approach that is being pursued by several PHE implementers at present (please contact pheinfo@blueventures.org if you'd like to know more, and further details will be included in version 2 of this guide).
  - Budgetary considerations / priorities will of course also shape the overall scope of your evaluation, and the feasibility of engaging an external evaluator. It may be that each partner already has a plan (and some funding) for monitoring and evaluating their own sector-specific work that you can build upon. If this is the case, you may want to focus any additional evaluation work looking at the synergies and interactions between these different components of your PHE partnership.
- Review all learning documented by programme staff to date (e.g. mission reports, team debriefs, learning journals, etc.) as well as all existing monitoring data (e.g. service delivery and activity records, survey results, most significant change stories, etc).
  - If you're wanting to understand how your PHE initiative functioned, you may like to map these data onto your PHE programme theory to assess whether it was valid and/or identify any gaps requiring further data collection.
  - You may also like to investigate any hypothesised causal mechanisms (processes through which you believe the observed outcomes may have been generated) using most significant change stories and/or focus group discussions with community members; these can help to pinpoint key activities or strategies for future PHE initiatives to prioritise.
  - Mixing quantitative and qualitative data in this way can strengthen evidence of programme outcomes and functioning, as quantitative data may be required by funders to assess the achievement of outcomes while qualitative data can help to illuminate how these outcomes were generated and what they meant to community members.

9. External communications

By the end of this chapter you should:	This chapter may be of particular relevance to:
■ Know why it's important to communicate externally about your PHE partnership ■ Know what communication channels you can use (social media, blogs, newsletters, webpages) ■ Know how to design an external communications plan (with details of your target audiences, key messages, and what you want them to think / feel / do as a result of your communications) ■ Know some potential media outlets to pitch to	■ Managers and communications staff of environmental organisations ■ Managers and communications staff of health organisations

Why communicate externally about your PHE partnership?

Raising the profile of PHE issues and cross-sector solutions including your PHE partnership is important for:

- Building understanding of the rationale for and benefits of this approach among potential partners
- Building support for this approach among funders and policy makers
- Encouraging uptake of this approach by other organisations

What channels can be used to communicate externally about your PHE partnership?

You can share concise and fairly informal updates using **social media**: Instagram, Twitter, Facebook, etc. Typically these would be photos with short captions, relevant hashtags (e.g. #popenviro #health) and mentions of partners, and links to newsletters or webpages or blogs for more information.

You can share more detailed updates as **blogs**. These could focus on aspects of PHE partnership development or most significant change stories from community members. Note that fully informed consent must be obtained for the use of most significant change stories and photos of community members, and it's not recommended to take photos of health service clients during consultations in order to respect their privacy. WordPress is a free and easy-to-use blogging platform.

You can also create simple **newsletters** (e.g. http://eepurl.com/cxra3f) using MailChimp (another free service like WordPress) to keep your supporters up-to-date with your work. These could include photos and short stories with links to relevant blogs or webpages for more information.

You should feature your PHE partnership on your organisation's website if at all possible. Ideally you would create a **dedicated webpage** (e.g. https://blueventures.org/conservation/community-health/) outlining:

- the problem / challenges that it seeks to address (e.g. unmet family planning and other community health needs, food insecurity, livelihood vulnerability, inadequate community capacity for natural resource management, etc) in the region(s) where you work
- the solution / PHE activities that you're facilitating (e.g. provision of voluntary family planning and other community-based health services, alternative income-generating initiatives, capacity building support for local natural resource management efforts, etc) and how these are integrated at the community level (e.g. integrated community outreach combining health and environmental topics)
- the impact / statistics (e.g. number and type of contraceptives distributed = couple years of protection provided, estimated number of unintended pregnancies averted, etc - possibly presented in infographic form) and most significant change stories from community members (with photos, quotes, etc - so long as fully informed consent has been obtained)
- your team and PHE partners (e.g. names and photos of your team members, names and logos of your PHE partners, etc)
- your values (e.g. listening and responding to communities, upholding reproductive rights, etc)
- links to relevant blogs

How to design an external communications plan for your PHE partnership?

Depending on your organisation's capacity for external communications, you may wish to simply communicate externally about your PHE partnership in a rather *ad hoc* way using some or all of the channels outlined above. However, it can also be valuable to reflect on what you hope to achieve through your external communications and to tailor your approach accordingly.

Some questions to consider:

- **Who is your target audience?** Individual supporters, institutional funders, potential partners, policy makers, etc?
- **What is your key message?** Can you condense this into a summary sentence?
- **What do you want them to think / feel / do?** What is the purpose of your communications?
- **Are there any risks that you need to mitigate?** Known sensitivities or potential for misunderstanding?
- **What media outlets do your target audience read?** Where do you need to get your message?
- **What kind of language and content is appropriate (for this target audience and media outlet)?** Technical or informal, quantitative results or qualitative stories, etc?

You could work through these questions and record your ideas in a table such as the one below:

Target audience	Key message	Think	Feel	Do	Risks	Media outlet	Language and content
*Staff of **potential environmental partners** in other regions where you hope to expand your PHE work*	*PHE is a powerful mechanism for enabling couples to plan the number and spacing of their births, thereby allowing women more time to engage in NRM and bolstering local NRM efforts, and can be easily incorporated into existing NRM initiatives through partnerships with specialised health agencies*	*Partnering with health orgs can advance and add value to my work*	*Don't need much new technical expertise to incorporate health into my work*	*Reach out to health orgs to explore partnership opportunities*	*Misunderstanding of the rationale for PHE (it's about addressing unmet family planning needs and upholding reproductive rights - ensuring full access and free choice - not driven by population-related environmental concerns or goals)*	*E.g. Mongabay*	*Can be fairly technical as for a specialised audience*
*Staff of **potential health partners** in other regions where you hope to expand your PHE work*	*PHE is a powerful mechanism for addressing unmet family planning needs of rural populations (by leveraging the operational infrastructure and community relations of environmental orgs - especially engaging men), and for improving community health more generally (especially nutrition and food security through sustainable NRM)*	*Partnering with environmental orgs can advance and add value to my work*	*Environmental orgs share my commitment to SRHR*	*Reach out to environmental orgs to explore partnership opportunities*	*PHE acronym (mention of "population" may trigger misconception of population control) vs. sensitivities around SRHR*	*E.g. Guardian Global Development Professionals Network*	*Can be fairly technical as for a specialised audience*
*Health / development / environmental **funders***	*PHE is a logical and cost-effective way of achieving health / development / conservation outcomes = win-win-win for all involved!*	*Funding PHE makes more sense than single-sector investments*	*Want to encourage my grantees to explore opportunities to work holistically*	*Proactively invest in and support wider uptake of PHE*	*Insufficiently compelling quantitative data relating to the "added-value" benefits of PHE*	*E.g. Stanford Social Innovation Review*	*Engaging and accessible, hard facts good*

Potential media outlets

The New Security Beat is the blog of the Wilson Center's Environmental Change and Security Program. It regularly features posts about PHE partnerships from across the world. They're interested in guest contributions so if you'd like to write a blog or if you've already written something that you think they might be interested in, just email a brief pitch or a link to their editor Schuyler Null outlining your idea and your expertise.

The Guardian Global Development Professionals Network is an online space for global development professionals to share knowledge and expertise. Because pieces are written for a professional audience - not for the general public - the aim is to share experiences and lessons learned. Pieces should be no more than 800 words and you can submit a pitch using this form.

Writing tips from the Guardian Global Development Professionals Network

How to develop your story

First, decide what you want to write about. You may have a rough idea; try to express that in one line. Then, write down the points that you want to discuss or highlight.

Next, back up those points with links to evidence – numbers, statistics, case studies or opinions (your own opinion, other opinions, those of your peers or people related to the topic).

Once you've gathered facts and opinions, you have your basic material. Now go back to your title and check whether your material is enough to express your idea in a blog? If yes, start writing.

Keep it simple

Good writing is simple writing. Even when writing for a professional audience, avoid clichés and jargon. Read and reread and strike out repetition, avoid or explain any cultural references and acronyms that you use.

Top tips for communicating externally about PHE partnerships

- Avoid the use of too many acronyms (PHE is ok if you spell it out the first time as "Population-Health-Environment" or "People-Health-Environment" and explain what it means)
- Back up your main points with evidence or quotes
- Create a platform for communities to share their own stories and experiences
- Consider using most significant change stories from community members to illustrate impact (so long as fully informed consent has been obtained to use these stories for external communications)
- Always acknowledge your implementing partners (and funders) - also note that you may need to get their approval for external communications before publishing
- Emphasise that this approach is centred on upholding reproductive rights and addressing unmet family planning needs by ensuring full access to voluntary services i.e. enabling all individuals to choose freely the number and spacing of their births (rather than being driven by population-related environmental concerns or goals)

Examples of some key phrases:

What is PHE?

- "Population-Health-Environment" (PHE) is an interdisciplinary approach to sustainable development, integrating voluntary family planning and other health services with community-based natural resource management initiatives
- This holistic way of working is often referred to as "Population-Health-Environment" (PHE) because of the way that it reflects the connections between people, their health and the environment

What does PHE do?

- The PHE approach reflects and addresses the interconnected challenges of poor community health, unmet family planning needs, food insecurity and environmental degradation
- The PHE approach empowers people to make their own family planning choices, while equipping them with the skills they need to manage their resources sustainably
- The PHE approach advances gender equality by involving women in natural resource management decision-making, while engaging men in discussions about family health
- PHE has been shown to produce greater impacts than single-sector health or environmental interventions (D'Agnes et al, 2010), and to generate additional benefits such as the increased engagement of women in alternative livelihood activities

What are the benefits of increasing access to voluntary family planning services as part of a PHE programme?

- Increasing access to voluntary family planning services improves maternal and child health outcomes, allows girls to delay their first pregnancy until after they have completed their education and affords women more opportunities to be economically active
- Empowering couples to plan and better provide for their families improves food security,


Photo credit: Garth Cripps

enables women to play a more active role in natural resource management and boosts the sustainability of local environmental conservation efforts

- In areas of high unmet family planning needs, increasing access to voluntary family planning services and upholding the reproductive rights of all individuals to choose freely the number and spacing of their births can enable couples to avoid unintended pregnancies and attain their desired family sizes, thereby bolstering community-based natural resource management efforts
- Through the provision of short-term and long-acting reversible contraceptive options, this PHE partnership is estimated to have averted more than XXX unintended pregnancies to date among a population of approximately XX,XXX (see chapter 8 for how to calculate this estimated outcome)

Note: the most powerful external communications about PHE are often rooted in personal testimonies and stories of community members, so the above key phrases should just be taken as examples of the sort of language that you may wish to use when describing your PHE work more generally.

Environmental degradation driven by population growth?

When communicating about PHE issues and solutions, it can be easy to fall into a simplistic narrative about unmet family planning needs and higher than desired fertility rates driving environmental degradation, with provision of voluntary family planning services as the key to promoting more sustainable natural resource use. Evidently the drivers of environmental degradation are much more complex though, with commercial demand for forest and seafood products often overshadowing local subsistence needs. It's therefore important to communicate PHE issues and solutions with nuance, recognising the roles that international markets are playing in natural resource depletion and local communities are playing in natural resource management.

10. Community-based natural resource management

By the end of this chapter you should:	This chapter may be of particular relevance to:
■ Know the main objectives of community-based natural resource management ■ Know how community-based natural resource management works in principle and in practice ■ Know some challenges that communities may experience when seeking to manage their natural resources	■ Managers and community-based staff of health organisations

What are the main objectives of community-based natural resource management?

- Ensure natural resources are available for local livelihoods, food security and nutrition
- Put communities that rely heavily on natural resources in charge of management efforts so that management plans are adapted to their needs and supported locally
- Conserve biodiversity and safeguard ecosystem health

How does community-based natural resource management work in practice?

In general, in countries where legal frameworks exist for community-based natural resource management, it works more or less as follows:

- Communities, often with the facilitation of a support organisation, organise into local management committees (ideally consisting of a small number of elected male, female and youth representatives)
- Local management committees consult with the wider community of resource users to design management plans and draw up management rules (ideally informed by evidence of local biodiversity and resource use patterns) e.g. closing off certain areas to fishing or forest extraction either periodically or permanently, applying certain restrictions on fishing gears, etc.
- Local management committees submit management plans and rules to relevant government authorities for approval
- Local management committees sensitise the wider community about management plans and rules
- Local management committees monitor natural resource use and enforce management rules with sanctions applied for infractions as appropriate


Photo credit: Garth Cripps

- Local management committees explore and pursue options for communities to undertake alternative food production and/or income-generating activities as appropriate
- Local management committees evaluate the effectiveness of their interventions based on appropriate sources of information and data (often collecting data themselves with tools and training provided by a support organisation) and adapt management plans regularly to improve their effectiveness

Communities are often accompanied through this process by environmental organisations or government authorities, in which case they may establish co-management arrangements whereby responsibility for natural resource management is assured jointly by local management committees and their supporting organisations.


Photo credit: Brian Jones

The legal status of community-managed areas varies from country to country in line with national policies and legal frameworks, so it's essential to consult the appropriate legislative documents in your country of operation for more specific details. As an example, communities in Madagascar have been granted *de jure* management rights over certain natural resources under the GELOSE (*gestion locale sécurisée*) policy, thereby strengthening the *de facto* management rights that they exercise through the application of customary rules (called *dina*). A number of other policies in Madagascar provide provisions for the legal recognition of community-managed areas as IUCN category V or VI protected areas, thereby assigning them a protected status once certain standards are achieved.

What are some challenges that communities may experience when managing their natural resources?

- Non-respect for management rules by community members - reasons for this may include:
  - Incoherence between rules and local needs (although unlikely / hopefully avoided as rules designed by communities themselves)
  - Lack of alternatives to illicit resource extraction (important to ensure that alternatives are available - e.g. through support for alternative income-generating activities - otherwise rules may be impractical)
  - Lack of understanding of rules and their benefits (insufficient community sensitisation)
  - Lack of buy-in to natural resource management efforts among the wider community (important to promote diverse representation, including of women and youth, in local management committees so that all sub-groups within the community have a say in decision-making)
- Implementation of inappropriate or insufficient management measures - reasons for this may include:
  - Lack of data to inform management measures (e.g. most appropriate sites for marine reserves)
  - Low levels of local knowledge about certain aspects of ecological systems - while local users often have very relevant knowledge about resources, certain resources may be difficult to monitor or understand locally (e.g. migrating species)
- Insufficient capacity for monitoring natural resource use - reasons for this may include:
  - Local management committee members unable to afford time away from livelihood activities for monitoring
  - Local management committee members lack equipment needed for effective monitoring
- Difficulties enforcing management rules - reasons for this may include:
  - Familial relations between local management committee members and infractors
  - Pressures originating from outside of the local community (e.g. migrating populations and illegal commercial extractive activities)
- Insufficient support from relevant government authorities and/or lack of supportive legal frameworks

11. Family planning

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know the benefits of family planning ▪ Understand that attitudes towards family planning vary across different cultures and religions - and that community consultations are helpful for evaluating local realities ▪ Understand why it's important to provide full information about different contraception methods ▪ Understand how different contraception methods work ▪ Know the effectiveness, advantages and disadvantages / risks / possible negative effects of different contraception methods	▪ Managers and community-based staff of environmental organisations
Note: The information presented in this chapter should be generalisable across contexts but please consult Ministry of Health documents and policies in your country of operation for specific guidance.	

PHE initiatives encompass the provision of family planning counselling and contraception methods. Often environmental organisations partner with health organisations that are able to ensure high quality family planning service delivery. Environmental organisations can (and should) nevertheless play an important role in increasing access to family planning information by integrating such information into their ongoing community outreach activities. It can therefore be very helpful for the staff of environmental organisations to have a basic understanding of family planning concepts and contraception methods as outlined below. Such information can be shared with community members through presentations and small group discussions. Health organisations will typically follow up with more detailed counselling for individual clients to ensure that they are making fully informed choices.

What are the benefits of family planning?

Family planning allows couples to choose the timing and spacing of their pregnancies and attain their desired family sizes. It is achieved through the use of contraception (and/or fertility awareness methods). Family planning can:

- Prevent pregnancy-related health risks for women
- Prevent closely spaced pregnancies and associated health risks for women and babies
- Prevent unsafe abortions
- Reduce maternal and child mortality (by around 25% or more in low-resource settings)
- Allow girls and women to pursue educational and income-generating opportunities
- Allow parents to invest more in each child (e.g. schooling, nutrition and medical care)

Is family planning acceptable to everyone?

Attitudes towards family planning vary across different cultures and religions, and even within individual communities and households.

Some cultures may value large families. For example, newly married couples in Madagascar are traditionally blessed with wishes for 7 boys and 7 girls. However, this isn't to say that family planning is unacceptable in Madagascar and often it can be highly desired for birth spacing. Furthermore, fertility preferences are subject to change; 4.7 / 5.1 is the average ideal total number of children reported by women / men in Madagascar's latest national Demographic & Health Survey.

While many religions value children as precious gifts and are therefore often perceived to prohibit family planning, they may also advise believers about spacing births and providing adequately for their households[1]. Some religious leaders may endorse certain teachings relating to family planning, while others may be more flexible. Overall, believers are likely to make choices based on such teachings and their own personal situations or preferences.

In conclusion, outside perceptions of non-supportive cultural or religious beliefs about family planning may not necessarily reflect local realities! This is why it's recommended to complete community consultations - ideally engaging with local religious and community leaders as well as groups of women and men of different ages - before starting a PHE initiative. Such consultations will enable you to understand whether or not family planning is desired and acceptable locally, and if so, which contraception methods would be most appropriate to offer (noting though that all individuals have the right to choose from a full range of options). It will also allow you to explore the viewpoints of local religious leaders, and if/how community members already using family planning balance their choices with any religious beliefs.

Most often family planning itself is broadly acceptable, particularly for spacing births and in light of the health benefits (e.g. saving the lives of mothers and children, preventing abortions, etc.) outlined above. However, hormonal and barrier methods may not be acceptable to some believers.

Why is it important to provide full information about different contraception methods?

All individuals have the right to full, free and informed choice with regards to family planning.

- **Full choice:** access to the widest possible range of methods from which to choose (short-acting, long-acting, permanent, hormonal, non-hormonal, natural, client-controlled, provider-dependent)
- **Free choice:** the decision of whether or not to use family planning and which method to use is made voluntarily, without barriers or coercion
- **Informed choice:** a decision based on complete, accurate, unbiased information about all contraceptive options including benefits, negative effects, risks and correct use

(Adapted from EngenderHealth's Checkpoints for Choice: An Orientation & Resource Package, 2014)

All individuals have the right to choose freely whether or not they would like to use contraception. If they choose to use contraception then they also have the right to choose freely which method they would like to use.

All individuals have the right to comprehensive and unbiased information about different contraception methods available to them - this includes the effectiveness, advantages and disadvantages / risks / possible negative effects of each method - so that they can make an informed choice about what is right for them personally.

There is no correct or incorrect answer - all individuals have the right to use this information to choose freely based on their preferences, values, beliefs, lifestyles, needs and reproductive intentions. Individuals may also decide to stop using their chosen method and/or switch to another method at any time.


Photo credit: Garth Cripps

1 *For example, Quran 2:233 encourages mothers to breastfeed for two years, which corresponds with WHO recommendations regarding birth spacing, while 1 Timothy 5:8 in the Bible warns strongly against failing to provide for your family members, which could be interpreted as necessitating a degree of family planning.*

What is contraception?

A woman gets pregnant if a man's sperm reaches and fertilises one of her eggs. Contraception (literally "against conception") tries to stop this happening by keeping the egg and sperm apart (for example, by using a barrier) or by stopping the release of eggs or by stopping a fertilised egg from implanting in the womb (for example, by using synthetic hormones). Many couples choose to use contraception in order to prevent pregnancy and/or to plan their families (for example, to space their births).

Reminder: The information presented below about different contraception methods should be generalisable across contexts but please consult Ministry of Health documents in your country of operation for more specific guidance.

Did you know?

Women are not fertile all of the time; they can only get pregnant for one week per menstrual cycle (which is normally 24-35 days long).

Women's ovaries release a single egg once every menstrual cycle. Once the egg is released, it can survive for 12-24 hours. (Very occasionally, two eggs are released within a 24 hour period. After this, the hormone progesterone suppresses the release of any further eggs until the following menstrual cycle.)

Sperm can survive inside a woman's reproductive tract for up to 5 days, so it's possible for women to get pregnant from an act of sexual intercourse occurring from about 5 days prior to an egg being released through to 24 hours afterwards (or 48 hours in the rare case of two eggs being released). For all intents and purposes, this means that women can get pregnant for about one week per menstrual cycle (this is often called the fertile window).

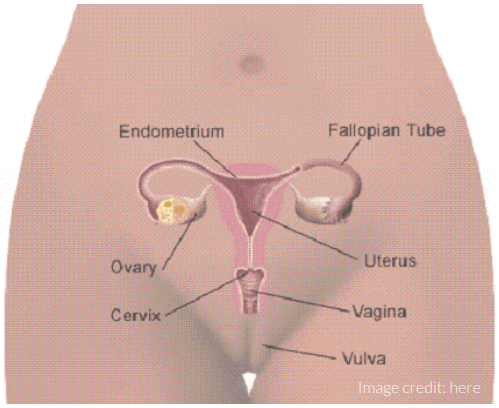
Condoms

A thin rubber sheath worn on a man's erect penis or inside a woman's vagina during sexual intercourse designed to stop the man's sperm from reaching the woman's egg.

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
Each condom can be used for 1 act of sexual intercourse only	18%-21% typical use failure rate[1] for male and female condoms respectively	▪ Protects against STIs & HIV as well as unintended pregnancies ▪ Can be used in combination with any other method ▪ No effects on general health, sex drive, hormones, etc	▪ Necessary to negotiate use of male condom with sexual partner ▪ Less effective than the methods below even when used correctly and consistently (2-5% perfect use failure rate for male and female condoms respectively) ▪ Male condom interrupts sexual activity (as it must be put on the erect penis once the man is aroused)

Pills

The combined oral contraceptive pill contains synthetic versions of the hormones oestrogen and progesterone (called progestogen). It's taken daily by women. It works by suppressing ovulation (preventing the ovaries from releasing eggs), making the mucus at the entrance of the womb (cervix) thicker so it's harder for the sperm to get through, and making the lining of the womb (uterus) thinner so it's less able to support a fertilised egg.



1 *Typical use failure rate is the % of couples who would get pregnant if using this method for one year - taking into account when users fail to use a method consistently or correctly. This statistic was found here.*

Did you know?

The workings of women's metabolic and endocrine systems are intricately connected with ovulation and the hormones produced via ovulation. The synthetic hormones contained in the pill, injections and implants are not the same as the hormones produced by women's bodies. This is why these hormonal contraception methods can have so many effects in addition to preventing pregnancy. They suppress the creation and fluctuation of hormones that make up the menstrual cycle, and replace that cycle with an artificial flat stream of synthetic hormones. They disrupt the endocrine system, which influences nearly all cells and functions of the human body.

The combined oral contraceptive pill is not suitable for women who smoke, are 35+ years old, have high blood pressure, suffer from migraines, have a family history of strokes, and/or are breastfeeding.

The progestogen-only pill contains a synthetic version of the hormone progesterone. It's taken daily by women. It works by making the mucus at the entrance of the womb (cervix) thicker so it's harder for the sperm to get through, and making the lining of the womb (uterus) thinner so it's less able to support a fertilised egg. Most often, depending on the type of progestogen-only pill, it also suppresses ovulation (prevents the ovaries from releasing eggs). It can be suitable for women who can't take the combined pill (containing a synthetic version of the hormone oestrogen) for the reasons stated above.

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
One pill packet offers 4 weeks of protection - a pill should be taken every day by the woman	9% typical use failure rate[1]	▪ Withdrawal bleeds can be lighter, less painful and more regular than menstrual periods ▪ Does not interrupt sex ▪ Highly effective when used correctly and consistently (0.3% perfect use failure rate) ▪ May protect against pelvic inflammatory disease ▪ Progestogen-only pill can be used while breastfeeding ▪ Female-controlled method	▪ Breakthrough bleeding and spotting is common in the first few months ▪ Need to remember to take a pill every day *(and at the same time every day for progestogen-only)* ▪ Nausea, breast tenderness, mood changes, headaches, weight gain and decreased sex drive are all possible and not uncommon effects (these may or may not go away after a few months) ▪ Has been linked to depression ▪ Does not protect against STIs & HIV ▪ Combined pill has been linked to an increased risk of breast cancer ▪ Combined pill can increase blood pressure and has been linked to an increased risk of blood clots (thrombosis)

1 *Typical use failure rate is the % of couples who would get pregnant if using this method for one year - taking into account when users fail to use a method consistently or correctly. This statistic was found here.*

Injections

The injection contains progestogen (a synthetic version of the hormone progesterone).

It's administered to women every 12-13 weeks. It works by making the mucus at the entrance of the womb (cervix) thicker so it's harder for the sperm to get through, making the lining of the womb (uterus) thinner so it's less able to support a fertilised egg, and suppressing ovulation (preventing the ovaries from releasing eggs).

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
One Depo-Provera injection (given into a muscle) offers 12 weeks of protection while Sayana Press (given under the skin) offers 13 weeks of protection - the injection should be administered by a trained community health agent or medical professional (although in some countries Sayana Press is licensed for self-administration)	6% typical use failure rate[1]	▪ No need to remember to take a pill every day ▪ Does not interrupt sex ▪ Highly effective when used correctly and consistently (0.3% perfect use failure rate) ▪ May protect against pelvic inflammatory disease ▪ Can be used while breastfeeding ▪ Bleeds may be lighter than menstrual periods or stop altogether (this may be considered desirable by some women though other women are concerned by this) ▪ Can be suitable for women who can't take the combined pill (containing a synthetic version of the hormone oestrogen) for reasons stated above ▪ Female-controlled method ▪ Use is very discreet	▪ Breast tenderness, mood changes, headaches, weight gain, acne and decreased sex drive are all possible and not uncommon effects ▪ The injection can't be removed from a woman's body so effects will last as long as the injection and for some time afterwards ▪ Bleeds are usually irregular and may be very heavy or long ▪ Has been linked to depression ▪ Does not protect against STIs & HIV ▪ Fertility can take months to return to normal after stopping injections ▪ Affects natural oestrogen levels which can cause thinning of bones (of particular concern to young women whose bones are still developing) ▪ Has been linked to increased risk of HIV infection

1 *Typical use failure rate is the % of couples who would get pregnant if using this method for one year - taking into account when users fail to use a method consistently or correctly. This statistic was found here.*

Implants

A small flexible tube inserted under the skin of a woman's upper arm (the skin is numbed at the beginning of the procedure).

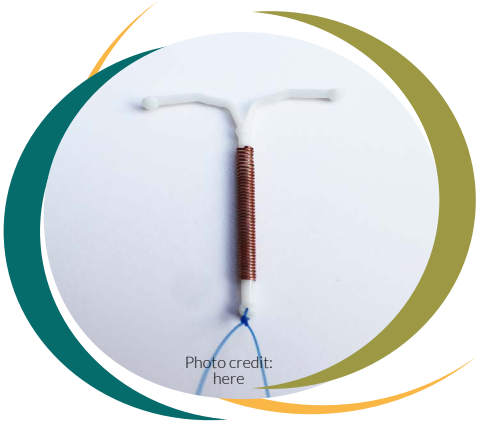
The tube is about 40mm long and contains progestogen (a synthetic version of the hormone progesterone) which is released slowly and steadily into the bloodstream. It works by suppressing ovulation (preventing the ovaries from releasing eggs), making the mucus at the entrance of the womb (cervix) thicker so it's harder for the sperm to get through, and making the lining of the womb (uterus) thinner so it's less able to support a fertilised egg.

Photo credit: here

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
One Implanon implant offers up to 3 years of protection (it can be removed earlier if so desired) and must be inserted by a medical professional	0.05% failure rate[1]	▪ No need to remember to take a pill every day or get another injection every 12-13 weeks ▪ Does not interrupt sex ▪ Highly effective once fitted ▪ Long-acting so can be a good option for women with infrequent access to service providers ▪ May protect against pelvic inflammatory disease ▪ Can be used while breastfeeding ▪ Bleeds may be lighter than periods or often stop altogether (this may be considered desirable by some women though other women are concerned by this) ▪ Can be suitable for women who can't take the combined pill (containing a synthetic version of the hormone oestrogen) for reasons stated above ▪ Female-controlled method	▪ Breast tenderness, mood changes, headaches, acne and decreased sex drive are all possible and not uncommon effects ▪ Bleeds are often irregular and may be very heavy or long ▪ Has been linked to depression ▪ Does not protect against STIs & HIV ▪ Requires access to a trained medical professional for insertion and removal

1 *Failure rate is the % of couples who would get pregnant if using this method for one year. This statistic was found here.*

Copper intra-uterine devices (IUDs)



A small T-shaped plastic and copper device inserted into a woman's womb (uterus).

It works by releasing copper, which changes the make-up of fluids in the womb (uterus) and fallopian tubes, thus stopping the sperm and egg from surviving there. It may also prevent a fertilised egg from implanting in the womb (uterus). It doesn't contain artificial hormones, so it doesn't suppress ovulation (eggs being released by the ovaries).

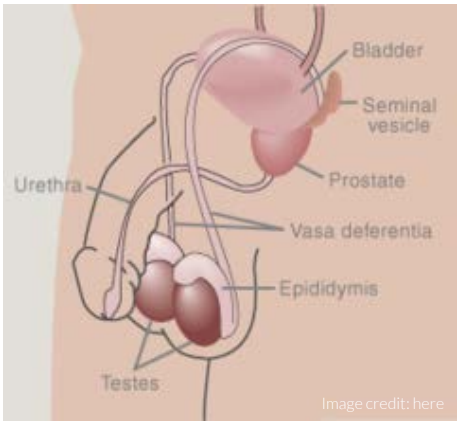
Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
One copper IUD offers up to 10 years of protection (it can be removed earlier if so desired) and must be inserted by a medical professional	0.8% failure rate[1]	▪ No need to remember to take a pill every day or get another injection every 12-13 weeks ▪ Does not interrupt sex ▪ Highly effective once fitted ▪ Long-acting so can be a good option for women with infrequent access to service providers (although should be checked by a medical professional a few weeks after insertion) ▪ Fertility should return to normal as soon as the IUD is removed ▪ Can be used while breastfeeding and in some cases can be fitted within 48 hours of giving birth (post-partum) ▪ Suitable for women who can't take the combined pill (containing a synthetic version of the hormone oestrogen) for reasons stated above ▪ Suitable for women who don't wish to use hormonal methods ▪ Female-controlled method	▪ Heavier, longer and/or more painful periods are common ▪ The insertion process can be uncomfortable and sometimes painful ▪ Cramps and bleeding may be experienced for a few days after having the IUD inserted ▪ Very small risk of pelvic infection within 20 days of the IUD being inserted (higher among women with an untreated STI) ▪ Very small risk that the IUD may be rejected (expelled) by the body or perforate (puncture) the womb (uterus) or entrance to the womb (cervix) ▪ Increased risk of ectopic pregnancy (when a fertilised egg implants outside the womb) in the unlikely event that this method fails ▪ Does not protect against STIs & HIV ▪ Requires access to a trained medical professional for insertion and removal

1 *Failure rate is the % of couples who would get pregnant if using this method for one year. This statistic was found here.*

Vasectomy (male sterilisation)

A permanent method of contraception whereby the tubes (vasa deferentia) that carry sperm from a man's testicles to the penis are cut, blocked or sealed.

The operation is usually carried out under local anaesthetic (the area is numbed but the man is awake), and takes about 15 minutes. It prevents sperm from reaching the seminal fluid (semen), which is ejaculated from the penis during sex. Semen is still ejaculated as normal, but it doesn't contain sperm so a woman's egg can't be fertilised.



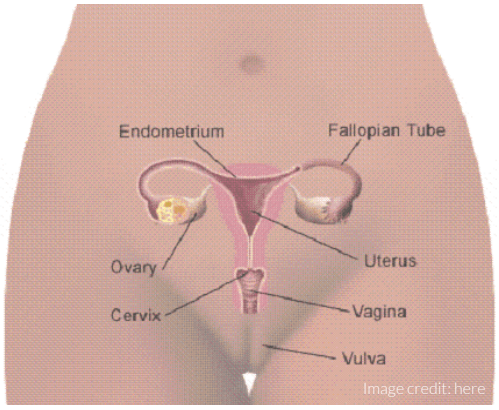
Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
Permanent	0.15% failure rate[1]	▪ Does not interrupt sex ▪ Highly effective once complete ▪ Permanent so can be a good option for couples with infrequent access to service providers ▪ No effects on sex drive, hormones, erections and ejaculation ▪ Rarely any long-term effects on general health ▪ Simpler than female sterilisation ▪ Male-controlled method	▪ Only suitable for couples who are sure they don't want any / any more children ▪ Mild discomfort, swelling and bruising of the scrotum (ball sack) common for a few days after the vasectomy ▪ Long-term testicular pain is a possible and not uncommon effect ▪ Takes a little time to clear remaining sperm in tubes (20-30 ejaculations on average) so another contraception method should be used initially (until tests show that there is no sperm in semen) ▪ Very small risk of sterilisation failing (tubes may rejoin but this is very rare) ▪ Does not protect against STIs & HIV

1 *Failure rate is the % of couples who would get pregnant if using this method for one year. This statistic was found here.*

Tubal ligation (female sterilisation)

A permanent method of contraception whereby the fallopian tubes that carry eggs from a woman's ovaries to the womb (uterus) are blocked (using plastic or titanium clamps), tied or cut.

The operation is carried out under general or local anaesthetic, and usually takes about 30 minutes. It prevents eggs from entering the womb (uterus), where they could be fertilised by sperm. Eggs are still released from the ovaries as normal, but they are absorbed naturally into the woman's body rather than travelling into the womb (uterus).



Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
Permanent	0.5% failure rate[1]	▪ No need to remember to take a pill every day or get another injection every 12-13 weeks ▪ Does not interrupt sex ▪ Highly effective once done ▪ Permanent so can be a good option for couples with infrequent access to service providers ▪ No effects on hormones, menstrual periods or sex drive ▪ Rarely any long-term effects on sexual or general health	▪ Only suitable for couples who are sure they don't want any / any more children ▪ Pain not uncommon in days following surgery ▪ Very small risk of complications e.g. internal bleeding and infection or damage to other organs ▪ Very small risk of sterilisation failing (tubes may rejoin but this is very rare) ▪ Increased risk of ectopic pregnancy (when a fertilised egg implants outside the womb) in the unlikely event that this method fails ▪ Does not protect against STIs & HIV

1 *Failure rate is the % of couples who would get pregnant if using this method for one year. This statistic was found here.*

Standard days method (CycleBeads)

A fertility awareness-based method using a fixed fertile window for women whose menstrual cycles are 26-32 days long. For women with menstrual cycles in this range, the standard days method presumes that days 8 through 19 are potentially fertile days. A user tracks the start date of her menstrual period and the days of her cycle, in order to know if she's on a day when pregnancy is presumed to be possible or not. If wishing to avoid pregnancy, couples should abstain from sexual intercourse or use a barrier method (e.g. condoms) on these potentially fertile days.

CycleBeads are colour-coded strings of beads representing a woman's menstrual cycle. They help women to track their cycles, to identify when are potentially fertile days and non-fertile days according to the standard days method, and to check that cycles are in range for use of this family planning method.

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
Ongoing, whenever in use	12% typical use failure rate[1]	▪ No effects on hormones, menstrual periods, sex drive and general health ▪ Acceptable to many faiths ▪ Involves sexual partner so can help increase feelings of closeness and trust ▪ Can be used for pregnancy avoidance or achievement ▪ Can support understanding of women's fertility and menstrual cycles ▪ Suitable for women who can't take the combined pill (containing a synthetic version of the hormone oestrogen) for reasons stated above ▪ Suitable for women who don't wish to use hormonal methods or a copper IUD	▪ Only suitable for women with regular menstrual cycles of 26-32 days ▪ Less effective[2] than the methods above even when used correctly and consistently (5% perfect use failure rate) so only recommended for couples who are comfortable with a risk of unintended pregnancy ▪ Requires abstinence or the use of a barrier (for example, condoms) on the 12 potentially fertile days per cycle (this may be considered undesirable by some couples and/or difficult to negotiate with sexual partner) ▪ Requires cooperation from sexual partner ▪ Does not protect against STIs & HIV

1 Typical use failure rate is the % of couples who would get pregnant if using this method for one year - taking into account when users fail to use a method consistently or correctly. This statistic was found here.

2 Other fertility-based awareness methods are more effective - for example, the sympto-thermal fertility awareness method (FAM), which involves women tracking basal body temperature, cervical fluid and cervical position trends to identify their individual ovulation patterns rather than using the assumptions inherent in the standard days method, has a 1.8% typical use failure rate (i.e. less than the typical use failure rate of the pill or injection) - but these are often considered less appropriate for low-resource settings.

Lactational amenorrhoea method (LAM)

When women breastfeed, the hormone (called prolactin) that is responsible for breastmilk production suppresses the release of other hormones (including oestrogen) that cause ovulation (the ovaries releasing eggs). This is why breastfeeding women usually experience no menstruation (lactational amenorrhoea).

Women who are breastfeeding can use the lactational amenorrhoea method to prevent another pregnancy, so long as:

- they have complete amenorrhoea (i.e. no menstrual periods - defined as two consecutive days of spotting or bleeding - at all since giving birth, as this suggests that ovulation hasn't yet resumed and if eggs aren't being released then they can't be fertilised)
- they are breastfeeding exclusively (this means that the baby is having breastmilk only - no other liquids or foods), on demand (whenever the baby needs feeding), both day and night (intervals of more than four hours during the day and six hours at night should be avoided to ensure consistent levels of the prolactin responsible for suppressing the release of the hormones that cause ovulation)
- the baby is less than 6 months old

When **any one** of these three criteria stop being met, the lactational amenorrhoea method is no longer effective.

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
Up to 6 months, so long as the other two criteria (detailed above) are still being met	2% perfect use failure rate[1]	▪ No negative effects on hormones, menstrual periods and general health ▪ Acceptable to all faiths ▪ Free and suitable for couples without access to family planning services (no products needed) ▪ Promotes newborn development and maternal bonding ▪ Safe for mother and baby	▪ Can only be used by women who are breastfeeding exclusively and for up to 6 months following birth ▪ Does not protect against STIs & HIV

1 *Perfect use failure rate is the % of couples who would get pregnant if using this method for one year - assuming that they are using the method consistently and correctly. This statistic was found here.*

Withdrawal method

The withdrawal method, also known as *coitus interruptus*, is the practice of withdrawing the man's penis from the woman's vagina and away from her vulva before ejaculation (the discharge of semen and sperm from the male reproductive tract, usually accompanied by orgasm). The goal of the withdrawal method is to prevent sperm from entering the vagina, so that the possibility of conception is reduced.

Using the withdrawal method requires significant trust and self-control. Men who use this method must be able to know when they're reaching the point when ejaculation can no longer be stopped or postponed so that they can withdraw in time. If they can't predict this moment accurately, the withdrawal method will not be as effective.

Even if a man withdraws in time, pregnancy can still happen. Some experts believe that pre-ejaculation fluid can pick up enough sperm left in the urethra from a previous ejaculation to cause pregnancy. If a man urinates between ejaculations before having sexual intercourse, it can help to clear the urethra and may increase the effectiveness of the withdrawal method.

Pregnancy is also possible if semen or pre-ejaculation fluid is spilled on the vulva.

Duration of protection	Effectiveness	Advantages	Disadvantages / risks / possible negative effects
Each act of sexual intercourse	22% typical use failure rate[1]	▰ No effects on hormones, menstrual periods, sex drive and general health ▰ Acceptable to many faiths ▰ Free and suitable for couples without access to family planning services (no products needed) ▰ Suitable for couples who don't wish to use condoms, hormonal methods or a copper IUD	▰ Less effective than the methods above even when used correctly and consistently (4% perfect use failure rate) so only recommended for couples who are comfortable with a risk of unintended pregnancy ▰ Requires significant trust and self-control ▰ Requires cooperation from sexual partner ▰ Requires the man to know when he is reaching the point when ejaculation can no longer be stopped or postponed so that he can withdraw in time ▰ Does not protect against STIs & HIV

1 *Typical use failure rate is the % of couples who would get pregnant if using this method for one year - taking into account when users fail to use a method consistently or correctly. This statistic was found here.*

12. Health service delivery

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know three different modes of health service delivery including their advantages, challenges and considerations to bear in mind ▪ Understand how environmental organisations can collaborate with health organisations to support community-based or mobile service delivery through PHE partnerships	▪ Managers and community-based staff of environmental organisations
Note: The information presented in this chapter should be generalisable across contexts but please consult Ministry of Health documents and policies in your country of operation for specific guidance.	

When developing a PHE partnership or initiative, it's important to understand and consider different modes of health service delivery that may be appropriate in your context. Often a combination will work best, with at least one mode (community-based or mobile) that ensures good physical access to services for isolated communities.

Community-based service delivery

Examples: community health agents / volunteers / workers, community-based distributors, peer educators, etc.

These are generally local community members who are trained and supervised to provide health information and also basic health services (depending on national health policies) in their villages. They may also refer clients to mobile or facility-based services for more advanced needs. They generally operate in or near their homes and/or go door-to-door to serve clients in their villages. They may also organise small group discussions to raise awareness of common health issues and the services that they / formal health facilities are able to offer.

They may or may not be paid a stipend depending on national health policies in your country of operation. For example, in Madagascar community health agents don't receive a stipend but they receive a small per diem for attending trainings and can sell products (e.g. short-acting contraception methods) to their clients at a fixed, subsidised and affordable retail price - keeping the small mark-up as a modest income for their otherwise voluntary work.

Blue Ventures collaborates with USAID Mikolo to support community health volunteers:

Blue Ventures is working with USAID Mikolo to increase access to child health services for remote coastal communities in southwest Madagascar, as part of an integrated PHE programme in the Velondriake locally managed marine area. In a region where 1 in 13 children dies before their fifth birthday, this collaboration is a critical step for advancing community-based management of preventable illnesses including diarrhoea and malaria. Not only is it set to improve child health outcomes, but it is also likely to increase demand for family planning services as couples become more able to ensure the good health of their children and more familiar with the services offered by community health volunteers.

USAID Mikolo is a five-year project implemented by Management Sciences for Health (MSH) and its local partners, covering 8 regions of Madagascar and targeting communities more than five kilometres from a public health centre, with the aim of improving access to community-based health services and promoting the adoption of healthy behaviours. Under its PHE partnership agreement with Blue Ventures, USAID Mikolo staff and local partner ASOS Sud have provided training in the management of childhood illnesses to more than 30 community health volunteers already active and supported by Blue Ventures. Next steps of the collaboration include working together to produce community outreach materials linking health and environmental topics.

Types of services offered by community-based providers *(can vary depending on national health policies)*	Advantages and strengths	Challenges and considerations
▪ Information about prevention of common illnesses, maternal health, family planning options, nutrition, water, sanitation and hygiene ▪ Promotion of health-enhancing behaviours (as detailed in chapter 13) ▪ Provision of non-hormonal and short-acting contraception methods (e.g. CycleBeads, condoms, pills, injections) ▪ Referral for long-acting and permanent contraception methods (e.g. implants, IUDs, vasectomy, tubal ligation) ▪ Provision of other health products (e.g. insecticide-treated mosquito nets, water purifying solution, oral rehydration salts) ▪ Management of common childhood illnesses (e.g. diarrhoea, respiratory infections, malaria)	▪ Community health agents should be elected by the community themselves and then approved by local authorities and health service providers ▪ Community health agents tend to have an excellent understanding of local health issues, strong and trusting relationships with other community members, and an ongoing presence in their villages ▪ Clients do not have to travel far to access services, and services / follow up should be available on an ongoing basis as community health agents live in their villages ▪ Community health agents can communicate priority health needs to health organisations active in the area	▪ Community health agents require a basic level of literacy in order to complete their training and be able to operate effectively (i.e. follow guidelines and keep reports), but adult literacy may be extremely limited in isolated communities; a short programme of literacy training may therefore be necessary prior to community health agent training ▪ Community health agents require initial training, validation, follow up reviews and supervision; generally this is provided by health organisations although environmental organisations may also be able to support with supervision in PHE partnerships ▪ Clients may have to pay for contraceptives or other products (although the prices are often fixed and subsidised heavily in order to ensure affordability) ▪ Female clients may prefer to see female community health agents for family planning - many national health policies reference giving preference to women for these roles when possible

Mobile service delivery

Examples: mobile outreach teams or clinics / brigades, mobile nurses or doctors, etc.

Mobile outreach teams or brigades are small groups of medical professionals who travel periodically by 4x4 (or other means of transport e.g. boats - sometimes provided by environmental organisations in PHE partnerships) to reach isolated communities and offer services out of host facilities (e.g. local health centres, school or community buildings). For example, Marie Stopes Madagascar's mobile outreach teams visit isolated communities every three months to offer a full range of contraception methods including long-acting and permanent options. Mobile outreach teams or brigades are often employed by health organisations with funding secured to reach under-served communities. Both environmental and health organisations can assist with the planning and facilitation of outreach missions to ensure that health services are provided to as many isolated communities as possible.

Mobile nurses or doctors are based in urban or peri-urban areas but available to travel to more isolated rural communities and offer services out of host facilities (as described above) and/or door-to-door. For example, Marie Stopes Madagascar's "MS ladies" are often able and

willing to travel occasionally to reach under-served communities in the rural areas surrounding their bases (generally environmental organisations in PHE partnerships would offer to cover their transport, accommodation and subsistence during these missions). Sometimes nurses or doctors working within national public health systems are also available to travel from their base to reach under-served communities.

Types of services offered by mobile providers *(can vary - e.g. some may specialise in family planning only)*	Advantages and strengths	Challenges and considerations
▪ Information about prevention of common illnesses and family planning options ▪ Provision of short-acting, long-acting and permanent contraception methods (e.g. condoms, pills, injections, implants, IUDs, vasectomy, tubal ligation) ▪ Antenatal and postnatal check ups ▪ Basic medical care (e.g. treatment of sores, wounds, infections) ▪ Vaccinations ▪ STI testing and treatment (including HIV)	▪ Clients do not have to travel to access services ▪ Mobile outreach teams, doctors and nurses are qualified to provide more advanced services than community health agents ▪ Community health agents can refer clients to these services and work with them ▪ Environmental organisations can leverage their operational infrastructure (e.g. transport) and frequent presence in communities to facilitate missions	▪ Follow up may be difficult if visits are infrequent or irregular ▪ Clients may be charged a small fee (although vouchers are often available) ▪ Female clients may prefer to see female medical professionals for family planning ▪ Weather and associated infrastructural challenges can alter outreach plans with little notice ▪ Service providers must be well prepared for working in remote areas, with particular attention to ensuring proper hygiene and infection prevention

Marie Stopes Madagascar (MSM) collaborates with the Lemur Conservation Foundation to reach isolated communities:

The Lemur Conservation Foundation is doing joint missions with MS ladies to several villages around the Anjanaharibe-Sud Special Reserve in northeast Madagascar. A recent visit to Befingotra village required a 90 minute drive from the commune centre of Andapa to Andasibe Mahaverika where the main road ends. From there it's a two to three hour walk uphill to Befingotra village. The Lemur Conservation Foundation hired taxi-motos and the MS ladies courageously rode them in about 60 bumpy minutes to Befingotra. Despite terrible weather (heavy rain) it all went really well and 18 women chose to receive three-year implants


Photo credit: Lemur Conservation Foundation

Facility-based service delivery

Examples: public health centres, private health clinics, etc.

Facilities are dedicated buildings from which medical professionals offer a range of services. They typically include at least one consultation room and may have a pharmacy attached. They may be part of a national public health system or they may be operated privately by health organisations or individual providers. For example, public health centres in Madagascar are called *Centres de Santé de Base* (CSBs) while health organisations such as Marie Stopes Madagascar and Population Services International operate their own franchises or networks of private health clinics (called *Blue Star* and *Top Réseau* respectively).

Types of services offered by facilities *(can vary depending on clinic level)*	Advantages and strengths	Challenges and considerations
▪ Information about family planning options ▪ Provision of short-acting, long-acting and permanent contraception methods (e.g. condoms, pills, injections, implants, IUDs, vasectomy, tubal ligation) ▪ STI testing and treatment ▪ Antenatal and postnatal check ups ▪ Safe delivery (birth with a skilled attendant) ▪ Vaccinations ▪ Basic medical care (e.g. treatment of sores, wounds, infections) ▪ Diagnosis and treatment of more complex medical conditions	▪ Facilities are equipped to provide more advanced and comprehensive services than community health agents ▪ Services in public health centres are often free ▪ Community health agents can refer clients to these services	▪ Clients often have to travel far to access services - this can be a significant barrier (addressed by the other two modes of service delivery detailed above) ▪ Female clients may prefer to see female medical professionals for family planning ▪ Public health centres in rural areas may be understaffed meaning that services may not be reliably available or comprehensive

13. Health-promoting behaviours

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Understand that health-promoting behaviours can improve community health outcomes and impact fertility preferences ▪ Know nine simple health-promoting behaviours - including why they're important, what they entail and how they work - that can be promoted through PHE partnerships	▪ Managers and community-based staff of environmental organisations
Note: The information presented in this chapter should be generalisable across contexts but please consult Ministry of Health documents and policies in your country of operation for specific guidance.	

In addition to increasing access to family planning and other health services, PHE initiatives typically seek to improve community health outcomes by promoting simple behaviours that can prevent ill health in the first place and/or effectively treat common illnesses. Such behaviours can be promoted by community health agents and/or environmental outreach workers as part of PHE partnerships.

Some behaviours require certain products (e.g. condoms, insecticide-treated mosquito nets, water purifying solution, oral rehydration salts, etc - all typically offered by community health agents) or access to services (e.g. antenatal care, safe birthing facilities, etc), while others (e.g. skin-to-skin contact for premature babies, exclusive breastfeeding, etc) can be implemented independently.

Did you know?

Health-promoting behaviours that improve community health outcomes and increase child survival can also impact fertility preferences and thereby support uptake of family planning.

Couples may choose to have many children if they're concerned that not all of those children will survive through to adulthood. Health promoting-behaviours that improve health outcomes and reduce child mortality can lead to lower fertility preferences as couples become more confident that their children will survive through to adulthood. Lower fertility preferences are in turn likely to support demand for and uptake of family planning services.

Using condoms to prevent transmission of STIs and HIV

Why is this important?

Sexually transmitted infections (STIs) such as chlamydia, gonorrhoea, herpes and syphilis can be passed from an infected person to another person through genital contact and/or the exchange of bodily fluids during unprotected sexual intercourse. STIs are transmitted more than 1 million times every day worldwide (WHO, 2016). Many are asymptomatic yet can lead to serious long-term health problems including infertility if left untreated. Untreated syphilis is one of the most significant causes of adverse pregnancy outcomes globally; it is estimated to have resulted in more than ¼ million adverse birth outcomes including stillbirths in 2012 (WHO, 2016).

The human immunodeficiency virus (HIV) can also be transmitted through unprotected sexual intercourse as it's found in the bodily fluids of an infected person. It attacks the immune system and weakens the body's ability to fight disease. There's currently no cure for HIV but there are treatments that can enable most people with the virus to live long, healthy lives. The availability of these treatments may be limited in some low-resource settings. Acquired immune deficiency syndrome (AIDS) is the final stage of HIV infection when the body can no longer fight life-threatening infections. With early diagnosis and effective treatment most people with HIV will not go on to develop AIDS. There are more than 36 million people living with HIV worldwide (WHO, 2016).

What is the behaviour to be promoted?

Using a male or female condom for every act of sexual intercourse.

Photo credit: SEED Madagascar

Male condom: check the expiry date on the packet and that the packet has air in it (has not been torn or punctured); open it carefully; hold the tip of the condom to remove any air and then roll it down to the base of the erect penis; after ejaculation, withdraw the penis from the vagina while still erect and hold onto the base of the condom while withdrawing so that it doesn't slip off; tie a knot in the end and dispose of it safely (e.g. in a trash pit where children cannot play with it).

Female condom: check the expiry date on the packet and that the packet has air in it (has not been torn or punctured); open it carefully; adopt a comfortable squatting position and hold the condom at the closed end with the open end hanging down; squeeze together the sides of the inner ring at the closed end (making a figure '8') and push it into the vaginal canal as far as it will go (do not worry about losing it inside); make sure the outer ring is hanging outside of the vagina; for intercourse, guide your partner's penis into the vagina, making sure that he enters the condom and the outer ring isn't pushed into the vaginal canal; after ejaculation, remove the condom by twisting the outer ring and gently pulling the condom; tie a knot in the end and dispose of it safely (e.g. in a trash pit where children cannot play with it).

How does it work?

Condoms act as a barrier between seminal and vaginal fluids through which STIs and HIV can be transmitted. You should contact the health authorities in your country to see what outreach materials are already available and approved to promote correct condom use.

Sleeping under insecticide-treated mosquito nets to protect against malaria

Why is this important?

Malaria is a life-threatening disease caused by parasites that are transmitted to people through the bites of infected female Anopheles mosquitoes. Nearly half of the world's population are at risk. In 2015 there were more than 200 million cases of malaria with an estimated 429,000 deaths – the vast majority of these in sub-Saharan Africa (WHO, 2016). Symptoms typically appear 10-15 days after the infective mosquito bite. The first symptoms – fever, headaches, chills and vomiting – may be mild and difficult to recognise as malaria but can progress to severe illness and death if not treated quickly and correctly.

What is the behaviour to be promoted?

Sleeping under insecticide-treated mosquito nets.

How does it work?

Most *Anopheles* mosquitoes are active at dusk or dawn (crepuscular) or at night (nocturnal). Sleeping under insecticide-treated mosquito nets that are well maintained (no holes) and tucked in (no gaps between nets and mattresses) can protect against infective bites as the nets provide an effective barrier between mosquitoes and human bodies.

Using water purifying solution to treat drinking water

Why is this important?

Water-borne diseases - caused by pathogenic microorganisms transmitted in contaminated fresh water - are thought to be responsible for more than ½ million deaths every year worldwide (WHO, 2016). Water-borne diseases can also contribute to malabsorption and undernutrition, which can have long-term consequences on growth and development.

What is the behaviour to be promoted?

In areas where safe drinking water is not available, using water purifying solution to treat drinking water.

Pictorial instructions can usually be found on the bottle of the water purifying solution. Generally they involve adding a very small amount of water purifying solution or a water purifying pill to fresh water and waiting 30 minutes before it's safe to drink. The water should be stored in a clean container that's closed or covered.

How does it work?

The solution - often sodium hypochlorite - disinfects water in a similar way to chlorine.

Handwashing with soap or ash after defecating and before preparing / eating food

Why is this important?

Diarrhoea is the second leading cause of death in children aged under five years; it's responsible for killing more than ¾ million children every year worldwide (WHO, 2013). Hygienic practices such as washing hands with soap at critical times can reduce the risk of diarrhoea by almost 50% (Curtis & Cairncross, 2003).

What is the behaviour to be promoted?

Handwashing with soap or ash after defecating and before preparing / eating food.

Wet your hands with either warm or cold water; apply soap or ash and lather well; rub your hands vigorously for at least 20 seconds; remember to scrub all surfaces including the backs of your hands, wrists, between your fingers and under your fingernails; rinse well; shake your hands to dry them.

There are a variety of locally appropriate solutions for encouraging and enabling hand washing, for example, simple "tippy tap" devices can be constructed using water bottles and string.

How does it work?

Organisms causing diarrhoea are transmitted through food and water contaminated with faeces. Handwashing with soap after defecating and before preparing / eating food can prevent the transmission of these organisms and thereby reduce the risk of diarrhoea.

Using oral rehydration salts to prevent and treat dehydration relating to diarrhoea

Why is this important?

Diarrhoea can leave the body without the water and salts that are necessary for survival. Most people who die from diarrhoea actually die from severe dehydration and fluid loss.

Since the World Health Organization (WHO) endorsed oral rehydration therapy in the late 1970s for preventing and treating dehydration relating to diarrhoea, the annual mortality rate for children suffering from acute diarrhoea has fallen from around 4.5 million to less than 1 million deaths worldwide today (WHO, 2000).

What is the behaviour to be promoted?

Oral rehydration therapy is a type of fluid replacement used to prevent and/or treat dehydration especially relating to diarrhoea. It involves drinking water with modest amounts of sugar and salt added while continuing to eat.

Oral rehydration salts (to be mixed with water) are often offered in sachets by community health agents. Oral rehydration solution can also be made at home using the following ratios: 6 level teaspoons of sugar and ½ teaspoon of salt to every 1 litre of water (WHO & UNICEF, 2008). Children aged under 2 years should be given ¼-½ large cup after every loose stool and children aged over 2 years should be given ½-1 large cup after every loose stool. **It's very important not to mix up the ratio of salt to sugar! A general rule of thumb is that oral rehydration salts should not taste salty like tears.*

If safe drinking water is not available for the oral rehydration solution then other fresh water should be used. The WHO recommends that oral rehydration therapy should not be withheld simply because the available water is potentially unsafe; rehydration takes priority (WHO, 2005). Nevertheless, water for oral rehydration therapy should be boiled or treated with water purifying solution if at all possible.

How does it work?

The salts and sugars (through the process of osmosis) draw water into the bloodstream and speed up rehydration of water lost through loose stools.

Attending antenatal check ups and giving birth with a skilled attendant where possible

Why is this important?

More than 300,000 women died from complications relating to pregnancy or birth in 2015 (WHO, 2016). Almost all of these deaths occur in low-resource settings and most could be prevented. Major complications that account for maternal deaths include severe bleeding (postpartum haemorrhage), infections (usually after birth), high blood pressure (pre-eclampsia) and difficulties during delivery.

Meanwhile in 2015 almost 3 million newborns died during the first week of life - and almost 2 million of these on the day of birth (WHO, 2016). In addition there were around 3 million stillbirths worldwide (WHO, 2016). Major causes of newborn deaths include infections, prematurity and low birth weight, and lack of oxygen at birth (asphyxia). Up to two-thirds of newborn deaths could be prevented if skilled health workers perform effective measures during the antenatal period (pregnancy), at birth and during the first week of life.

What is the behaviour to be promoted?

Attending antenatal check ups and giving birth with a skilled attendant where possible. This will generally necessitate travelling to the nearest health facility.

How does it work?

Antenatal check ups, skilled birth attendance and postnatal care can significantly reduce the risk of maternal and newborn mortality by screening and treating maternal infections including syphilis during pregnancy, monitoring maternal blood pressure, supplementing iron and folic acid to reduce the risk of low birth weight, vaccinating pregnant women against tetanus, ensuring clean delivery and umbilical cord care, providing assisted ventilation to help newborns breathe if necessary, promoting skin-to-skin contact especially for premature babies and those with low birth weight, and encouraging immediate and exclusive breastfeeding.

Prolonged skin-to-skin contact for premature babies and those with low birth weight

Why is this important?

Every year an estimated 15 million babies are born prematurely (before 37 completed weeks of gestation) and almost 1 million of these subsequently die due to complications (WHO, 2016). Additionally every year more than 20 million babies are born weighing less than 2.5kg - the vast majority in low-resource settings (WHO, 2016). These newborns are at increased risk of infectious diseases and death during infancy. Conventional neonatal care of premature babies and those with low birth weight is extremely challenging in low-resource settings. Skin-to-skin contact (also known as "kangaroo mother care") is recommended by the WHO as a safe and effective alternative to conventional neonatal care (WHO, 2016).

What is the behaviour to be promoted?

Early, continuous and prolonged skin-to-skin contact between mothers and their newborns (positioning the baby close to the bare chest and securing it using a soft piece of cloth), with frequent and exclusive breastfeeding. The baby's head and feet should be covered with a hat and socks, then the mother covers herself and the baby with her usual dress. Fathers can also participate occasionally in providing skin-to-skin contact for the newborns, and mothers should maintain skin-to-skin contact while breastfeeding.

Mothers carrying their newborns in the "kangaroo care" position can sit, stand, walk, engage in income-generating activities and do household tasks as necessary, and sleep in a semi-reclined position. It is recommended to phase out "kangaroo mother care" when the baby reaches term (gestational age around 40 weeks) or 2.5kg - around this time the baby generally outgrows the need for "kangaroo mother care".

How does it work?

Skin-to-skin contact can help to stabilise the baby's heart rate and breathing, provide warmth, support weight gain and promote bonding. It's broadly equivalent to conventional neonatal care (incubators) in terms of thermal protection.

Exclusive breastfeeding for six months following birth

Why is this important?

Breastfeeding is one of the most effective ways to ensure newborn survival and long-term health.

If every infant was breastfed within an hour of birth, given only breast milk for the first six months of their life, and continued breastfeeding up to the age of two years, an estimated 800,000 child lives would be saved every year (WHO, 2016). Yet globally, less than 40% of infants aged under six months are breastfed exclusively.

Breast milk is the ideal food for newborns and infants. It's safe and contains antibodies that help to protect infants from common childhood illnesses such as acute respiratory infections and diarrhoea; the two primary causes of child mortality worldwide. Breast milk is readily available and free, which helps to ensure that all infants get adequate nutrition at the beginning of their lives no matter where they're born.

What is the behaviour to be promoted?

Initiation of breastfeeding within the first hour of life (the mother's first milk, colostrum, is especially important as it's very rich in protective antibodies so it should **not** be discarded!); exclusive breastfeeding for the first six months of life (the infant receives only breast milk - no food or liquids, not even water); breastfeeding on demand (as often as the infant wants, both day and night); no use of bottles or pacifiers.

How does it work?

Breast milk gives infants all of the nutrients that they need for healthy development. It should not be supplemented with any food or liquids during the first six months of life.

Early and formal care-seeking for treatment of common childhood illnesses

Why is this important?

Almost 6 million children aged under five years died in 2015 (WHO, 2016). More than half of these deaths could be prevented or treated with simple and affordable interventions. From the end of the neonatal period and through the first five years of life, the main causes of death are respiratory infections, diarrhoea and malaria. Undernutrition is the underlying contributing factor in about 45% of all child deaths, making children more vulnerable to severe diseases (WHO, 2016).


Photo credit: Garth Cripps

What is the behaviour to be promoted?

Preventative practices already stated in this chapter, followed by early and formal care-seeking from trained community health agents or medical professionals in health facilities for treatment. This may necessitate community education about symptoms (e.g. congestion, difficulty breathing, loose stools, blood in stools, fever, chills, sweats, etc) of respiratory infections, diarrhoea and malaria.

How does it work?

Prompt recognition and treatment of common childhood illnesses is crucial as mortality rates among untreated children are high and death can occur rapidly. Educating communities about common childhood illnesses and encouraging them to seek formal care as early as possible offers children the best chance of survival.

14. Behaviour change / community mobilisation approaches

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Understand that health-related behaviours are determined by more than just knowledge and attitudes ▪ Understand why health education is often not enough to achieve behaviour change ▪ Know what kind of community mobilisation approaches can be used to support health-promoting behaviours ▪ Know how these principles can be applied to promote environmentally friendly behaviours	▪ Managers and community-based staff of environmental organisations ▪ Managers and community-based staff of health organisations

How are health-related behaviours determined?

Mainstream health psychology and social cognition models basically state that:

Knowledge + attitudes (+ perception of risks / benefits) -> behaviour

These models have been criticised for numerous reasons. For a start, they aren't very good at predicting intentions, let alone actual behaviour! A review of studies using these models has shown that they only predict 19-38% of variance in behaviour... so what are they missing?

- Social norms and identities can play a very important role in mediating (that is to say supporting or constraining) possibilities for health-promoting behaviours
- Diverse social meanings and values may be attached to health-promoting behaviours (e.g. intimacy or trust is often associated with unprotected sexual intercourse)
- Individuals generally can't make health-related choices independently of wider structural factors like gender relations and poverty
- Individuals may require access to certain products (as outlined in chapter 13) to enact certain health-promoting behaviours

It's clear that the determinants of health-related behaviours are complex: knowledge and attitudes, yes, but also social norms and identities, social meanings and values, wider structural factors like gender relations, and access to certain products.

SEED Madagascar engages female elders to promote exclusive breastfeeding practices among women of reproductive age:

A maternal and child health research study completed by SEED Madagascar / ONG Azafady in the town of Fort Dauphin found that female elders play an important role in shaping social norms around breastfeeding practices. Many women of reproductive age reported knowing about the importance of exclusive breastfeeding but continuing traditional practices (such as dumping colostrum, feeding newborns herbal liquids and early weaning) because these are encouraged by female elders. Rather than just targeting women of reproductive age, the study concluded that future maternal and child health promotion efforts in the region should also engage female elders to build an enabling environment in which women of reproductive age are supported to practice exclusive breastfeeding.


Photo credit: SEED Madagascar

Why is health education often insufficient for achieving behaviour change?

Efforts to promote the adoption of health-related behaviours have traditionally focused on increasing knowledge by disseminating information to targeted individuals and groups. Didactic health education is based on the assumption that sharing information will lead to behaviour change. However, as we've seen above, it's now widely accepted that **knowledge is necessary but not sufficient for behaviour change to occur**.

Even when individuals know and understand why it would be beneficial to adopt a health-promoting behaviour, there may be other barriers to behaviour change (such as unsupportive social norms or unequal gender relations) that need to be tackled. Sometimes a simple lack of access to information may be the major block faced by communities, in which case health education is certainly appropriate, but more often than not there may be other barriers to behaviour change that will need to be addressed as well.

What kind of approaches can be used to support behaviour change?

In recent years there's been a shift in behaviour change thinking and practice towards **community mobilisation** approaches. These work to create social environments that support the development of health-enhancing social norms. In addition to equipping community members with the **knowledge, skills and products** that they need to enact health-promoting behaviours, these community mobilisations approaches create **social spaces and opportunities for dialogue and critical thinking** about health-related behaviour.

Such safe and trusting spaces can enable community members to:

- Process new health information by engaging in debate
- Air any doubts or confusions regarding how this information resonates with their own experiences and existing knowledge
- Develop actionable understandings of how to improve their health by exploring ways in which they might apply this information to their own lives
- Think critically about any social roots of their health issues (such as unequal gender relations)
- Renegotiate any social norms and identities that undermine possibilities for health-promoting behaviours
- Build a sense of ownership and responsibility for tackling their health issues

Blue Ventures facilitates discussions about health-environment linkages and sexual health issues through interactive theatre sessions:

Interactive theatre has been used by Blue Ventures as an entertaining way to engage diverse audiences in PHE discussions. Storylines have included a husband refusing to let his wife use family planning yet then struggling to provide for his family and reverting to destructive fishing practices, and another family member falling ill due to poor hygiene practices thereby restricting their ability to engage in livelihood and natural resource management activities. Skits are written and performed by staff and community members, and the shows draw from everyday life so that audiences can identify with the storylines: they find themselves laughing, learning and thinking critically together. Local actors spend the day facilitating small group discussions on the same topics so that the evening theatre sessions serve as a chance to summarise, reinforce and follow up on these discussions.

Another sexual health-focused interactive theatre initiative facilitated by Blue Ventures with middle school students has proactively involved audience members in the skits, inviting them to intervene and experiment with changing the direction of storylines as a rehearsal for real-life situations. The debates and the discussions that follow are also a great way of facilitating critical thinking and strategies around sexual health issues.

Examples of community mobilisation activities include:

- Community meetings with time for individual testimonies and dialogue
- Facilitated small group discussions with women's groups, youth clubs, mixed age and gender radio listening groups, etc
- Interactive theatre sessions modelling and exploring the consequences of different behaviours
- Household visits and facilitated discussions
- Champion household schemes

JSI and members of the Voahary Salama platform develop a "champion community" approach for advancing and celebrating PHE progress:

The "champion community" approach includes participatory exercises to identify community needs, agree on feasible targets and activities to undertake within specified timeframes, mobilise communities, monitor progress, conduct transparent evaluations and celebrate achievements through public ceremonies. The approach was originally developed by JSI and its partner AED for community health promotion, then adapted with members of the Voahary Salama platform in the early 2000s to include some environmental components. In the late 2000s it was scaled up as a "champion commune" model ("Kaominina Mendrika" in Malagasy) by two USAID-funded health and environmental projects, in order to support communes to work towards achieving their own health and environmental objectives.

What about environmental behaviours?

Although developed largely by community health psychologists and practitioners, many of the above principles apply to environmental behaviours. For example, community mobilisation approaches can be used to support the appropriate use of mosquito nets (for malaria prevention rather than destructive fishing) and compliance with natural resource management rules. In general, PHE initiatives seek to simultaneously promote the adoption of both environmentally friendly *and* health-promoting behaviours through community mobilisation approaches.

15. PHE linkages, discussion points and messages

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know why it's important to develop an integrated community outreach plan ▪ Know how to develop an integrated community outreach plan ▪ Know some key PHE linkages and discussion points to raise with communities ▪ Know how to develop rights-based PHE messages	▪ Managers and community-based staff of environmental organisations ▪ Managers and community-based staff of health organisations

What is an integrated community outreach plan?

An integrated community outreach plan outlines how you intend to engage with communities (the type and frequency of your activities), what the purpose and themes of this outreach are going to be (the critical thinking and/or behaviours you're seeking to promote), and who is responsible for facilitating this outreach (staff within your organisation and/or community members and/or your partners).

Why develop an integrated community outreach plan?

Integrated community outreach can be considered the glue that binds all of the components of a PHE initiative together; it ensures that the different workstreams within a PHE initiative aren't implemented in parallel but rather complement and proactively reinforce each other. Integrated community outreach is also key to advancing gender equality in natural resource management and family health. An integrated community outreach plan will allow you to collaborate effectively with your partners to ensure that messages are linked and community members are fully engaged in all elements of your PHE initiative.

How to design an integrated community outreach plan?

The findings from your community consultation (particularly regarding health practices and community compliance with natural resource management rules) can be used to inform the development of an integrated community outreach plan.

You can start by identifying a few key behaviour change priorities (e.g. some of the health-promoting behaviours detailed in chapter 13, increased support for family planning among men, increased participation of women in natural resource management decision-making, and increased community compliance with natural resource management rules), bearing in mind which behaviours which would have the greatest benefit to communities and ecosystems, and identifying any areas of overlap or synergy between them.

Then, based on your understanding of the barriers to the uptake of these behaviours (e.g. lack of information, lack of access to services, lack of alternatives, insufficient risk perception, unsupportive social norms, unequal gender relations, etc) also gained from your community consultation, you can select one or more appropriate behaviour change approaches (detailed in chapter 14).

Example plan:

Behaviour to promote	Key barrier(s) to uptake	Most appropriate behaviour change approach(es)	Target group(s)	Behaviour change indicator and monitoring method[1]
Support for family planning among men	Lack of awareness Fertility preferences and unequal gender relations	Informational sessions e.g. at natural resource management meetings Small group discussions and/or interactive theatre sessions to facilitate critical thinking and dialogue	Men	Proportion of men who report supporting contraception use / family planning choices - individual surveys / focus groups
Using condoms to prevent transmission of STIs and HIV	Unequal gender relations Unprotected sex symbolising intimacy and trust in relationships	Interactive theatre sessions to facilitate critical thinking and dialogue	Youth	Proportion of people who report using a condom the last time they had sexual intercourse - individual surveys
Exclusive breastfeeding for six months following birth	Lack of awareness Lack of support from female elders	Informational sessions Small group discussions to facilitate critical thinking and dialogue	Women of reproductive age Female elders	Proportion of mothers with a child <1 year who report having breastfed / planning to breastfeed for six months with no other liquids or solids given during this time - individual surveys
Participation in natural resource management meetings by women and youth	Social norms Lack of confidence and insufficient literacy	Interactive theatre sessions to facilitate critical thinking and dialogue Informational sessions and literacy training	All community members Women and youth	Proportion of women and youth attending and speaking at NRM meetings - meeting registers and records
Support for local natural resource management rules	Lack of awareness and buy-in Lack of alternatives to illicit resource extraction	Small group discussions and/or interactive theatre sessions to facilitate critical thinking and dialogue Linking with appropriate alternative food production / income-generating activities	All community members	Proportion of people who report agreement with local natural resource management rules - individual surveys / focus groups


Photo credit: Garth Cripps

This plan can be developed in more detail by including names of communities and the frequency of the activities to be facilitated (e.g. weekly small group discussions, monthly informational sessions, etc).

You may like to use PHE (e.g. healthy families, healthy environment) as an umbrella theme for linking priority health-promoting and environmentally friendly behaviours, as this can also be a good way of engaging non-traditional target groups in different topics. In addition to integrated community outreach, you may also like to consider concrete ways of linking across activities to advance gender equality in natural resource management and family health; you can find specific guidance about engaging men in family planning here.

1 *Please note the limitations to self-reported behaviours outlined in chapter 8.*

What are some key PHE linkages and discussion points to raise with communities?

Communities are likely to have a good understanding of PHE linkages as they experience them in their everyday lives, but it can nevertheless be helpful to surface and facilitate discussions about the connections between various health and environmental issues in order to support communities to think critically about their situations and the consequences of the decisions that they make.

Available now!

A package of illustrated PHE story cards / discussion aids designed for use with communities in both marine and terrestrial environments. Download them here.

The following PHE linkages and discussion points can be raised with communities through interactive theatre workshops, facilitated small group discussions and community meetings:

Connections between community health and community engagement in livelihood activities / natural resource management efforts

- How might the health of community members impact their ability to engage in livelihood activities / natural resource management efforts?
- How might livelihood activities / natural resource management efforts impact nutrition and community health outcomes?

Connections between family planning decisions and household food security

- How might the timing, number and spacing of a couple's children impact their ability to secure adequate food for the whole family?
- How might a family's food security situation influence a couple's family planning decisions?

Connections between family planning decisions and the sustainability of natural resource management efforts

- How might the number and spacing of a couple's children impact the sustainability of their community's natural resources / natural resource management efforts?
- How might the availability of natural resources influence a couple's family planning decisions?

Connections between family planning decisions and women's engagement in livelihood activities / natural resource management efforts

- How might family planning decisions (regarding the number and spacing of births) impact women's availability to engage in livelihood activities / natural resource management efforts?
- How might women's engagement in livelihood activities / natural resource management efforts influence their family planning decisions and their role in such decisions?

The key is not to suggest answers to these questions but rather to allow community members to voice their opinions, explain their logic and come to their own conclusions. The questions are quite abstract so it may be helpful to ground these discussions in role play scenarios, real-life testimonies and/or storytelling sequences (illustrated PHE story cards are available now via the Madagascar PHE Network's website).

How to develop rights-based PHE messages?

Although discussion-based community mobilisation approaches are likely to be most effective at promoting behaviour change (for the reasons outlined in chapter 14), it may also be appropriate to develop and disseminate PHE messages as part of your integrated community outreach activities, either to prompt further discussions or to reinforce key PHE linkages that you wish to promote.

To avoid any misconceptions about population control, it's a good idea to highlight reproductive rights (free and fully informed family planning choices) when communicating about the connections between people, their health and the environment. Indeed, using reproductive rights and natural resource management rights (or human and ecosystem health) as an umbrella theme can be an effective way of linking priority health-promoting and environmentally friendly behaviours.

Messages should ideally be created in close collaboration with community members and accompanied by illustrations for those with limited literacy. These messages and illustrations should be tested in focus groups with community members before printing and dissemination in order to ensure maximum clarity and acceptability.

Lambahoany (sarong) designed by Blue Ventures and local artist Nady to promote the links between birth spacing and livelihood sustainability in the Velondriake locally managed marine area.

Slogan: *"My choice: to space my births so that I can manage my marine resources well and make my livelihoods sustainable."*

Cartoon designed by Blue Ventures and local artist Nady to prompt discussions about the links between birth spacing and livelihood sustainability within a reproductive rights-based framework.

Slogan: *"Space my births to improve my life, increase my livelihoods and improve my future. Let's all choose!"*

Annex I - supplemental resources for focus group facilitators

Suggested outline for training session with focus group facilitators

- Introductions
  - Personal introductions
  - Introduction to the PHE approach
  - Purpose of these focus groups
  - Icebreaker
- What is a focus group?
  - Small group discussion
  - Open-ended questions (not just yes / no or single word answers)
  - Interactive, two-way conversation (but structured around a topic guide)
  - Qualitative and exploratory research
- How to open a focus group
  - Introduce self
  - Introduce organisation
  - Explain the purpose of these focus groups
  - Propose and agree ground rules
  - Obtain permission if going to record
  - Ask everyone to introduce themselves
  - Icebreaker
- Focus group questions
  - Review each question together to check understanding
- Facilitation
  - Is everyone understanding the discussion? If you're not getting responses, try using different words
  - Is somebody shy? Don't call them out and make them uncomfortable, but you can delicately ask if they have anything to add
  - Is somebody taking over the group? Express appreciation for their input and participation, then try to open up the discussion for others - e.g. "that's interesting, what does everybody else think about that / does anyone else have anything to share?"
- Probing
  - Importance of probing for deeper understanding of issues - e.g. if women say a barrier to contraception use is that their husbands forbid it, you would ask about the reasons why these men forbid it
- Taking notes (for note-takers)
  - No need to write down every word
  - Listen and take note of key themes
  - Summarise information shared from the group for each topic or question
  - If something interesting comes up that does not fit under one of the topics or questions you should still write it down

- Role play
  - Have facilitators practise in the language they will use to conduct the focus groups - this will also allow them to practise facilitation and probing techniques
- Logistics
  - Focus group schedule (which groups / villages when) including pilot
  - Payment of focus group facilitators (if relevant)

Guide for opening of focus groups

- Introduce self
- Introduce organisation
  - History of work in the area
  - Mission and key activities
- Explain the purpose of these focus groups
  - To understand your community's strengths, priorities and needs in order to explore how we might work together to improve the health of people and the environment
- Ask, propose and agree ground rules
  - Everyone's opinions are important
  - Respect everyone's opinions and experiences
  - Listen to each other and allow everybody time to speak
  - Share only what you feel comfortable sharing
  - Don't interrupt when someone else is speaking
  - Confidentiality parameters
  - Does anyone have anything else to add?
- Ask everyone to introduce themselves
- Icebreaker exercise

Facilitation and probing questions for focus group facilitators

Facilitation questions:

- Someone who is shy: *Do you have anything to add?*
- Someone who is dominating the discussion: *That's interesting. What does everybody else think about that / does anyone else have anything to share?*

Probing questions:

- *That's interesting. Can you explain more? What are the reasons for this?*
- *Can you give me an example?*
- If everyone simply says they agree with one person: *Can you please explain in your own words what he/she is saying? Why do you agree?*

Annex II - sample questions for integrated social surveys

Note: The following questions are just suggestive; you should **select** (and supplement) questions in line with the indicators that your PHE programme theory and monitoring plan require.

Introduction

Hello, my name is [surveyor name]. [Organisation names] are working together with communities in this area on [type of activities]. Today we are doing a survey on behalf of [organisation names]. We'd like to gather some information about you and your household relating to your livelihoods, food situation, health practices and family planning choices. We're interested in your views and personal experiences so there are no right or wrong answers. The survey should take approximately [time expected] to complete. Do you understand?

If no - clarify and seek to confirm understanding again.

We'll keep all of the information that you provide confidential. We may publish a summary of some of the information that we collect but we'll make sure that you can't be personally identified in any way. Are you happy to provide the sort of information we've described and for it to be published without any identifying details?

If no - don't proceed.

Your participation in this survey is entirely voluntary. If you choose not to participate, this won't affect your relationship with [organisation name]. If you choose to participate and then change your mind, you can tell us to stop asking questions at any time. Do you understand?

If no - clarify and seek to confirm understanding again.

Do you have any questions now?

If yes - seek to answer them and then ask if you can proceed.

Is everything clear?

If no - clarify and seek to confirm understanding again.

Do you consent to participate in this survey?

If no - don't proceed.

If you wish to withdraw your consent or ask any questions at a later date, you can contact [contact name within organisations] on [phone number] or speak with your community leader and they'll facilitate communications with us.

Household questions

Demographic information

List the sex and age of each household member, and assign each household member a number (if recording livelihood activities below).

For each woman of reproductive age (15-49 years), record the number of live births in the last 12 months.[1]

1 *This is if you'd like to calculate general fertility rate (demographic indicator).*

Livelihood activities[2]

For each household member who is actively working, list the activities that they undertake in order to generate food or income.

Household dietary diversity[3]

Now I would like to ask you about the types of foods that you or anyone else in your household ate yesterday during the day and at night.

> Any rice, bread, noodles, biscuits, or any other foods made from millet, sorghum, maize, rice or wheat?
>
> Any cassava, manioc, potatoes, yams, or any other foods made from roots or tubers?
>
> Any vegetables?
>
> Any fruits?
>
> Any beef, pork, lamb, goat, bushmeat, chicken, duck, or other birds, liver, kidney, heart, or other organ meats?
>
> Any eggs?
>
> Any fresh or dried fish or shellfish?
>
> Any foods made from beans, peas, lentils, or nuts?
>
> Any cheese, yogurt, milk or other milk products?
>
> Any foods made with oil, fat, or butter?
>
> Any sugar or honey?
>
> Any other foods, such as condiments, coffee, tea?

Household food insecurity access[4]

> In the past four weeks, did you worry that your household would not have enough food?
>
> In the past four weeks, were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources?

---

2 This is if you'd like to know the average number of household income-generating / food production activities (cross-cutting indicator), and / or the average proportion of household income-generating / food production activities undertaken by women (cross-cutting indicator).

3 This is if you'd like to know the average household dietary diversity score (cross-cutting indicator). Please see this USAID Food and Nutrition Technical Assistance (FANTA) Project document for more details. The USAID FANTA Project recommends that the timing of surveys including this question should be during the period of greatest food shortage such as immediately prior to a seasonal harvest. When using the 24-hour recall method (recommended for maximum accuracy), the surveyor should first determine whether the previous 24-hour period was "usual" or "normal" for the household. Questions should be asked of the person who is responsible for food preparation or, if that person is unavailable, of another adult who was present and ate in the household the previous day. The questions refer to the household as a whole, not any single member of the household. The respondent should be instructed to include the food groups consumed by household members in the home, or prepared in the home for consumption by household members outside the home (e.g. at lunchtime in the fields.) As a general rule, foods consumed outside the home that were not prepared in the home should not be included. While this may result in an underestimation of the dietary diversity of individual family members (who may, for example, purchase food in the street), the household dietary diversity score is designed to reflect household dietary diversity, on average, among all members. Including food purchased and consumed outside the household by individual members may lead to overestimating household dietary diversity overall. However, in situations where consumption outside the home of foods not prepared in the household is common, you may decide to include those foods. Such decisions should be clearly documented, so that subsequent surveys will use the same protocol and to ensure correct interpretation and comparison.

4 This is if you'd like to know the average household food insecurity access scale score (cross-cutting indicator). Please see this USAID Food and Nutrition Technical Assistance (FANTA) Project document for more details.

In the past four weeks, did you or any household member have to eat a limited variety of foods due to a lack of resources?

In the past four weeks, did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?

In the past four weeks, did you or any household member have to eat a smaller meal than you felt you needed because there was not enough food?

In the past four weeks, did you or any household member have to eat fewer meals in a day because there was not enough food?

In the past four weeks, was there ever no food to eat of any kind in your household because of lack of resources to get food?

In the past four weeks, did you or any household member go to sleep at night hungry because there was not enough food?

In the past four weeks, did you or any household member go a whole day and night without eating anything because there was not enough food?

If yes (to any of the above questions in this section), how often did this happen?

Rarely (once or twice in the past four weeks)

Sometimes (three to ten times in the past four weeks)

Often (more than ten times in the past four weeks)

Health-promoting behaviours[5]

Does your household have any mosquito nets?

If yes, please can you show me these mosquito nets? *(Visual check)*

If yes, did anyone sleep under these mosquito nets last night?

Do you do anything to the water you drink to make it safer to drink?

If yes, what do you do?

Anything else?

I would like to learn about the places where household members wash their hands. Can you please show me where members of your household wash their hands?

(Visual check for water)

(Visual check for soap or ash)

---

5 These are if you'd like to assess uptake of certain behaviours that you may have chosen to promote through your PHE partnership: use of mosquito nets, water purifying solution, handwashing with soap or ash (health indicators). The wording for these questions have been taken / slightly simplified from those used for Demographic & Health Surveys. You can access them in full detail here.

Individual questions

Demographic information

Record sex, age, marital status and highest level of schooling completed.

Participation in natural resource management[6]

Do you attend natural resource management meetings?

If no, does someone go to natural resource management meetings on your behalf?

If yes, do you speak at natural resource management meetings?

Family planning knowledge, attitudes and practices

Now I would like to talk about family planning (the various ways or methods that a couple can use to delay or avoid a pregnancy). Have you ever heard of:[7]

Male condoms
Female condoms
Pills
Injections
Implants
IUDs
Vasectomy (male sterilisation)
Tubal ligation (female sterilisation)
Standard days method (CycleBeads)
Lactational amenorrhoea method
Withdrawal
Have you heard of any other ways or methods that women or men can use to avoid pregnancy?

If yes, please specify:

Now I would like to ask a question about your sexual activity. Let me assure you again that your answers are completely confidential and will not be told to anyone. If you would prefer not to answer this question just let me know and we will go to the next question.

The last time you had sexual intercourse, was a condom used?[8]

Yes / no / never had sex before / prefer not to answer

---

*6 Note: these questions are **not** required to assess the proportion of women and youth attending and speaking at natural resource management meetings (cross-cutting indicator), as these should rather be calculated through meeting records. However, these questions may be worth including if you'd be interested in exploring potential associations between variables such as women's contraception use and participation in natural resource management meetings.*

7 This is if you'd like to know the proportion of people who know at least X number of contraception methods (family planning indicator). The wording for these questions have been taken from those used for Demographic & Health Surveys. You can access them in full detail here.

8 This question may be deemed to be too intrusive for inclusion. You should think carefully about whether you really need to collect such information in this way and consider the impact that asking such a question could have on your organisation's relationship with community members. Ethical approval for such a question is of course imperative.

For women aged 15-49 years only[9]

Do you have any children?

If yes, how many?

If yes, are any under 5 years old?

If yes, are any under 1 years old?

For women aged 15-49 years with a child < 1 year old

How many months did / do you plan to exclusively breastfeed your baby (with no other liquids or solids given)?[10]

For women aged 15-49 years with a child < 5 years old

The last time your child displayed symptoms of diarrhoea / suspected malaria / respiratory infection, did you seek advice or treatment from any source?[11]

If yes, where did you first seek advice or treatment?

Anywhere else?

For women aged 15-49 years

a) Are you with someone right now?[12]

1) Yes

0) No

b) Are you pregnant now?

1) Yes

0) No

If b1 ->

c) When you got pregnant, did you want to get pregnant at the time?

1) Yes

0) No

---

9 These questions should be used to filter respondents for the questions below. If the questions below are not asked then these questions may not be necessary.

10 This is if you'd like to assess uptake of certain behaviours that you may have chosen to promote through your PHE partnership: exclusive breastfeeding for six months (health indicator). Note that this is not a standard question used for Demographic & Health Surveys.

11 This is if you'd like to assess uptake of certain behaviours that you may have chosen to promote through your PHE partnership: formal care-seeking for treatment of common childhood illnesses (health indicator). The wording for this question has been taken / slightly simplified from a set of questions used for Demographic & Health Surveys. You can access them in full detail here.

12 Note: Blue Ventures has used this question as a culturally acceptable yet clear way of asking whether respondents are sexually active because the more explicit question ("When was the last time you had sexual intercourse?") used for Demographic & Health Surveys was deemed overly intrusive locally. You should consult with community-based staff and trusted community members when deciding which question wording to use. Bear in mind the degree of specificity you're aiming for and the impact that asking such a personal question could have on your organisation's relationship with community members. The wording of all of the other family planning questions in this section correspond with those used for Demographic & Health Surveys. You can access them in full detail here.

If c0 ->

d) Did you want to have a baby later on, or did you not want any (more) children?

0) No (more) children

1) Later

If b0 ->

e) Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?

1) Yes

0) No

If e1 ->

f) Which method are you using?

1) Female sterilisation

2) Male sterilisation

3) IUD

4) Injections

5) Implant

6) Pills

7) Male condoms

8) Female condoms

9) Standard days method (CycleBeads)

10) Lactational amenorrhea (exclusive breastfeeding)

11) Withdrawal

12) Other modern method

13) Other traditional method

If e1) ->

g) Where did you get it from?

If b0 ->

h) Would you like to have a / another child, or would you prefer not to have any (more) children?

0) No more / none

1) Have a / another child

2) Undecided

If h1 ->

i) How long would you like to wait until the birth of a / another child?

1) Number of years:

2) Undecided

If e0 + h0 ->

j) You have indicated that you do not want any (more) children, but that you are not using a method of contraception. Could you tell me why you are not using contraception?

1) Not having sex
2) Infrequent sex
3) Menopause / hysterectomy
4) Can't get pregnant
5) Not menstruating since last birth
6) Breastfeeding
7) Up to God
8) Respondent opposed
9) Husband / partner opposed
10) Others opposed
11) Religious prohibition
12) Knows no method
13) Knows no source
14) Side effects / health concerns
15) Lack of access
16) Costs too much
17) Preferred method not available
18) No method available
19) Inconvenient to use
20) Interferes with body's normal processes
21) Family planning makes one infertile (and maybe I want to have another child later)
22) Not interested because what happens will happen
23) Don't know

If e0 + i1 ≥ 2 ->

k) You have indicated that you do not want another child soon, but that you are not using a method of contraception. Could you tell me why you are not using contraception?

1) Not having sex
2) Infrequent sex
3) Menopause / hysterectomy
4) Can't get pregnant
5) Not menstruating since last birth
6) Breastfeeding
7) Up to God
8) Respondent opposed
9) Husband / partner opposed
10) Others opposed
11) Religious prohibition
12) Knows no method
13) Knows no source
14) Side effects / health concerns
15) Lack of access
16) Costs too much
17) Preferred method not available
18) No method available
19) Inconvenient to use
20) Interferes with body's normal processes
21) Family planning makes one infertile (and maybe I want to have another child later)
22) Not interested because what happens will happen
23) Don't know

Top tips for sensitive questions

It's a good idea to put the most sensitive questions (e.g. those relating to sexual practices and family planning choices) at the end of your survey so that respondents can be put at ease by some more general questions at the start. You should test the wording of your questions to ensure cultural acceptability. In some cases you may need to balance methodological rigour with cultural sensitivity.

Proper and thorough training of surveyors is also key to ensuring sensitive questions are asked appropriately. Surveyor training should involve role plays and problem-solving around challenges that may arise when asking sensitive questions. Remember that sensitive questions may include non-health questions as well such as those relating to income or resource management infractions. All such questions must be ethically approved.

Calculating the contraceptive prevalence rate

The proportion of women of reproductive age who are sexually active (a1) and using a modern contraception method (f1/2/3/4/5/6/7/8/9/10/12)

Or

The proportion of women of reproductive age who are married / in union (marital status) and using a modern contraception method (f1/2/3/4/5/6/7/8/9/10/12)

Note: To extrapolate findings to the whole population, the frequencies / proportions from the sample must be weighted appropriately.

Calculating unmet family planning needs[13]

Infecund women

Those not pregnant (b0) who say they are not using a contraception method (e0) because they are menopausal / have had a hysterectomy (j3 / k3) or cannot get pregnant (j4 / k4)

Women with no need for family planning

Those pregnant (b1) who wanted to get pregnant at the time (c1)

Those not pregnant (b0) and fecund (≠ j3/4 / k3/4) who want a / another child within 2 years (i1<2)

Women with met need to space births

Those using contraception (e1) and wanting a / another child (h1) or undecided about having another child (h2)

Women with met need to limit births

Those using contraception (e1) and not wanting a / another child (h0)

Women with unmet need to space births

Those pregnant (b1) who wanted to have a baby later (d1)

Those not pregnant (b0), fecund (≠ j3/4 / k3/4), not using contraception (e0) and undecided about having a / another child (h2) or wanting a / another child in 2+ years (i1 ≥ 2) or undecided about timing of next child (i2)

Women with unmet need to limit births

Those pregnant (b1) who did not want any (more) children (d0)

Those not pregnant (b0), fecund (≠ j3/4 / k3/4), not using contraception (e0) and not wanting a / another child (h0)

Note: To extrapolate findings to the whole population, the frequencies / proportions from the sample must be weighted.

13 This is a slightly simplified way of calculating unmet family planning needs using a selection of Demographic & Health Survey questions. Thanks to Laura Subramanian at Pathfinder International for her guidance on this.

Annex III - PHE partnership MoU template

Memorandum of Understanding

Between

[Organisation name and logo]

And

[Organisation name and logo]

This Memorandum of Understanding (MoU) sets for the terms and understanding between *[organisation name]* and *[organisation name]* regarding their PHE partnership in *[intervention zone]* for the period *[start and end date of initial agreement]*.

Agreement

[Organisation name], based at *[organisation address]* and represented by *[contact person name]*: *[contact person's email address]* and *[contact person's phone number]*,

And

[Organisation name], based at *[organisation address]* and represented by *[contact person name]*: *[contact person's email address]* and *[contact person's phone number]*,

Have agreed the following:

1. Purpose

*[**Insert purpose of partnership** - e.g. to expand the reach of [health organisation name]'s services into [environmental organisation name]'s intervention zone and to integrate community health promotion with ongoing environmental community outreach work with an emphasis on reproductive rights in order to support uptake of these services and increase local capacity for natural resource management.]*

2. Intervention zone

*[**Insert a list of communities served (ideally with population numbers)** and a map if helpful.]*

3. Key activities, roles and responsibilities

*[**Outline key activities, role and responsibilities** - e.g. in a table such as the one below.]*

Activity	Organisation name	Role / responsibility	Completion date (if applicable)
E.g. Deliver family planning services	E.g. Marie Stopes Madagascar (MSM)	E.g. MSM mobile outreach team to visit villages every 3 months and to inform Blue Ventures of their schedule at least 4 weeks in advance	Ongoing
	E.g. Blue Ventures	E.g. Blue Ventures to inform communities of MSM services ahead of quarterly visits by the mobile outreach team	Ongoing
E.g. Train environmental outreach workers to disseminate family planning information and facilitate discussions about reproductive rights	E.g. Marie Stopes Madagascar (MSM)	E.g. MSM to deliver training and provide informational materials to environmental outreach workers	April 2017
	E.g. Blue Ventures	E.g. Blue Ventures to ensure that environmental outreach workers integrate community health promotion into their work plans	Ongoing

4. Shared values

*[**Insert details of any important shared values** - e.g. both organisations are committed to upholding the reproductive rights of the communities served by this partnership - that is to say that all couples and individuals should be able to decide freely and responsibly the number, spacing and timing of their children without coercion or discrimination in line with human rights law.]*

5. Funding arrangements

*[**Insert details of any cost-sharing or sub-granting** - e.g. this partnership involves no transfer of funds between [organisation name] and [organisation name] but is rather based on in-kind contributions in the form of complementary expertise and services. Neither organisation will be required to provide each other with any financial reports under this MoU.]*

6. Operational resources

*[**Insert details of any transport / equipment sharing arrangements** - e.g. [environmental organisation name] regularly makes boat trips between [regional town name] and [remote village name] so will be able to transport [health organisation name] staff at no cost to [health organisation name] when space is available and work plans align. [Environmental organisation name] will also be open to planning regular joint missions with [health organisation name] staff using their boat on a schedule that matches their needs and capacity.]*

7. Data sharing

*[**Insert details of data sharing and any donor reporting requirements** - e.g. MSM will share all service delivery data (number and type of contraceptives distributed) with Blue Ventures via the Madagascar PHE Network every quarter. Blue Ventures will provide MSM with a verbal update on community health promotion activities (including approximate number of people reached) at the quarterly review meetings detailed in Article 8.]*

8. Periodic reviews

[Organisation name] and *[organisation name]* commit to exchanging views about the partnership's progress / activities, outcomes / achievements, challenges / issues and potential solutions / improvements on a quarterly basis through meetings between *[contact person name]* and *[contact person name]*. These periodic reviews will be very important for the development and effective functioning of the partnership so the meeting appointments will be respected by both organisations.

9. Duration, modification or termination

This MoU shall become effective upon signature by authorised officials from *[organisation name]* and *[organisation name]* and shall remain effective until *[end date]* unless modified or terminated earlier.

This MoU may be extended or otherwise modified by mutual written consent of authorised officials from *[organisation name]* and *[organisation name]*. Either organisation may terminate this MoU with a notice period of *[conservative number]* days. Non-fulfilment of responsibilities stated in Article 3 may lead to the termination of this MoU by either organisation without any notice.

Signed on *[date]*

[Signature]

By *[contact person name]*

For *[organisation name]*

[Signature]

By *[contact person name]*

For *[organisation name]*

Annex IV - PHE cross-training workshop outline

Workshop objectives:

1. To increase community health agents' understanding of community-based natural resource management and how it relates to community health promotion
2. To build the capacity of community health agents to contribute to community-based natural resource management and facilitate discussions about health-environment linkages
3. To increase environmental outreach workers' understanding of community health promotion and how it relates to community-based natural resource management
4. To build the capacity of environmental outreach workers to contribute to community health promotion and facilitate discussions about health-environment linkages
5. To jointly design integrated community outreach activities that will advance women's engagement in natural resource management and men's engagement in family health

Workshop facilitators and participants:

1. Programme managers
2. Community health agents and/or health organisation staff
3. Environmental outreach workers and/or environmental organisation staff

Two-day workshop outline:

1. Welcome (introductions, ground rules, icebreaker) - facilitated by a programme manager
2. Overview of the PHE approach (rationale for cross-sector working, importance of reproductive rights as per chapter 1) - presented by a programme manager
3. Overview of community-based natural resource management (objectives, process, challenges as per chapter 10) - presented by environmental organisation staff / environmental outreach workers
4. Specific details regarding community-based natural resource management initiatives in PHE partnership zone (what's being done, where, why and by whom) - presented by environmental organisation staff / environmental outreach workers
5. How community-based natural resource management relates to community health promotion (storytelling exercises / role plays / small group discussion and feedback) - facilitated by a programme manager
6. Brainstorming of ways that community health agents can help to advance community-based natural resource management initiatives (particularly increasing women's engagement) - facilitated by a programme manager

7. Overview of community health promotion (rationale, key health-promoting behaviours, family planning options, behaviour change approaches as per chapters 11, 12, 13 and 14) - presented by health organisation staff / community health agents
8. Specific details regarding community health promotion initiatives and community health services in PHE partnership zone (what's being offered, where, by whom and how frequently) - presented by health organisation staff / community health agents
9. How community health promotion relates to community-based natural resource management (storytelling exercises / role plays / small group discussion and feedback) - facilitated by a programme manager
10. Brainstorming of ways that environmental outreach workers can help to advance community health promotion initiatives (particularly increasing men's engagement) - facilitated by a programme manager
11. Reflection and discussion session regarding the resonance of a rights-based PHE approach with the worldviews and religious beliefs of all training participants - facilitated by a programme manager
12. Summary session coordinating work plans, brainstorming possibilities for sharing resources, and designing integrated community outreach activities - facilitated by a programme manager

Would you like more support with this? Blue Ventures can design and facilitate bespoke PHE cross-training workshops for your organisation and your partners. To find out more please contact pheinfo@blueventures.org.

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