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HEALTH POLICY PROJECT MIDTERM EVALUATION

FEBRUARY 2014

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ACRONYMS

AOR	Agreement Officer's Representative
BCC	Behavior change communication
CA	Cooperative Agreement
CEDPA	Center for Development and Population Activities
CIP	Costed implementation plan
COP	Chief of party
CRA	Commission of Revenue Allocation (Kenya)
DFID	Department of International Development (UK)
FG	Futures Group
FGGO	Futures Group Global Outreach
FP	Family planning
FP2020	Partnership in Action - Family Planning 2020
GF	Global Fund for AIDS, TB, and Malaria
GH	Bureau for Global Health, USAID
GH/AA	Assistant administrator for Global Health, USAID
GIZ	Deutsche Gesellschaft für International Zusammenarbeit (Germany)
HCF	Health care finance
HEPP	Health & Education Policy Project (Guatemala)
HFG	Health Finance and Governance Project
HIDN	Office of Health, Infectious Disease and Nutrition, Bureau of GH, USAID
HIV	Human immunodeficiency virus
HPI	Health Policy Initiative
HPP	Health Policy Project
HQ	Headquarters
HRH	Human resources for health
ICC	Interagency Coordinating Committee on Health Financing (Kenya)
IDUs	Injecting drug users
IQC	Indefinite quantity contract
KM	Knowledge management
LMG	Leadership, Management and Governance Project
LOE	Level of effort
M&E	Monitoring and evaluation

MCH	Maternal and child health
MDG	Millennium Development Goals
MH	Maternal health
MOE	Ministry of Education
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOSD	Ministry of Social Development
MSM	Men who have sex with men
NCD	Non-communicable diseases
NGO	Nongovernmental organization
NHA	National health accounts
NHIF	National Hospital Insurance Fund
OAA	Office of Acquisition and Assistance, USAID
OCA	Organizational capacity assessment
OHA	Office of HIV-AIDS, Bureau of GH, USAID
OGAC	Office of the Global AIDS Coordinator, U.S. Department of State
PAHO	Pan American Health Organization
PASCA	Central American HIV/AIDS Project (Futures Group)
PEPFAR	Presidents' Emergency Plan for AIDS Relief
PETS+	Public Expenditure Tracking Survey Plus
PHE	Population, Health and Environment (Ethiopia)
PRH/PEC	GH Office of Population and Reproductive Health, Policy Education & Communication Division
PMP	Performance management plan
PMT	Project Management Team
PPD-ARO	Partners in Population and Development – Africa Regional Office
PPP	Public-private partnerships
PRB	Population Reference Bureau
PRH	Population and reproductive health
PWID	People Who Inject Drugs model
RAPID	Resources for the Awareness of Population Impacts on Development
RH	Reproductive health/
RTI	Research Triangle Institute – International
TA	Technical assistance
TO	Task order
TOT	Training of trainers

UHC	Universal health care
TWG	PEPFAR Technical Working Group
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WRA	White Ribbon Alliance

EXECUTIVE SUMMARY

EVALUATION PURPOSE

The Bureau for Global Health (GH) at the United States Agency for International Development (USAID) conducted this independent assessment of its Health Policy Project (HPP) from November 18, 2013, through March 21, 2014. The evaluation comes after the midpoint of the agreement as a new HPP director and deputy director of family planning/reproductive health (FP/RH) take over. The purpose is to assess the project's technical approach, client satisfaction, and management. GH also asked for recommendations for this and similar future projects.

PROJECT BACKGROUND

The HPP five-year, \$250 million cooperative agreement (CA) was awarded in late 2010, to Futures Group (FG) as prime recipient, working with PLAN International (formerly the Centre for Development and Population Activities [CEDPA]) Population Reference Bureau (PRB), RTI International, Futures Institute, White Ribbon Alliance (WRA), and Partners in Population and Development Africa Regional Office (PPD ARO). HPP's goal is to strengthen developing country national and subnational policy, advocacy, and governance for strategic, equitable, and sustainable health programming. This goal is addressed through a results framework¹ in close relationship to cross-cutting issues of sustainability, gender, monitoring and evaluation, and reduction of stigma and discrimination. Mission field support provides most of the funding.

EVALUATION QUESTIONS AND METHODOLOGY

The methodology for this evaluation centered on in-depth interviews, supplemented by review of project documents and an HPP self-assessment. In 115 interviews, the evaluation team spoke with members of the USAID management team and with staff of HPP consortium members, local field offices, governments, grantees, nongovernment and donor partners, USAID Missions, and colleagues in the U.S. Office of the Global AIDS Coordinator (OGAC) served by HPP. The team visited Guatemala and Kenya in person and made a virtual visit to Afghanistan.

FINDINGS AND CONCLUSIONS

Technical Approaches

HPP is meeting project objectives using four technical approaches: policy development, advocacy, finance, and governance. There are impressive examples of complex mixtures of these approaches. For instance:

- In Kenya, the government is devolving authority to 47 counties. HPP is assisting the Ministry of Public Health as convener and advisor as the government builds consensus, reorganizes the health ministry, and trains county health officials.
- In Guatemala, HPP is building the capacity of civil society associations and separate observer groups to monitor policies and act as whistleblowers. HPP is also supporting set up of a presidentially mandated public access information system for decision-making and tracking.

¹ FG Technical Application to the Health Policy Project Request for Assistance (RFA) p. 47.

- In Malawi, as a result of HPP assistance parliamentarians have become more engaged in maternal health (MH), family planning (FP) and reproductive health (RH). Female parliamentarians have been equipped to serve as champions for MH/FP/RH and for the first time the government is putting its own resources into FP.

Policy development and advocacy were central to predecessor projects. Finance has become more important as governments move beyond basic legislation and better data makes costing and financial planning more accurate. Though the governance approach is requested less often, when used it can be critical to meeting project objectives. Gender empowerment and reduction of stigma and discrimination are integrated into country work plans.

Monitoring and evaluation (M&E) and knowledge management (KM) are also integral to HPP's work. The M&E strategy covers both internal project needs and assistance to government and nongovernment entities. HPP is currently invigorating the evaluation of its own work to learn more about HPP results.

Capacity building is incorporated into country work plans and measured through the PMP. HPP has demonstrated its commitment and ability to transfer skills and is finalizing resource guides on competencies in capacity building.

Respondents explained how tools and models helped meet objectives. In Ukraine, for example, HIV NGOs working with men who have sex with men (MSM) and injection drug users (IDUs) were concerned with prevention, and government medical personnel were concerned with treatment for HIV patients. The groups were able to use the Goals Model, which links program goals and funding, to help identify more effective and efficient mix of prevention and treatment.

International donor partners articulated great respect for HPP's collaborative approach, country experience, and staff talent on activities like FP2020 (Partnership in Action – Family Planning 2020), the follow-on to Ouagadougou, and a new HIV hot spots activity. Collaboration and cost-sharing with donors is extending HPP's reach.

HPP Management

HPP leaders are highly experienced, and two new regional director positions help meet field needs. However, one of four major personnel positions specified in the Cooperative Agreement (CA) is presently vacant. The HPP matrix management system gives staff a vertical line of reporting but assigns them activities outside their organizational unit. This makes it difficult for the USAID Project Management Team (PMT) to keep track of who is assigned to what.

Futures Group reports that consortium staff members co-located at Futures are contributing usefully, though more engagement of Consortium corporate leadership could be helpful. Co-located staff members feel well-integrated into HPP.

There are HPP country offices in 12 of the 47 project countries. They have access to implementing partners, can sustain momentum, and provide technical assistance (TA) and trouble-shooting. Country directors and teams undertake complex policy assistance using a country-led approach. TA adds value to country team work, and it is commendable that 75% of TA is provided by local staff and experts.

Country Implementation

Missions value HPP country team responsiveness and the quality and timeliness of HPP work. Some Missions reported that startup was slowed by the time it takes for work plan drafting, review, and USAID clearances, though all have improved over the last year.

Country teams report that HPP HQ provides good backstopping on program and financial issues. Country offices and programs regularly report on results and give summary program updates for semiannual reports to GH and the Performance Management Plan (PMP). They also report to USAID and PEPFAR teams in-country, some of which have stringent reporting requirements. In some cases, the length or format of routine reporting makes it difficult to explain thoroughly what is happening in the field.

Core Activities

The HPP core activities portfolio incorporates operational and economic research, modeling, and investigation of new approaches, but the universe of activities lacks strategic focus, partially or perhaps substantially due to the fact that core funding comes from numerous accounts and, for HIV activities, subaccounts.

Core activities sometimes have difficulty garnering Mission support for fieldwork and in HIV HPP must deal with slow obligation of funds and multiple interactions with PEPFAR Technical Working Groups (TWGs). There is also concern about HPP being out of the loop on USAID planning for significant global health initiatives. The evaluation team also questions whether the HPP conceptual framework for linkages between policy and health systems and health outcomes will have the necessary impact as the activity moves into fieldwork. These issues are solvable but will require senior management attention, and in some cases further funding.

Client Satisfaction

There is a consensus that this is the preeminent policy project in global health. “Policy” and “advocacy” were most often mentioned as its comparative advantage. Examples given of what HPP does well and what it is known for are:

- In RH/FP: policy development and implementation, advocacy, tools and modeling, use of data for decisions, costing and finance related to funding gaps, resource mobilization, contraceptive security, and women’s empowerment.
- In HIV: policy development and monitoring, advocacy, reducing stigma and discrimination, civil society and networks, tools and modeling, key populations (MSM, IDUs), gender (including MSM and transgender people), and costing and finance related to increased country ownership.

Missions say that HPP country offices are critical because they are technically strong, flexible, responsive, collaborative, and client-centered. Both Missions and host governments say the project has a genuine country-led approach,

The Future

Although missions like using the field support mechanism for a policy project, they feel the five-year timeframe is too short for significant policy development.

The recommendations resulting from the evaluation call for HPP to continue its good work in meeting objectives, building capacity, and ensuring that models and tools are user-friendly. Some

are directed to HPP and USAID focus on continued work to meet staffing needs, address a few Mission concerns, and improve the efficiency of reviews and clearance and of communication between HPP and the PMT. There are also recommendations for addressing barriers to core activities, such as taking a more participatory approach to designing fieldwork, and improving internal and partner coordination as GH engages in global initiatives.

On the technical side, future policy projects could incorporate emerging trends and needs, such as “transitions”—activities related to devolution, decentralization, and graduation from donor support; “equity”—meeting objectives for reducing stigma and discrimination, key populations, gender, youth, and human rights; universal health care; and noncommunicable diseases. Other recommendations for the future are for early dissemination of policy development and project experience, and perhaps considering the development of local policy development entities.

I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this performance evaluation is to provide the United States Agency for International Development (USAID) Bureau for Global Health (GH) with an independent assessment of the USAID Health Policy Project (HPP) Cooperative Agreement (CA). The evaluation, which comes after the midpoint of the agreement, assesses HPP's technical approach, client satisfaction, management structure, processes, and staffing patterns. GH also asked for recommendations for this and future projects and for information on emerging global health issues relevant to the project.

EVALUATION QUESTIONS

The team was asked to cover these three tasks:

Task 1: Assess the HPP technical approach to achieving project objectives: its quality, progress in taking the program forward, and how the management structure, processes, and staffing patterns have helped or hindered progress toward achieving project goals.

Task 2: Measure the satisfaction of GH offices, Missions, Regional Bureaus, PEPFAR, and OGAC in-country teams, as well as other clients and partners.

Task 3: Provide feasible recommendations to be incorporated into the management and conduct of future projects. Assess options for implementing the highest-priority recommendations. Identify current and emerging trends in policy, advocacy, financing, and governance.

See Annex I for the evaluation Scope of Work.

II. PROJECT BACKGROUND

PRIOR USAID/GH INVESTMENT IN HEALTH POLICY WORK²

USAID has invested in centrally-managed projects related to health policy for more than 30 years. The main projects have been RAPID I-IV (FY78–95), OPTIONS I-II (FY86–95), POLICY I-II (FY95–05), and the Health Policy Initiative (HPI) (FY06–10), which all provided technical assistance (TA) for formulating policies related to family planning (FP), maternal health (MH), and later HIV/AIDS.

HPP's immediate predecessor, HPI, was a five-year multiple-award indefinite quantity contract (IQC) with global Task Order 1. The primary contractors were Abt Associates, Chemonics International, Futures Group International, and Research Triangle Institute International. HPI's main objective was to enhance the enabling environment for health, especially for FP/RH, HIV/AIDS, and MH. Futures Group, RTI, and Abt were awarded HPI TOs. Futures Group had 6 of the 8 task orders (TO1; South Africa, Peru, Central American HIV/AIDS Project (PASCA), and Tanzania; and the costing TO). RTI had the TO for the Mekong region and China and Abt the TO for Vietnam. TA covered policy, advocacy, health financing, resource allocation, multisectoral coordination, and improving the knowledge base for health decision-making. Core-funded activities were supported to advance USAID's technical leadership in global policy and advocacy in priority.

DESIGN OF THE HEALTH POLICY PROJECT (HPP)

The HPP was competitively awarded as a CA late in 2010. This five-year project has an estimated life-of-project funding of just under \$250 million. The prime awardee is the Futures Group but the award also includes a consortium of partners: PLAN International (formerly known as the Centre for Development and Population Activities [CEDPA]), the Population Reference Bureau (PRB), RTI International, Futures Institute, White Ribbon Alliance (WRA), and Partners in Population and Development Africa Regional Office (PPD ARO). The majority of funding comes from Mission field support, the rest from GH, USAID Regional Bureaus, and OGAC.

The HPP carried forward most of the essential technical contents of the HPI, but with much more emphasis on capacity building. Like the Global Health Initiative and PEPFAR II, the HPP RFA stated that HPP would

strengthen the engagement of host countries in leadership, decision-making, and management of their health programs. Technical assistance supports national strategies to develop the long-term capacity of governments to direct, manage and finance their health programs. Emphasis also is placed on supporting multi-sectoral donor and host country coordination in the development and implementation of health sector strategies.³

² Material in the section is drawn mainly from the HPP RFA, 2010, pp. 37–38.

³ HPP RFA, p. 38.

In-country programming funded with field support contributes to HPP goals by building individual and institutional capacity for critical governance areas and national and subnational leadership. TA covers

- Policy development and implementation
- Financing and allocation of resources
- Advocacy and policy communication
- Closer multisectoral coordination and stakeholder/civil society participation
- Use of data and monitoring and evaluation (M&E) for informed decision-making and strategic planning
- Transparency and financial accountability
- Building up country and regional institutions to support long-term capacity development.

Core-funded activities are policy analysis, health systems strengthening, health governance and financing, building advocacy capacity, and advancement of global knowledge-sharing.⁴

HPP RESULTS FRAMEWORK

HPP addresses its goal through the results and subresults presented in the Detailed Results Framework⁵ (table 1), in close relationship to the cross-cutting issues.

Table 1: HPP Detailed Results Framework

<p>Activity Objective: Strengthen developing country national and subnational policy, advocacy, and governance for strategic, equitable, and sustainable health programming.</p>
<p>Result 1: Individual and institutional capacity for stewardship, policy development, implementation, and financing strengthened</p> <p>1.1: Strengthen capacity to lead and manage strategic policy direction, development, and implementation.</p> <p>1.2: Strengthen capacity cost policies, identify revenue sources, and effectively and equitably allocate and expend resources.</p> <p>1.3: Strengthen host country policy and governance undergraduate, graduate and continuing professional development programs.</p>
<p>Result 2: Individual and institutional capacity for advocacy, accountability, leadership, and ownership strengthened.</p> <p>2.1: Build developing country capacity to effectively advocate for policies that support equitable and sustainable health programming.</p> <p>2.2: Strengthen accountability for health policies and programs.</p> <p>2.3: Build in-country leadership and ownership of FP/RH, MCH, and HIV/AIDS issues and policy responses.</p>

⁴ HPP Mid-term Evaluation Scope of Work, p. 2.

⁵ Futures' Technical Application to the HPP RFA, p. 47.

<p>Activity Objective: Strengthen developing country national and subnational policy, advocacy, and governance for strategic, equitable, and sustainable health programming.</p>
<p>Result 3: Individual and institutional capacity for strategic data use, analysis, and evidence-based decision-making increased.</p> <p>3.1: Strengthen data analysis use and modeling skills for advocacy and strategic planning.</p> <p>3.2: Strengthen capacity to assess, monitor, and evaluate implementation of policies and impacts on health outcomes.</p> <p>3.3: Support incorporation of modeling techniques, tools, and best practices into university and institutional curricula and training programs.</p>
<p>Result 4: Multisectoral coordination for advancing health elements, systems strengthening, and program integration increased.</p> <p>4.1: Support development of strengthened processes for multisectoral policy dialogue, stakeholder participation, and coordination.</p> <p>4.2: Advance practices for coordinated financial planning, including participation of the private sector in delivery of health services.</p>
<p>Result 5: Development, dissemination, and uptake of models, tools, and global best practices advanced.</p> <p>5.1: Develop, validate, and apply new and existing technologies, tools, and methodologies to advance knowledge and generate information for evidence-based decision-making.</p> <p>5.2: Promote innovative collaborations and partnerships to advance global knowledge sharing and in-country use of promising evidence-based practices, tools, and methodologies.</p>
<p>Cross-Cutting Issues: Gender, health equity, reducing stigma and discrimination, and monitoring and evaluation</p>

The Futures Group and its consortium began to implement HPP on or about October 1, 2010.

USAID’s March 2012 Management Review of the HPP project recommended that it “develop ‘thematic’ areas” beyond population and HIV as a way to build a stronger constituency for the Project’s work and encourage more cross-fertilization among project activities.”⁶ In response HPP now presents its semiannual reports on FP, RH, HIV, and MH using policy, advocacy, governance, and finance as themes to organize reporting, and the reports also discuss the crosscutting areas of capacity building, M&E, gender, and reduction of stigma and discrimination.

⁶ Health Policy Project (HPP) Management Review, March 2012, p. 1.

III. EVALUATION METHODS AND LIMITATIONS

This assessment was conducted from November 18, 2013, through March 21, 2014, by the two-person team of Constance Carrino, Ph.D., former director of the Office of HIV/AIDS (OHA) and deputy principal for PEPFAR, and Richard M. Cornelius, M.A., former senior health policy advisor for USAID's Program and Policy Bureau and deputy director of the Office of Field and Program Support in the USAID Global Health Bureau.

The main evaluation methodologies were document review and in-depth key informant interviews. The team reviewed major project reports, official agreement documents, and project strategies. Annex III lists documents consulted. They also applied their own experience with health policy approaches and programs. In cooperation with the AOR and her management team, the evaluators drafted guideline questions for the interviews and a set of self-assessment questions for HPP to answer in writing

Between December 2, 2013, and January 23, 2014, the team held wide-ranging interviews with 115 stakeholders including the AOR and members of the USAID project management team, HPP staff, consortium members, HPP field office staff, grantees, and government, nongovernment, and donor partners, USAID Missions, and OGAC colleagues served by HPP. (Annex II lists those interviewed and annex IV contains the interview guide.)

To thoroughly investigate the questions posed in the SOW, the team made case study visits to Guatemala December 9–13 and Kenya December 16–20, 2013 and conducted a virtual case study review in Afghanistan January 20–22, 2014. In each country Missions identified a wide range of stakeholders to be interviewed from the Mission, the national government, the NGO community, and HPP country offices. In Kenya, the team also interviewed international donor partners and in Guatemala private subcontractors.

To elicit discussion, different open-ended questions from the interview guide were chosen for each category of stakeholders: USAID Management Team, Futures, Consortium, country offices, Missions, and partners. As the team moved through the initial interviews, the questions were edited for clarity. To answer the questions posed in the SOW the team collected experiences and opinions from people from different cultures, work environments, and roles within and outside HPP.

Team members conducted most of the interviews together but each did some individually. All interviews were collated into a master document to facilitate analysis by task and question. Because interviewees were assured that answers would not be attributed to them, GHTech was given a redacted version of the notes.

The self-assessment questions for the Futures Group gave the prime cooperating agency an opportunity to provide carefully prepared responses to some key questions (see annex V), which proved very useful. Answers to several those questions are referred to below.

Mission schedules and priorities changed the timing of the case studies and the holiday season slowed the interview schedule. Initially, the end-date of the GHTech Bridge-4 agreement with USAID precluded extending the timeframe. Recognizing the problem USAID cut the list of

people to be interviewed. Still, due to work commitments or non-responses, the team was unable to interview the Agreement Officer in the USAID Office of Acquisition and Assistance (OAA) and staff in two Missions, Jordan and Mozambique. Nevertheless, the team collected a considerable amount of information to analyze.

The case study countries were from three different regions (Africa, Asia, and Latin America), and each case had a rich variety of policy work areas. However, all three have received a substantial investment of HPP human and financial resources, so the results achieved in these programs are not necessarily typical.

IV. FINDINGS

TECHNICAL APPROACH, MANAGEMENT STRUCTURE, AND STAFFING

Technical Approach

Principles and Approaches

As large, complex, and technically diverse as this project is, there was consensus among respondents as to its principles and building blocks. Highest on the list of approaches that HPP uses are these:

- Evidence-based knowledge and analyses to influence and make policy decisions
- Models and tools to analyze, guide decisions, and give those using them credibility with their audiences
- Collaborative approaches that are strategic and well-informed
- Local expertise whenever possible.

Generally, evaluation respondents each identified several technical approaches taken by HPP:

- *Policy development*: Developing an enabling environment, and advising government on developing and implementing policies, strategic and operational plans, laws, or commitments at local, national, regional, or global levels.
- *Advocacy*: Raising the awareness of government, thought leaders, and the public to improve formulation, implementation, and elicit government accountability for policies and programs.
- *Governance*: Advising governments through critical transitions, such as devolution, reorganizations, and stewardship of the private sector; assisting non-governmental organizations or groups of NGOs to create their own systems of governance to function as valuable partners in the health sector.
- *Finance*: Advising governments on health care financing (HCF), e.g., UHC and resource mobilization. Helping to conduct and interpret national health accounts (NHAs) and public expenditure surveys.

Respondents noted that policy development and advocacy, along with creating models and tools to help with implementation, have been the approaches of predecessor projects for 20 years. Finance and governance are newer, and growing, priorities.

Finance and systems strengthening were not among the approaches put forth when HPP began in 2010; however, the USAID management team and the project's directors explained that a Task Order (TO) from the predecessor HPI for costing work extended into the HPP timeframe and thus covered the approach at first. Respondents also noted, and work plans in countries like Afghanistan, India, and Kenya corroborated, that finance has assumed higher priority as governments move beyond legislation to analyze and implement policies, especially subnational.

Though requested less often, the governance approach can be critical for meeting objectives, as with devolution in Kenya, government transparency in Guatemala, and human rights monitoring in Ghana. In Guatemala, for example, HPP's multisectoral work on expanding decision-maker use of accessible information and putting information into the public domain relies on a three-tiered governance, technical, and technology structure, with governance coming from a ministerial group. The Minister of Education and technical leads in the ministries of Education, Health, and Social Development noted that governance has been critical to designing and now rolling out the initiative.

In technical areas, HPP has provided tracking and training tools, models, costing analyses, M&E constructs, and capacity building, and respondents also recognized that the project was addressing crosscutting issues.

Meeting objectives

On the ground multiple technical approaches operate at once, and the environment is also complicated by multiple constituencies and policy issues. Respondents discussing successes mixed results with activities needed to expand once a result is obtained. Policy development or commitment building in one stage leads to implementation or fine-tuning in another. For example:

- In Kenya, the national government is devolving authority to 47 counties. HPP is assisting the Ministry of Public Health (MOPH) as convener and advisor as the government builds consensus, reorganizes the health ministry, and trains county health officials. HPP similarly helped strengthen Kenya's new Commission of Revenue Allocation (CRA) and the Interagency Coordination Committee (ICC), and provides technical expertise to government and World Bank surveys (e.g., 2014 NHA, Household Expenditure Survey and Public Expenditure Tracking Survey Plus [PETS+]). HPP also helped the government to convene stakeholders for the National Hospital Insurance Fund (NHIF) and provides state-of-the-art costing analysis for HIV program decision-making.
- In Guatemala, HPP is building the capacity of departmental and national civil society organizations and separate observer groups to monitor and whistle blow if policies, such as using alcohol tax revenue for FP commodities, are not carried out; the project used the Spectrum Policy Modeling System⁷ to conduct country-level analysis and publish results in user-friendly formats; and formulated strategies for civil society to encourage mayors and national policymakers to commit to national health goals, such as the MDGs. HPP is also supporting installation of information systems in the ministries of Education, Health, and Social Development to allow public access to decision-making and tracking.
- In Malawi, parliamentarians are more engaged in MH, FP, and RH because of HPP assistance; women in Parliament are equipped to serve as champions; and for the first time, the government has invested its own resources in FP. HPP works with religious groups to improve their support for FP and has trained several NGOs on modeling so they can do evidence-based advocacy. It is also supporting the Ministry of Gender on better coordinating

⁷ The Spectrum Policy Modeling System consolidates a series of models (there are currently 9) to use separately or together to analyze demographic, manpower and financial aspects of a wide range of global health and development issues.

its various departments; the ministry has created a task force and trained staff on ways to improve teamwork.

- HPP has helped governments to honor their Ouagadougou commitments⁸ through action meetings of parliamentarians convened by PPD ARO, including special training and meetings for female parliamentarians, and by helping leaders in Malawi, Uganda, Ghana, and Ethiopia review, analyze, and ground-truth their implementation plans.

The informed opinion of those interviewed was that in these examples and others HPP's work was very important, if not critical, for meeting its objectives. Yet because the work is multidimensional, HPP evaluation experts find it difficult to mount meaningful empirical research.

Models and Tools

Respondents noted that HPP's approaches, especially policy development and advocacy, have been honed over time by members of the consortium to meet the priorities of USAID, host governments, NGOs, and donors. In recent years, thanks to HPP tools and based on actual data, more is known about unit costs and estimates. HPP brings costing into models for resource allocation, targeting, and mobilization at the international, national, and subnational levels. Malawi's experience with using the Resources for the Awareness of Population Impacts on Development (RAPID) model is a case in point:

- More than two decades ago a RAPID presentation helped raise the awareness of Malawi leaders about the development consequences of rapid population growth. An international presenter showed scenarios on an attractive, small computer. This generation's RAPID allows country experts and health experts in Malawi to use local and real cost data to populate the model and train local health officials to use it for planning and budgeting.

Among tools and models HPP offers are the Costed Implementation Plan (CIP); Stigma and Discrimination Healthcare Measurement; Policy a Analysis and Advocacy decision model for People Who Inject Drugs (PWID) and another for MSM, transgender people, and sex workers; and RAPID Women, Demographic Dividend, ImpactNOW, GAP tool, One Health, and online resources on What Works for Women and Girls. The models help governments, advocates, and technical experts understand the dynamics, alternatives, and costs of public policy decisions. The Futures Group's Center for Development Informatics also contributes expertise that serves the needs of the Guatemala program, among others, both directly and virtually.

Respondents explained how such models helped meet objectives:

- In Ukraine, the Goals Model was used to compare scenarios for prevention and treatment. Together HIV NGOs working with MSM and IDUs focused on prevention and government medical personnel concerned with HIV treatment could look at scenarios and identify effective and efficient options for both.
- In Guatemala, regional and department-level NGOs learned how to use the Spectrum model for local FP/MH advocacy.

⁸ Commitments refer to those made by governments at the 2011 International Conference on Population, Development, and Family Planning, West Africa Call to Action, held in Burkina Faso.

- In Nigeria, the government is using a RAPID model to bring people together. Advocates get reliable data, ministries share data, and trainees use it in their own programs, such as government commissions.

Respondents representing government offices, NGOs, and community networks reported that HPP tools were helping them in such areas as M&E (India and Afghanistan); organizational assessment and capacity building (Caribbean); FP/MH advocacy (WRA countries); health facility surveys (Africa); finance and costing analyses (Kenya); and decision making (Guatemala and Ukraine).

For the most part, Missions and local partners working with HPP are clear about the project's technical approaches and tools and models and are convinced that these have helped meet their objectives. Nevertheless, the respondents are not always aware of HPP experience with other approaches, e.g., in Kenya some are not aware of the project's advocacy work; in Guatemala, its work in finance is not known.

Donor Coordination

Another project approach is coordination and joint programming with other donors, which within a country extends the reach of its networking, convening ability, and at times resources. In work plans other donors are specified when an activity, e.g., a public expenditure survey, is co-funded or when donors are among those being convened for a meeting or activity to develop consensus. And while USAID Missions usually take the lead in health sector donor groups, HPP country teams often have more day-to-day contact with donors on technical issues.

At the international level, HPP provides technical analysis, staff expertise, and in-country follow-up to major donor initiatives. International partners articulated great respect for such contributions on activities such as FP2020, the Ouagadougou follow-on, and the new HIV Hotspots TA to the Global Fund (GF). However, both project leadership and USAID managers felt that USAID could do a better job of preparing for major international initiatives, especially meetings. For example, during the recent FP meeting in Ethiopia⁹ both HPP and the GH Bureau were involved, but HPP had little insight into USAID objectives or plans for the meeting, and policy staff in GH felt they also lacked information about USAID's vision and planning for the meeting.

HPP Management Structure and Staffing

HPP Management Structure

The HPP project director functions as its CEO with full management control of staff and operations and is ultimately accountable for project performance. The director also corresponds directly with USAID and formally represents HPP before the USAID AO and AOR. Dr. Sarah Clark served from inception of the project until December 31, 2013; and Dr. Suneeta Sharma succeeded her as of January 1, 2014. Next in command is the senior deputy director, Nancy McGirr, who has full authority to act in the director's absence. Her main responsibilities are to oversee HPP financial and administrative operations.

The structure of the rest of the management team has evolved over the years. For the first three years the management team was composed of the director, senior deputy, and technical deputy directors for HIV and for FP/RH, who managed work plan submission, tracked their own

⁹ International Conference on Family Planning, Addis Ababa, Ethiopia, November 12-15, 2013

portfolio activities, managed staffing, and monitored budgets. Initially, field support was managed by a single global country coordinator.

As the field support program grew so much that it was no longer manageable by one person, global country coordinator responsibilities were divided between two new regional directors. As HPP leadership recognized that cross-cutting issues were not receiving focused management attention, a deputy director for cross-cutting issues was added. The expanded management team meets weekly for problem-solving and management.

HPP also started with five technical directors, for M&E, gender, knowledge management, capacity development, and MH. As the portfolio of costing activities grew, a technical director for finance and costing was added. The USAID Project Management Team (PMT)¹⁰ meets with some of the technical directors monthly to discuss technical and management issues.

The evaluation team interviewed the project director, all the deputy and regional directors, and several technical directors. These are all highly qualified and motivated and have many years of experience in their areas of responsibility. Although the number of senior managers seemed large at first, it appears that the changes HPP made in the management structure were warranted by the need for strong and consistent leadership as the portfolio of activities spread over an ever-larger number of technical and cross-cutting areas.

In the CA the project director, the technical deputies for FP/RH and HIV/AIDS, and the technical director for capacity development are designated as key personnel. The evaluation team is therefore concerned about the difficulties HPP has had in attracting a qualified technical director for capacity development.

HQ Staffing Structure

As of December 31, 2013, HPP headquarters staff consisted of 90 technical staff and managers from the Center for Policy and Advocacy in Futures Group, other Futures Group staff, and full- and part-time staff in partner organizations.¹¹ Represented on the staff are well-qualified demographers, economists, public health specialists, political scientists, sociologists, anthropologists, mathematicians, advocates, trainers, clinical staff, communications specialists, editors, graphics designers, and writers. The skilled Futures team of program operations and financial management staff also support HPP.

Futures uses a matrix management model at HQ where staff members have a vertical line of reporting, but where they are involved with a number of activities managed outside their organizational unit.

Staff Skills Mix and Deployment

Staffing assignments are made according to the skills, interest, availability, and geographic expertise of each individual because activity budgets rarely allow full-time application to a single activity. One activity may require several specialized skills, such as survey review, advocacy tool development, modeling, training, costing, M&E, and capacity development. It is not unusual for a single staff member to work on three activities, field or core, serving as activity manager on one and as a critical technical resource within a multidisciplinary team on others. This flexibility is

¹⁰ The PMT includes the AOR, GH/PRH Program Analyst for the Project, three members from the GH Office of HIV/AIDS, and one from the GH Office of Health, Infectious Disease and Nutrition.

¹¹ The reported number of HQ staff (90) includes those working at least 50% of their time on HPP.

meant to allow for maximal application of the skills and talents of the individual. In assignments consideration is also given to encouraging professional development, and staff members are encouraged to identify activities that they believe would be a good fit with their interests and skills.

In addition to project assignments, staff members typically have a supervisory role at the home institution. Individual staff members are generally supervised in the organization where the majority of their funding originates (Futures Group, RTI, Plan, Futures Institute, PRB, or WRA) and follow its organizational structure and review schedule, with input from HPP managers. For centrally funded activities, a manager is usually assigned to lead an approved activity. For field activities, HQ staff generally have coordinating roles (e.g., as a country focal person) or provide TA or capacity development, with most of the work in-country conducted by field staff or consultants.

Managing this process can be tricky. Activity schedules are often not predictable or smooth. An activity may be delayed for any number of reasons, such as the review process or absence of a key contact, so an assigned staff person is no longer available when needed and an alternative must be arranged.

This process may look inefficient, but since the goal is to optimize technical expertise and capacity development, it typically works well, based on interviews with nearly all HPP staff and many of the USAID AOR/PMT staff. One drawback may be that accountability is not always clear, so it is hard to know how or when to reshape a lagging activity. However, there are weekly management updates where problems can be identified.

One concern some USAID PMT members raised is that HQ staffing assignments and changes are not transparent, so that it is very difficult for the PMT to keep track of who is assigned to what activities at any given point and whether members of a team have the requisite skills. This causes frustration. The evaluation team was able to obtain from Futures Group a table, current as of late 2013 (see annex VI), showing staff assignments to all core-funded activities and the case-study countries for this evaluation.

HPP HQ Support to Country Offices and Representatives

One of the most important roles of HQ is to provide technical and administrative support to field staff and consultants implementing FS-funded field activities. Field staff was asked to comment on how helpful HQ has been in providing the support they needed.

Several respondents expressed appreciation for the support they receive from the country focal point (backstop) and from administrative operations staff. One country office director described HQ colleagues as “great advisors or sounding boards” as issues come up. Another commented that HQ support was especially crucial to her in the early days, before her office was fully staffed. Often, there are weekly phone calls between the country focal point and the country office director and calls or emails to other HQ staff to follow up on specific items. Country office staff also said they greatly appreciate the visits they receive from HQ technical or management staff.

Field staff also had ideas for enhancing HQ support. One country office director noted a growing need for TA from HQ on health financing, to mirror HQ support in costing. Another field staffer expressed frustration with HQ progress reporting limitations, stating that the text

she sends is edited so much that it no longer conveys what is going on. A review of country reporting indicates that is hard for large HPP programs to get comprehensive stories out.

Use of Consortium Partners

The Futures Group strategically selected its HPP consortium partners based on capabilities, expertise, and experience they brought on all facets of the work. Its primary strategy for integrating partners into HPP activities has been to co-locate full-time partner staff in their office. The interviews indicated that co-located staff members are functioning well as members of the HPP team and there are regular meetings and informal discussion on such matters as project design. Futures Group also draws on the deep expertise of partners through short-term TA on core and field activities. Annex VII shows partner involvement in HPP activities for the past six months.

In addition to work on individual activities, partners also have provided technical leadership and direction to HPP. For example, for a time PLAN International provided the Director for Capacity Development; PRB provided the first KM director; RTI contributes technical leadership in stigma and discrimination, and governance, Futures Institute technical leadership in modeling and HIV costing, and WRA technical leadership for MH.

In the interviews, USAID staff, Futures Group HPP staff, and partner HPP staff were asked whether they thought consortium partners were adequately involved in the project. Responses varied as follows:

- USAID staff all thought some partners were being used more than others, although they did not necessarily agree on which were used most. The overall view, though, was that the partners could be more involved.
- Futures staff all stated that co-located partner staff were functioning very well and making important contributions but felt partner corporate leaders were not as engaged.
- Partner staff co-located at Futures all said they feel very much integrated into the HPP work and are treated just like Futures staff.

The project communication channels ensure that all staff and partners have access to key information (working group meetings, management meetings, newsletters, an intranet, etc.) and opportunities to contribute to planning and project design. As recommended in the 2012 HPP management review, Futures Group has instituted quarterly partner meetings in DC to provide a forum for senior corporate, USAID, and technical leadership to contribute ideas, strategies, and commentary.

Country Offices

There are country offices in 12 of the 47 countries where HPP is working. Usually they are strictly HPP offices, but in some HPP staff may be co-located with staff working on other Futures Group projects. The evaluation team is convinced that these country teams represent a HUGE asset to the project, for several reasons. Having a country office results in far easier access to implementing partners, leading to more sustained momentum and far more frequent opportunities for TA and trouble-shooting than less frequent short-term visits by US-based TDYers.

Country offices are exclusively or predominantly staffed with local experts who are already known and respected, making it easier for them to gain the trust of local partners. Local staff members know the language, the culture, and the local political context. Although the costs of maintaining a country office are not insignificant, they appear to be offset by lower labor costs than for expatriate staff or consultants.

Feedback from partners working with HPP country offices was generally positive. Key words describing HPP the team heard over and over from them were “very responsive” and “flexible,” indicative of a very client-oriented approach to project implementation. Although a few country offices are not as strong as others and have had problems of leadership turnover, uneven staff performance, and difficulties recruiting qualified staff, HPP country offices generally are doing excellent work and are contributing to project objectives, particularly in capacity building and promoting country ownership.

HPP HQ contributes standardized operational procedures for HPP work, which according to country teams are then adapted to the local context. Country teams have regular contact with country point persons in HQ and have access to other HQ experts.

However, HQ micromanagement and multiple layers of review appear to a problem. One USAID officer stated, “There is micromanagement from HPP HQ, and this was the main reason the COP left. This problem was discussed with the HPP AOR.” An HPP staffer had a similar complaint: “Too many people review what we do. Three review and the third person disagrees with what the first one said. It would be better if they got together and could agree on one set of comments.” Technical review is needed to maintain quality control, but if multiple levels of review slow the project, they can undermine both performance and morale.

In most countries Missions also have management requirements. In Jamaica the country office must report biweekly (though briefly) to the Mission, quarterly to HPP, and annually to PEPFAR. In Afghanistan, HPP provided input for ad hoc congressional requests and data for a country database.

Management of HPP Technical Assistance

HPP provides TA covering the full range of technical areas and cross-cutting issues listed in its Results Framework.¹² It also strives to support partner countries in addressing (1) promotion of health equity, (2) significance of gender issues, (3) reduction of stigma and discrimination, (4) effective M&E of project activities, and (5) sustainability of skills with institutional and individual capacity building.

Missions and host country partners, the evaluation team was told, most often ask for assistance in policy development and implementation, financing and resource allocation, advocacy, accountability and civil sector participation, and use of models for evidence-based decision-making. Among the cross-cutting issues, TA was also requested on gender, M&E, key populations, and reduction of stigma and discrimination.

Interviewees were asked about the sources of TA and upon request Futures Group also prepared a table showing the percentage distribution of 2013 TA from various sources (table

¹² See HPP Detailed Results Framework, in the Project Background section above

2).¹³ In 2013, the table shows, 75 percent of field TA was provided by in-country staff, which supports the HPP goal of building local capacity. The next highest LOE (14 percent) comes from Futures Group HQ staff providing TA to field programs.

table 2: Level of Effort Days for Field Support, January–December, 2013¹

Region/Country	HQ staff	In-Country staff	Partners	U.S./Global Consultants	Local Consultants
Africa					
Botswana	107		260		
Côte d'Ivoire		1	1		54
Ethiopia*	352	1,663	15		
Ghana	152	97	72		57
Kenya*	1,128	2,806	116	4	163
Malawi*	236	502			317
Mali (thru 5/31/13)*	1	625			
Mozambique	395		53	24	233
Nigeria	237	322		2	10
Swaziland	7		15		
Uganda	154		55		
West Africa (Benin, Togo, Burkina Faso, Guinea, Mauritania)*	421	255		31	287
Zambia	6				
Zimbabwe	38				
AME					
Afghanistan*	1,076	17,488	155	506	
AME Bureau (Timor Leste, Nepal, Laos, Cambodia, Philippines)	715	1	151	7	218
Central Asia Republic	40			24	
India*	196	3,406	65		32
Jordan (thru 9/30/13)*	426	449	12		489

¹³ Table C presents LOE in days charged from January 1 to December 31, 2013, for HPP field support countries and regions, by source of the TA. The categories include FG HQ staff; in-country FG personnel; sub-recipient partner labor for RTI International, FI, Plan, PRB, and WRA; and FG consultants as either U.S./Global support or in-country local assistance. Programs with a country office are designated with an asterisk. Because the Mali, Jordan, E&E Bureau, and Russia programs ended in 2013, their level of effort (LOE) does not cover a full 12 months.

Region/Country	HQ staff	In-Country staff	Partners	U.S./Global Consultants	Local Consultants
E&E Bureau (thru 7/31/12)					
Russia (thru 8/31/13)	10				
Ukraine	93		9		461
LAC					
Caribbean Region (St. Kitts and Nevis, Dominica, Barbados, Antigua)*	190	21	30	164	11
Dominican Republic*	365		14		153
Guatemala*	227	8,764	46		181
Jamaica*	269		3	23	441
Latin American and Caribbean Regional Sustainable Development	54				13
TOTAL	6,883	36,400	1,070	785	3,120
% of Total LOE	14%	75%	3%	2%	6%

¹ HPP Self Assessment, pp. 27-8.

* In-country HPP office.

USAID AOR and PMT

The Agreement Officer's Representative (AOR) in GH/PRH/PEC provides technical direction to HPP management to help Futures Group achieve the project's intended results. She leads a project management team (PMT) of five staff representing the three GH Bureau technical offices (PRH, HIV/AIDS, and Health, Infectious Disease and Nutrition (HIDN) that provide core funding for the HPP. During the evaluation Missions and HPP were asked about communications with the AOR and the PMT.

With Missions: Since HPP field activities usually are funded through field support buy-ins, Missions are responsible for overseeing those activities. Missions generally stated they had contact with the AOR and the PMT only as needed. HPP issues that do require communication between Mission HPP backstops and their HQ counterparts are work plan approval, processing of incremental funding, and approval of TDYers. Missions generally commented that they have good relationships with the AOR and PMT. However, one Mission complained that some TDYers had failed to debrief the Mission and presenting the findings in Washington without the knowledge of the Mission. These practices were a concern for this Mission with any GH project.

In Côte d'Ivoire, in collaboration with a Technical Working Group, HPP implemented a costing study of HIV services for key populations that included an initiative to build the capacity of host-country counterparts on data analysis techniques and approaches. In the April 2013 PEPFAR Côte d'Ivoire newsletter PEPtalk, the director of the Key Populations Program in the Ministry of Health and AIDS, is quoted as saying: "Rarely has a partner [HPP] empowered and involved us to this degree in an activity of operations research. My program has truly been strengthened. ... There was a real ownership by the government and a deep respect and consideration for the technical working group throughout this work."

With HPP HQ and Country Offices: HPP HQ managers noted that the PMT has made many valuable contributions to frameworks and strategies that help operationalize key elements of HPP’s work. For example, during interactions between HPP staff and the PMT, it became clear that the Futures Group needed an explicit conceptual framework to describe HPP. Selecting topics for the HPP evaluation strategy and approaches to monitoring country ownership was also a joint effort. Further, as work plans are drafted, HPP leaders felt they have fruitful discussions and receive useful feedback from USAID/Washington and Missions.

HPP HQ and country offices and representatives generally felt that the frequency and types of communications and meetings with the AOR and PMT members were about right. Field staff appreciated PMT efforts to provide helpful technical and administrative support; and HQ interviewees likewise were satisfied with the regular progress reviews and management meetings with the AOR and PMT.

However, a few HPP country offices, representatives, and Missions spoke about too much review and long delays in getting work plans approved, which delayed startup. This was particularly a problem early on in, e.g., Kenya and Malawi; recent examples, such as an add-on to work in Guatemala, show vast improvement.

Most of the senior staff at HPP HQ also had concerns that the review process in USAID/Washington, primarily related to HIV activities, takes too long and involves too many people.

CAPACITY BUILDING

Building on previous policy-related projects, HPP integrates capacity development into all its activities. In countries ranging from India to Mozambique, the project is helping partners to

- Increase program staff knowledge of FP policies and guidelines
- Promote use of data to assess and advocate for improvements in access to and the quality of FP, HIV, and MH services
- Increase local use of costing and other methodologies to evaluate policy options
- Strengthen advocacy to promote better quality services for the populations most at risk of HIV
- Strengthen governance systems to enable direct funding to local organizations for activities
- Enhance multisectoral coordination to further disseminate and promote enforcement of laws, especially related to domestic violence
- Create stewardship for health policy by fostering interactions and coordination between stakeholders.

Capacity Building Objectives and Approach

HPP’s support of in-country partners strives to improve health by fostering country-led ownership of the policy process. Efforts to build capacity in developing countries that focus only on individual skills or organizational development are typically not sufficient to promote systemic change. Promoting strong policies, governance, and social participation requires individuals with the necessary knowledge and skills, capable organizations, and stakeholder capacity to interact productively to foster better systems. HPP therefore uses an overall systems approach that recognizes capacity needs at the individual, organizational, and collective (systems) levels.

Employing multiple and simultaneous strategies to strengthen capacity at all levels has been found to be most effective (see table 3).

Table 3: Capacity Strengthening Strategies and Levels

<p>Skills Building: Knowledge Transfer</p> <p><i>Capacity diagnostics</i></p> <ul style="list-style-type: none"> • Training needs assessments, organizational capacity assessments, network analysis <p><i>Techniques</i></p> <ul style="list-style-type: none"> • Direct TA, training, informal learning opportunities, e-learning, other distance learning techniques
<p>Skills Application: Institutionalization</p> <p><i>Organizational level</i></p> <ul style="list-style-type: none"> • Institutionalization of capacity by creating structures, standards, practices, or mechanisms <p><i>Individual level</i></p> <ul style="list-style-type: none"> • Application of new skills to job performance with further instruction (e.g., coaching, mentoring, secondment, working together)
<p>Systems Building: Process Improvement</p> <ul style="list-style-type: none"> • Helping partners to improve efficiency and effectiveness of their work and processes or establishing a system where one is lacking • Sponsoring study tours and South-to-South exchanges, or twinning organizations with partners that have more advanced systems
<p>Systems Application: Building Reservoirs of Learning and Local Expertise</p> <ul style="list-style-type: none"> • Reinforcing the ability of in-country program staff to lead local capacity development • Engaging local leaders to build capacity of other project partners • Establishing “Centers of Excellence” in partnership with universities, training institutes, government departments, NGOs, and networks
<p>Consensus Building, Brokering, and Facilitation</p> <ul style="list-style-type: none"> • Supporting visioning, planning, and strategy development processes • Supporting multistakeholder bodies • Strengthening linkages between government and citizen groups to improve dialogue and accountability

Source: HPP Mid-term Self Assessment, 2.

Strengthening Individual Capacity

To increase resources for reproductive health, HPP conducted advocacy training in 2012 for women parliamentarians in Africa. In 2013 when the women MPs from Malawi learned that the line item in Malawi’s budget for FP had no funding attached, they applied their new skills and advocated for funding, and the Malawi government then appropriated US\$80,000 for FP commodities.

In Jamaica, HPP built the capacity of civil society representatives to address gender-based violence, stigma, and discrimination within HIV programs. As part of this work, HPP trained people living with HIV and engaged them in drafting and adapting a peer outreach program using the Positive Health Dignity and Prevention curriculum.

At the *individual* level, HPP helps government and nongovernment actors to build skills through training needs assessments, organizational capacity assessments, and network analysis as well as through direct TA, training, informal learning opportunities, and e-learning and other distance learning techniques.

At the *organizational* level, HPP works to institutionalize skills and create supportive structures and standards—for example, by including skill sets in job descriptions and practices.

At the *systems* level, HPP focuses on fostering relationships and interaction between organizations and individuals. A key aspect of country ownership is the ability to facilitate the capacity development process, drawing on local expertise. Building consensus and formulating strategies are particularly important at the inter-organizational and system levels.

Capacity-Strengthening Tools

To support its systems approach, HPP has compiled and is testing an Organizational Capacity Assessment (OCA) suite of materials that operationalizes its Framework and Approach for Capacity Development in Health Policy, Governance, and Social Participation. These materials describe how to carry out participatory OCAs and design capacity-development plans. The suite consists of 16 resource guides, a facilitator’s guide, and a scoring template.

During recent tests of the suite in Afghanistan and Guatemala, the scoring template and spreadsheet were designed and have since been pretested in Kenya. The University of Nairobi team noted that the visual representation of their capacity scores made it easy to identify priority areas for building capacity and were impressed that graphs and an OCA report could be generated from the spreadsheet. When finalized, the materials will be available online for use by all who are working to build capacity in the areas of health policy, advocacy, governance, and finance.

Strengthening Organizational Capacity

In 2012 the HPP team in India initiated a formal process to build up health systems in Jharkhand. The mandate in Jharkhand was to increase, institutionalize, and scale up the capacity of health functionaries for stewardship, policy development, and implementation. HPP supported formation of a State Resource Group of master trainers from government and nongovernment institutions, including the State FP Cell. The group then built the capacities of health functionaries in three focus districts and provided mentoring and supervisory support to the district and block program management units. In August 2013 HPP assesses the results, and preliminary analysis found an increase in the perceived capacity of state, district, and block-level trainees. The assessment found the largest impact of the supportive supervision was establishment for facility staff of an open and enabling environment for collective problem-solving and a will to improve conditions and services within the resources available.

Stakeholder Feedback on HPP Capacity Building

Asked how HPP has reinforced and institutionalized local capacity, many respondents gave examples that demonstrated the integration of capacity development. For example:

In **Kenya**, the devolution process has generated huge training and capacitation needs. Led by the Ministry of Health (MOH), HPP has provided guidance on how the new Kenya Constitution affects strategic planning and budgeting in health and facilitated a workshop for county executives to better understand how devolution changes what they are responsible for in health.

In **Guatemala**, the Health and Education Policy Project (HEPP)¹⁴ helped the Ministry of Education to improve how it presented information and establish a user-friendly “dashboard” interface that makes performance data much more accessible to high-level decision-makers and the public. After a review the President of Guatemala mandated that the system be extended to all ministries. At the Ministry of Social Development the evaluation team saw demonstrations of how officials interviewed use the dashboards on their phones. The Mission considers the president’s interest a huge success, and HEPP is planning a training of trainers (TOT) rollout to transfer and sustain the activity locally.

¹⁴ In Guatemala the HPP Country Program is multisectoral.

HEPP's work with civil society has also equipped associations of health, education, and nutrition NGOs to acquire new skills for doing policy development work. The associations are monitoring application of FP and mother and child health (MCH) policies at the national and departmental level, helping local elected officials to identify and resolve issues in schools and clinics, and bringing a nonthreatening community-based NGO voice to Parliament that leaders say they find useful.

In **Afghanistan**, capacity building has been integrated into all of HPP's efforts. An international consultant provided excellent training and TA on analysis of cost-effectiveness. HPP supported long-term training for emerging (MOPH) leaders. Nine MOPH staff were selected for master's degree training; six have graduated and three will graduate next year. HPP also provided assistance to improve the MOPH MIS and to build the capacity of the MOPH Public-Private Partnership Unit through study tours and on-line and in-service training. The project also helped with publicity and establishment of a web site.

Building System Capacity

In Afghanistan the health sector is constrained by laws, policies, and other factors limiting its growth and the quality of medicines and supplies. A potential engine for change is the Afghan National Medicines Services Organization (ANMSO), which represents importers and manufacturers of pharmaceuticals and medical supplies and equipment. As part of a broader capacity-strengthening effort, HPP organized a study tour to Turkey in June 2013 for seven ANMSO representatives and the Afghan government's General Director of Pharmaceutical Affairs. Participants learned about how to build up their association and the pharmaceutical sector. The directors of pharmaceutical affairs and ANSMO have since been mobilizing support for new tax policies based on lessons from Turkey.

In **Cambodia and Laos**, HPP is working with NGOs to promote gender equality in their programs and working to strengthen civil society to advocate against gender-based violence.

In HIV programs working with **populations most at risk**, HPP is working through civil society, providing mentoring as well as training to local organizations. This approach has been very useful. HPP helps with advocacy, tracking policies, and engaging with government; teaching organizations how to work on policy; and including a capacity-building element to promote program sustainability.

HPP **consortium partners** also contribute directly to capacity building. For example:

- White Ribbon Alliance is building capacity for effective advocacy in local civil society in Malawi and Nepal. It also works on social accountability and respectful maternity care. The capacity building has helped local members mobilize huge campaigns. Unfortunately, the WRA does not have much health funding to pursue this work.
- PPD ARO has worked to identify energetic leaders in Africa to advocate to create and maintain FP momentum and find and train champions for FP in parliaments who will mobilize other parliamentarians to push for increased support for FP/RH. HPP helps to assemble evidence for ministries to share with parliamentarians so that everyone knows what the needs really are. HPP HQ actually has also helped build ARO's capacity and taught it to make sure that commitments are specific and measurable.

Compared to earlier policy projects, which placed more emphasis on building individual capacity through training, the design of HPP emphasizes building institutional capacity. HPP's approach calls for *simultaneous* and *coordinated* efforts to improve capacity at multiple levels: individual,

organizational, and systemic. An interview question on the emphasis on individual vs. institutional capability was intended simply to ground-truth how far the transition to a more institutional approach has progressed. Happily, more than 85 percent of respondents stated that activities clearly emphasize institutional capacity; some respondents also made the valid point that these activities simultaneously strengthen individual skills.

Modeling and tool-kits have a useful role in HPP's capacity-building. In a few countries respondents stated that HPP HQ staff still sometimes do the work of preparing the models and tool-kits and discuss the findings with government officials, but the vast majority reported that models and tool-kits now come with training on how to use the data more effectively for decision-making and how to use the models on their own. Several country partners confirmed that they were in fact using models on their own, and we heard about one local government technical expert to trained to adapt models herself.

Several respondents also acknowledged that HPP has faced some challenges in fully implementing its approach. Some are inherent in the nature of institutional capacity: in some developing countries, skilled technical staff are in short supply, and the best ones often are lured to more lucrative positions elsewhere; and new skills, if not applied immediately, may be forgotten. Capacity building is a long-term process.

HPP HQ also faces internal challenges. Although capacity building was front and center in the RFA and CA directions for HPP, the project has no budget line item for it. HPP has done an excellent job of incorporating capacity building into country work plans, and while initially there was push back from Missions, there is now more interest in capacity building in the field and HPP has managed to work it in successfully. Nevertheless, if USAID wants to intensify the capacity development aspect, it should have a dedicated budget line item.

HPP is presently recruiting a technical director for capacity and plans to evaluate its work on capacity building.

IMPLEMENTATION AND CLIENT SATISFACTION

Implementation

In-country Start Up

Country activities begin when Missions request assistance: the AOR and Mission come to a basic agreement by telephone and there is then a call with HPP, a staff team is assembled and sent to the country, and a work plan is drafted. Preferably, there is a dialogue with major partners, e.g., the MOH, before the basic scope becomes a work plan that incorporates staffing and TA requirements. The budget is usually known ahead of time. For multiyear programs with budgets over \$500,000, HPP offers the extensive participatory planning process already discussed. Respondents in the field reported that the participatory process allows HPP to ground-truth approaches, begin or refresh local relationships, and begin a working relationship with the government and other local partners. This is especially important where a country office needs to be opened from scratch. For HQ, the process helps answer questions about staffing, international TA assistance, and country presence, including legal requirements. It also insures that cross-cutting issues, e.g. gender, M&E, and capacity building, are incorporated into the work plan.

HPP HQ staff said they find implementation is smoother in countries that had participatory assessments, such as Kenya, than in those that did not, such as Ethiopia. The Kenya Mission felt

the project assessment corroborated its own, and that the time it took allowed HPP to get to know the environment and begin to engage. One Ministry official said he had been part of the design and referred to the assessment as “ours.” Yet the resulting work plan for Kenya had to be revised very soon when devolution of government to the counties became a national priority.

A concern for HPP leaders is the perceived inability to market the project to Missions. A Mission that does not know what the project can do is unlikely to ask for its assistance. Without some organized outreach it is hard to determine whether there is unmet demand for the project.

Finally, Mission, PMT, and project staff expressed concerns about slow startups—concerns also raised in the 2013 Management Review of HPP and the HPP Self-Assessment. Although some of the slow starts, such as in Malawi, occurred early in the project, vigilance is still important. In its Self-Assessment HPP suggests such solutions as greater use of participatory assessments, shortening work plan formats and time tables, more proactive recruitment of HQ staff with specific language and regional skills, and HQ reviews that take less time.

Work Plans

Country offices, Futures Group Outreach Offices, and HPP HQ track progress of work plans and funding, and some authority is delegated to country offices for sub-agreements. For HPP HQ semi-annual reports to GH and the PMP, country offices and programs provide regular results reporting and summary program updates. Country offices also report to USAID or PEPFAR teams in-country. This reporting ranges from one-on-one conversations with USAID to weekly and quarterly reports of specific data (i.e., AFGHAN-Info).

Planning and reporting are different for each country, often because of Mission requirements. In Guatemala, the Mission requires that HPP HQ and the country team prepare an annual work plan. As part of the process the country team develops an operational plan used throughout the year to track activities and subgrants. In Kenya, the 2012 work plan covers 2013–15 and is very long. At the strategic level the plan works well, but specifying activities two years head for work in a fluid policy environment means that some components are no longer relevant to the original USAID goals. The USAID/Kenya manager would like a more flexible work plan.

Donor Collaboration

Brought into high-level donor initiatives, HPP has attracted considerable cooperation and support from donors. Respondents reported in-country collaboration with donors, of which cost-sharing is a large part, in Afghanistan (WHO, UNFPA), Ethiopia (DFID), Ghana (MacArthur Foundation), Guatemala (UNFPA, PAHO), India, Kenya (WB, GIZ), Malawi, Ukraine (Clinton Foundation, GF) and Zimbabwe (UNFPA Coordination with international NGOs such as the International AIDS Alliance and the International Planned Parenthood Federation also occurs at the country level.

Internationally HPP has been considered an important partner, as demonstrated in an African regional project targeting at-risk populations where HPP, UNDP, and the South Africa AIDS Trust (SAT) each support a third of the initiative. Respondents noted that HPP staff and program expertise as a leader on at-risk populations was an attraction to other donors and NGOs. Donor respondents identified HPP technical expertise in FP gap and budget analyses as important to FP2020.

Extensive cost-sharing is evident both internationally and in-country, such as the co-funding with the Gates Foundation for work on FP index effectiveness; a joint activity in Ghana where HPP provided a cost implementation plan and the MacArthur Foundation supported services through a gift to HPP; and work in West Africa co-funded by HPP, UNDP, and the AIDS Trust.

Donors expressed appreciation and trust in HPP staff and their skills. In both Guatemala and Kenya respondents said that HPP has a philosophy of coordination that projects do not always have. In Kenya, one donor also noted that HPP is faster and more flexible than donors, which was critical when the government's devolution decision came earlier than expected.

Strategy for Core Funding

As of the last Semi-annual Report, HPP had 46 core activities, categorized by funding source: mixed, FP/RH-specific, MH-specific, and HIV-specific. Core activities are the source of most of HPP's contributions to global initiatives, such as FP2020, conceptualization and research on policy decision-making, contributions to advocacy, gender work, and improvements in modeling, tools, and training protocols. Many core activities have field-based pilots, trials, or research; in all cases the objective is to serve the project and the field of health policy. Because policy work takes a long time, several core activities are carry-overs from earlier projects.

At first there was an attempt to use core funding to pursue integration in PRH, HIV and MH, but early on that became too difficult because of the inflexibility of HIV core activities, which are funded by PEPFAR, and MH core funds, which are in the WRA work plan. Thus, there is no special technical strategic focus for core activities beyond the HPP technical approaches and cross-cutting issues. The project has not yet cofunded global activities with other system strengthening projects (e.g., Leadership, Management and Governance (LMG) or Health Financing and Governance (HFG), though the HFG technical advisor believes the HFG AOR may reach out for HPP cooperation on a WHO request for assistance. The AOR and HPP may make, and have made, changes in the portfolio depending on needs and the popularity of an activity as it moves to the field.

As this evaluation was underway, a core activity mentioned by many respondents was a conceptual framework for linking health outcomes with policy interventions.¹⁵ Several HPP experts together developed a conceptual framework to address the quintessential question faced by policy (and all system-strengthening) projects: what is the relationship between policy work and health systems and health outcomes? Their work has been presented internationally and brown-bag meetings were held at USAID. An article in *Health Affairs* is forthcoming and a pilot of the work is part of 2014 core activities. This work should be a service to the policy development community, especially within USAID, where policy and other systems work has not had the empirical push needed. However, even in Washington respondents outside HPP, did not mention the activity, though it may be too soon. Experts outside the project were consulted, but it is still an HPP activity that could benefit from review beyond the project as it moves to the fieldwork stage.

¹⁵Hardee, K., Laili Irani, Ron MacInnis, and Matthew Hamilton. 2012. *Linking Health Policy with Health Systems and Health Outcomes: A Conceptual Framework*. Washington, DC: Futures Group, Health Policy Project.

Core Activity Startup

For core-funded startups, barriers mentioned centered on dependence on Mission participation in research or pilots, slow obligation of funds, and confusion surrounding the role of PEPFAR TWGs.

When a core activity cannot garner Mission support for a pilot, an activity can end before it begins, and identifying countries can take a long time. Similarly, slow obligation of funds, usually on the HIV side, translates to slow startup. Core activities tend to be visible, involve coordination with other donors, and may have specific staffing requirements.

The HPP Self-Assessment also noted that it is difficult to keep activities relevant to USAID needs over time, and turnover among government counterparts can be a problem.

The most vocal feedback about slow startup related to the role of PEPFAR TWGs in the Headquarters Operational Plan (HOP) process. Two OGAC representatives asked about the TWG role explained that the HOP process is designed to operate as follows:

- USAID puts forth a proposal for HPP to do work as part of its HOP submission (including any proposed USAID activity that is part of a multi-agency activity). The relevant TWG(s) reviews the proposal and request for funds. If approved, the request goes to the deputy principals, the principals, and then the OGAC coordinator for approval. After that the USAID manager, not the TWG, is responsible for oversight.

Respondents report that this process takes more time than project leaders feel is appropriate. Moreover, because the HOP and OGAC approval schedules do not coincide with the PRH budgeting schedule, joint PRH/HIV programming is difficult.

M & E and Knowledge Management

The HPP M&E and KM strategy is a mix of meeting USAID requirements, such as the PMP and results reporting notes, and furthering the field of health policy (e.g., M&E training for partners, project-related analysis and research, emerging issues). Population funds are in a pool for M&E work, and for HIV costs for M&E are assigned to each activity. M&E is included in the WRA sub-agreement.

Monitoring is integrated into the project in the field and within the core-funded portfolio. The PMP has undergone minor revisions, and respondents familiar with it find it useful. Since major program approaches are difficult to quantify, the emphasis on individual and institutional capacity is generally considered a sensible choice for the PMP rubric.

HPP monitoring work extends beyond monitoring itself. Numerous elements in the portfolio of core-funded activities are directed to improving models, tools, and approaches for policy work. Activities to strengthen monitoring within governments and NGOs are integrated into work plans. HPP has created tools and advised other programs, e.g., MEASURE evaluation, WHO, and OGAC. For example, it set up a monitoring framework for the OGAC-initiated country partnerships with applications for other policy and resource monitoring.

On the evaluation side, a large number of core-funded activities and numerous items on the HPP list of completed products are assessments of HPP technical approaches, including targeted

operational studies such as the E² series.¹⁶ Yet the evaluation agenda for the project itself has been stymied. HPP leads view this as an area to concentrate on now that a new M&E lead and other staff are in place. There is recognition that this element has been neglected. In Guatemala, the evaluation team did see the report of a study on the budget effects of policy to fund FP commodities via a tax on alcohol (available on the HPP webpage). Also, in Afghanistan there is a plan to evaluate HPP reinforcement of the MOPH Gender Directorate.

The HPP Knowledge Management and Communications Strategy completed in July 2013 is designed to share knowledge and achievements via presentations, reports, peer-reviewed articles, and the web (through social media, listservs, e-newsletters, and databases). The strategy is comprehensive. It gives examples of how to meet the information needs of identified HPP audiences. Several HPP members and some PMT members noted that KM is a strong element of the project, often noting the high level of hits on their websites for project publications, tools, and activity summaries. Colleagues in USAID Washington and OGAC noted seeing or hearing about HPP presentations. Technical advisors from similar projects and OGAC colleagues said they would appreciate hearing more about what the project does, and two OGAC colleagues thought presentations like one HPP did on the framework for combatting stigma and discrimination in health facilities was a good example of what their colleagues would like to hear more about. Most respondents did not access project information via the web, and three who did had trouble finding things.

There is a special emphasis on strengthening the KM and communication programs in Africa. The evaluation team received a presentation and numerous publications on Kenya during the country visit. The HPP logo appears on all publications, sometimes alone, sometimes with USAID's, and sometimes with PEPFAR's. Most are done in cooperation with the MOPH. Kenya plans to experiment with social media. In terms of dissemination, leadership in the USAID health office felt that HPP should be checking with the Mission before disseminating information in Washington about work in Kenya.

In Guatemala, locally prepared materials, some from predecessor projects, are used with policymakers and NGOs. There is also an English-language brochure on the project. Over 10 copies of the brochure were the only materials in the lobby of the USAID mission when the team visited. Government officials in the Ministry of Social Development (MOSD) demonstrated the HPP developed dashboard system for decision-makers on their phones.

In Afghanistan, the Mission was sensitive to the difficulty of quantifying HPP results and suggested that what would be useful would be short policy briefs (the Mission has a format) to educate and disseminate what the project does, e.g., how do you conduct an expenditure survey and what do you do with the results.

Global Leadership

HPP technical personnel are recognized international experts in the fields of PRH, HIV, resource decision-making, advocacy, costing, and monitoring policy development and implementation. They are advisors to USAID, PEPFAR, WHO, and other UN agencies, and through this project have contributed to such important global initiatives as FP2020, Advance Family Planning, and

¹⁶ E² is an HPP research briefs series that reports on research that helps governments and program managers improve efficiency and effectiveness of global health programs. The research itself is customarily based on discrete policy research questions.

Monitoring Country Frameworks for PEPFAR. HPP and the PMT would like to continue to strengthen HPP's global leadership position. Implementation of the new KM and communications strategy is seen as one way to accomplish this.

At the people-to-people level and in international initiatives, respondents noted the following three barriers: (1) HPP does not have or has not allocated sufficient resources for global leadership; (2) it is not sufficiently integrated into USAID's planning process for large global initiatives; and (3) the CA is not long enough to pursue global issues.

A concern that HPP leaders have is that when GH plans involvement in global initiatives, HPP is not involved even though its participation might be critical to the inputs and the follow-on of the initiative, e.g., FP2020. Agreeing, USAID respondents noted that involvement and planning were not GH-wide when GH engaged in an initiative.

One respondent who has worked on global initiatives noted that a five-year horizon is not long enough to take on a larger leadership role in global initiatives. For example, taking the lead in helping countries transition from GF to government support for HIV services would need to be a multiyear activity with a flexible end point.

Client Satisfaction

Respondents discussed the quality of HPP work and Missions spoke to its timeliness and quality. Respondents also gave opinions about the field support mechanism and communication with and within Washington.

Comparative Advantage

There was a solid consensus that this is the preeminent policy project in global health within USAID and beyond. Asked what the project's comparative advantage is, the two most frequent responses were "policy" and "advocacy." Specific responses indicated both what HPP is known for and what it does well, with similarities and differences based on health area:

- *In FPIRH*: policy development and implementation, advocacy, tools and modeling (e.g., OneHealth), use of data for decisions, costing and finance related to funding gaps, resource mobilization and contraceptive security, women's empowerment (streamlining programs, working with women politicians), country presence, and experience with governments
- *In HIV*: policy development and monitoring, advocacy, reduction of stigma and discrimination, civil society and networks, tools and modeling (e.g., GOALS), at-risk populations, gender (including women, MSM, and transgendered people), costing and finance related to increased country ownership, and specific innovations, collaborative approaches (bringing disparate groups together and developing consensus), and local expertise.

The few respondents who discussed MH said that evidence-based policy and advocacy are the main HPP comparative advantages. Civil society and government respondents appreciated HPP's help with capacity and accountability. Respondents in Afghanistan said HPP's comparative advantage is in private sector development, including PPPs and social marketing. In Kenya, devolution is seen as a major comparative advantage, along with policy and health care financing.

Respondents who differentiated HPP from other projects noted that it worked on larger, big-P policy, and other projects could handle project-theme-specific policy issues, e.g., human

resources for health (HRH) or FP commodities. HPP was thought to be flexible and knowledgeable about cost-sharing, and its country presence was important.

Working with Governments

Respondents praised the assistance provided to governments, especially parliamentarians. Among impressive government, and HPP, successes mentioned were getting FP into the budgets in Malawi and Ethiopia; making multisector data accessible for ministers in Guatemala; kick-starting devolution to counties in Kenya for health and other sectors; using private firms to expand the reach of the health sector in Afghanistan; and operationalizing how to meet Ouagadougou commitments. Missions and government respondents corroborate that the HPP approach is country-led, although one government respondent in Afghanistan felt the government should be taking more of a lead.

Government respondents said what they found most useful was

- Advice from technical experts with in-depth knowledge of the country situation
- Provision of training, tools, and models for analysis and convening support
- Specialized TA on costing analysis, surveys, organizational and financial management, law and capacity building
- Use of embedded staff
- Flexibility and responsiveness.

Missions consider the work done by HPP to be theirs and the work done with government as the Mission partnering with government.

Quality and Timeliness

For USAID Missions, quality and timeliness are crucial. Missions reported that HPP generally submitted work plans and reports on time and was very responsive to Mission and partner needs. The documentation required, however, tends to slow the country teams down. No Missions reported pipeline problems and HPP data show no critical pipeline issues.¹⁷

A few specific concerns were mentioned. The Kenya work plan will likely have to be revised this year as program activities and funding availability becomes clearer. As in the past the work plan will be prepared in collaboration with government. In Guatemala, where work in the western highlands is well-managed, staff at the national level may be over-extended. This concern may be exacerbated as the Mission asks for more assistance with information systems.

The issue of staff turnover in Ethiopia and the need for more staff in West Africa has already been mentioned, but the Mission in Ethiopia is pleased with HPP's accomplishments, as is the West Africa Regional office, which noted completion of five country and two reports on key populations in the first year.

Asked about the size and quality of the staff, Missions said they were pleased with the COP and staff in-country. The HPP commitment to hiring experienced local and regional staff is seen as a real positive. The COPs and office leads for Futures Group Global Outreach (FGGO) tend to be politically savvy but not politically affiliated, and most have considerable managerial or

¹⁷ HPP Self-Assessment, p. 29-32.

technical experience, or both. Some of the FGGO leads have long-standing relationships with the Futures Group, and FGGOs are either registered or soon to be registered as local NGOs in their own countries, enabling them to bid and work directly in-country.

Field Support

Several Mission respondents see field support as the right technical solution for a policy project and its flexibility to add and change activities as a plus. The West Africa regional office said it reviewed its experience with a regional flagship project and decided to break it up for follow-on work. It chose HPP for the policy follow-on. In Kenya, the Mission's systems-strengthening portfolio uses four USAID-Washington projects to cover the WHO elements of health systems strengthening, and the Mission views HPP as the policy development element. HPP is working in the rapidly evolving areas of health care finance and devolution and needs to be flexible to changes in the policy environment. In Guatemala, the Mission felt that the adaptability of HPP's technical approaches and the flexibility provided by field support allowed the project's approaches to be used beyond health, first in education and more recently in social development. The Mission in Afghanistan appreciates being able to tap the project as a bridge to on-budget government programming.

When field support is used for any project, there is a perception that HPP is expensive and that money is going out of the country. Yet there were no concerns about Washington management of HPP from countries using field support, or at least none that could not be worked out in dialogue with the AOR.

Alternatives to HPP

Missions that saw a choice between HPP and alternatives within the USAID portfolio tend to be looking for work on finance. USAID Kenya found HPP as an alternative to HS2020 when the later was not available and believes it is a very good fit. USAID Guatemala is weighing whether to move into HCF with HPP or an alternative. In Botswana, another project was chosen to receive field support for work done by someone who could have completed it under HPP. Both project ceilings and knowledge about project capabilities come into play.

Other respondents mentioned using local groups as an alternative to HPP but no Mission seems ready to do so. In West Africa the Mission sees going local as the next step but does not think the capability exists yet. In other regions, such as Central Asia, local groups, including FGGOs registered as NGOs, could assist USAID, the GF, or other donors, even though governments are not set up to pay.

Communication With and Within Washington

USAID, HPP, and the project's partners are all clients and their patterns of communication can contribute to project success.

Missions and the AOR communicate well on both routine issues like incremental funding and travelers and on problem-solving. The Guatemala and Kenya Missions would like the AOR to visit their programs; both have complex HPP portfolios undergoing change and feel it would help to have the AOR familiar with the work. The GH/AA visited Guatemala and will be invited to a regional finance meeting in Kenya.

Larger HPP country teams may have occasion to talk to the AOR. Their primary contacts at HPP headquarters are the focal person for their country and the regional directors. Offices feel

well-served by their HQ counterparts. Government counterparts report a mix of Mission and project contact. They tend to ask USAID for support and work out the details with HPP. NGOs consulted for the evaluation work exclusively with HPP, but that may not be the case in all countries. All these groups report good working relationships with HPP counterparts.

Donor representatives based in the U.S. and Kenya work directly with HPP; donors interviewed in Kenya—the World Bank and GIZ—work separately with the Mission in a donor forum but have much more contact with HPP than with USAID officials.

In Washington, communication between HPP HQ and the PMT is a work in progress to which both sides are committed. Regular meetings have been scheduled and a user-friendly dashboard tool tracks progress. Quarterly in-depth country or technical focus meetings have been set up. The USAID PMT drew up a list for HPP staff to use when they are not sure who to call, e.g., one PMT member follows HIV and gender issues in the Caribbean and Central Asia. The project director and AOR meet regularly. Nevertheless, respondents on both sides spoke of too many people talking to too many people, and some report being out of the loop. In the HPP Self-Assessment, the description of the matrix management system explains why a staff member may, for example, work on a civil society team in one situation and an M&E team in another.

The USAID PMT has three members from the Office of HIV/AIDS. To make its oversight more efficient, the AOR has asked that only one member of the HIV team review work plans, reports, and other documents.

EMERGING TRENDS AND FUTURE DIRECTIONS

One of USAID's goals for this evaluation was to identify current and emerging trends in policy, advocacy, financing and governance that the Project is encountering.¹⁸ The evaluation team therefore questioned respondents about policy issues they see emerging now or in the near future and then asked about the extent to which HPP currently is addressing emerging issues, and what issues should be addressed in a follow-on policy project.

Emerging Trends

Each stakeholder group has its own list of emerging policy issues. For in-country respondents table 4 breaks comments out by country and HPP technical approach; a summary is provided at the end of this section.

Views from the Field (Missions, HPP Teams, and Country Partners

Table 4, which is organized alphabetically by country and by HPP primary work areas, summarizes emerging trends cited by the field.

¹⁸ HPP Evaluation Scope of Work, Task 3, page 4.

Table 4: Emerging Policy Issues and Challenges: Feedback from the Field

COUNTRY	HPP PRIMARY WORK AREAS			
	POLICY	ADVOCACY	FINANCING	GOVERNANCE
AFGHANISTAN (Mission, country team, partners)	<ul style="list-style-type: none"> • Revise and update Ministry of Public Health (MoPH) regulations. • Continue to improve quality of care standards in the MoPH. • Build general awareness about gender based violence (GBV). • Provide more support for midwives to help address maternal mortality. 	Continue advocacy for the private health sector.	<ul style="list-style-type: none"> • Work on building capacity in MoPH in health financing. • Partner with the private sector to run the three new hospitals in the Kabul area. • Continue to work on national health accounts, especially the child health subaccount. • National health insurance is the future of the health sector; HPP is working now with MoPH on a feasibility study for expansion of health insurance coverage. • MoPH also needs more help with costing of key health interventions. 	Continue work on private sector investment and public/private partnerships in health services.
CARIBBEAN (Partners)	There is new information about behavior change that people are not using; there needs to be a transfer of that knowledge into action.	<ul style="list-style-type: none"> • Youth need to be better informed about the consequences of alcohol and drug abuse. • Reach out more to vulnerable populations; there are challenges for vulnerable groups in accepting services, even if they are free. 		
ETHIOPIA (Mission)	The current Health Policy in Ethiopia was drafted in 1993, and needs to be updated.		Work more with the Population Council's project in Amhara.	

COUNTRY	HPP PRIMARY WORK AREAS			
	POLICY	ADVOCACY	FINANCING	GOVERNANCE
GUATEMALA (Mission, country team, partners)	In some areas 26% of girls under 14 are becoming pregnant. The vice president is putting on political pressure to address this problem. Looking ahead three to five years, it will be necessary to reform the health code (last updated in 1991). Also, continue working on the strategic plan while better implementing current policies. There is a push for universal bilingual education. Another priority for youth is to provide adequate funds to include sports and culture in schools. Provide scholarships to keep kids in school.	Continue to empower women to speak out about their demands and needs in health, education, and nutrition.	Contraceptive security and logistics are central, as is financing for health care.	Need more empowerment at local levels to manage schools. Use OSAR approach for education to empower civil society to demand accountability. Since education is going to be decentralized, it will be necessary to advance knowledge on the rights and benefits of decentralization. In RH, increase the accountability and transparency of the policy implementation process. Expand public and civil society participation. Structurally the Ministry of Health is a mess. It is not meeting the MDGs.
INDIA (Country team)	The government has a well-articulated lifecycle approach to health care, but the challenge is to implement it properly. There is a need to improve the quality of service and available FP choices.	Continue efforts to inform/equip parliamentarians on the benefits of FP and its positive impact on population welfare and development.	The problem is how to cost and roll out universal health care (UHC).	
JAMAICA (Mission)		Work with the Anglican Church and faith-based organizations FBOs on an HIV policy.		

COUNTRY	HPP PRIMARY WORK AREAS			
	POLICY	ADVOCACY	FINANCING	GOVERNANCE
<p>KENYA (Mission, country team, partners)</p>	<ul style="list-style-type: none"> • What needs to happen to make devolution a reality? • Policy guidelines and procedures are urgently needed for county health services managers. • Need a careful study on the technical and cost implications of moving forward with UHC, i.e., policy and costing analysis of the most cost-effective options in a resource- constrained environment. • Study the needs of special populations, though but this issue is still being debated in the NASCOP. • Give policy guidance to counties on HIV/AIDS planning and implementation. 	<ul style="list-style-type: none"> • Urge counties to advocate for an adequate health budget (MOH has a health promotion unit to assist counties with advocacy). • Educate the public about the growing burden of NCDs. 	<ul style="list-style-type: none"> • How should USAID and other donors engage with county governments? • How do we help counties understand the financing implications of devolution? • We need more costing training to develop a critical mass of people who can do this work. • A strategy for increasing government investment in HIV/AIDS is needed. 	<ul style="list-style-type: none"> • Governments need to work together; counties need to be guided and held accountable for funding health services. • The current MOH staffing structure does not make sense in view of devolution. • Learn how to engage with the private sector for HIV implementation. • Build county capacity for HR management, financial management, and commodity management.
<p>MALAWI (Mission, country team)</p>	<p>Youth need better access to FP services—a huge issue, since 50-60% of the population is younger than 24 years.</p>	<ul style="list-style-type: none"> • Step up advocacy to keep girls in school; e.g., urge clergy not to agree to perform marriages involving girls younger than 18. • Continue to engage civil society to hold government accountable for its commitments for health and FP and to increase their investments in FP (using costing model data). 		

COUNTRY	HPP PRIMARY WORK AREAS			
	POLICY	ADVOCACY	FINANCING	GOVERNANCE
NIGERIA (Country team)		Work more actively to equip networks of civil society groups to hold national and state governments accountable for their commitments and to advocate for a larger investment in FP/MCH.		
UKRAINE (Country team)	First step: draft bylaws to encourage more civil society involvement.	Engage civil society in community health delivery (currently not feasible).	<ul style="list-style-type: none"> • Health care reform announced, but money not following the patient—still financed on number of beds. • Change health care approach; perhaps support community-based clinics. 	

AOR and the Management Team

- Allow HPP to take an even larger role in global leadership on health policy and be viewed as the experts; disseminate their tools and publications more widely.
- Given OGAC interest, accelerate work on hot spots.
- Health financing (how to pay for services and commodities) is heating up.
- How to increase country investment in health/FP services is a problem.
- How can the private sector be harnessed to help get the work done?
- Place more emphasis on accountability and transparency.
- Country ownership and sustainability of HIV/AIDS programs: HPP has started to work on this, but demand for TA will increase. Countries need assistance in plotting trajectories for service delivery needs and budget resources (costing models are an essential tool here), and how much donor support might be needed. Guyana has made a good start, but much more needs to be done to engage a wide group of stakeholders.

- More work is needed on how to transition HIV/AIDS funding for key populations, gender, or other special groups to the country and other donors.
- There is a need for more work with civil society, youth, and USAID funding of interagency agreements.
- There must be more sharing of knowledge and lessons learned.

Futures Group

- Empowering civil society to hold governments accountable is an important and growing area. HPP has provided civil society networks with tools for tracking government adherence to its commitments, including changes in government budget expenditures in key health areas. PPD ARO has been capacitated to do this tracking for several African countries.
- Better research is needed on the impact of policy work on health outcomes, including case studies and retrospective/prospective studies.
- Use new technology to better inform host country and USAID policymakers and to respond more quickly to their requests for information.
- Work toward UHC: how better to build in and strengthen health equity in health services what interventions are needed, and the measures of success.
- Stay involved in global movements to help make sure budget resources are being allocated where they are most needed. HPP is very involved already with FP2020 and the FP model Smart Start Approach.
- *Procurement issue*: Explore the possibility of a longer-term CA for the next policy project; five years is not enough time to accomplish all the desired results. Policy development and implementation take time.
- *Financing the sustainability of health sector programs*: How can governments mobilize more funds for health, and then spend the resources as efficiently as possible?
- Extend and work on better data systems for management decision-making.
- Continue to work on gender, especially on moving from written policies to real behavior change.
- Much work still is needed on building strong and sustainable local capacity.
- Partner with democracy and governance, i.e., do cross-bureau projects like the recent Haiti DG and health policy project.
- Take a closer look at the political space: unpack the political will related to closer integration of FP and HIV/AIDS.
- Investigate how to achieve more consistent financing across health areas (e.g., commodities, RH health).
- Not enough countries have done HIV/AIDS policy assessments.

- More attention is needed to equity, gender, stigma reduction, and quality, especially during devolution.
- Define policy in the government's terms. There is little agreement on terminology. This is something that needs working on now.
- How can HIV/AIDS investments be made sustainable after “graduation”?
- Look at the FP2020 goals and work through implementation and the power dynamics. Targeting must be planned. Continue working with DFID, the Dutch, and Gates to promote social justice and equity.
- In December 2013 in Paris at a country ownership meeting, engagement with the public and understanding of quantitative results were two issues raised.

Consortium Partners

- Increasing budgets toward the Abuja commitment for health generally and FP specifically.
- More heavily promote national budget appropriations for FP.
- Make sure adequate resources are extended equitably.
- Continue to strengthen FP policy development *and* implementation.
- More rigorous methodologies in policy and consistency of work are needed. More money is needed for big studies that look at impact over time.
- It is important to look at integration of health systems. Countries have different combinations of needs. Ministries of public health often have silo programs and do not always understand how to work toward integration.
- *Administrative/procurement issue:* Chopping HPP's work into activities creates implementation challenges and administrative challenges in reporting time worked on multiple activities.
- Transition planning and financing are important.
- The question is how to do more with less, especially how to manage with less funding for prevention activities and how to better use new technologies.
- In MH, HPP should get involved with the post-2015 MDG agenda and work with civil society organizations on priorities post-2015; A Promise Renewed gives potential to roll out plans to monitor government commitments for advancing MH.
- It is necessary to understand how to work with decentralized governments.
- It is also necessary to go on beyond current thinking on country ownership. HPP and others should be moving away from the current models and toward government funding. Here political will is a big issue that needs to be tackled.
- How can FP2020 be successfully implemented?
- Health systems need to be less vertical and more integrated.
- Look at interactions between population and climate change.

- Find better ways to operationalize policy changes.
- How can underserved populations be reached better?
- Move more toward a “total market approach.”
- Help countries to better plan and implement phase-out or graduation from donor support.
- Improve engagement of the public and civil society.
- Work for improvements in HIV/AIDS human rights.
- Use implementation (evidence-based) science more widely.

Donors, OGAC and other USAID/Washington Staff

- Increasingly, other bureaus and sectors want to work with GH. For specific scenarios, perhaps HPP could do modeling on the links and synergies between sectors.
- Prepare and plan for countries to graduate from policy assistance.
- What health financing efforts can be made to increase country investment in FP/RH services?
- Policies are needed for beginning to invest in non-communicable diseases (NCDs) and how best to invest in them without decreasing support for other health interventions.
- How can Missions help support the move to UHC?
- Providing health coverage for marginal groups needs costing and financing.
- Ways to work best with devolution and decentralization are needed (examples: Indonesia, Philippines, Burma).
- Articulate and manifest a more open data policy that could be widely adopted internationally.
- Invest in youth to maximize their productivity and earning potential (a key component of the Demographic Dividend)
- Keep kids in school, and provide job skills training for adults
- Revise labor and employment policies to enable more employment of women.
- Ensure food security and better nutrition.
- Better promote the importance of health policy efforts.
- Maintain the FP cafeteria approach and insure a wide variety of safe and effective methods.
- Improve youth access to FP/RH, and increase the availability of services to underserved groups.
- Study the implications of urbanization for FP/RH service delivery systems.
- Ramp up country capabilities and involvement in context-specific policy planning.

- Promote more public/private (NGO) partnerships to deliver FP services.
- Improve standards of health/FP care.
- Consider providing more health support in West Africa, perhaps out of the East Africa Regional Office at USAID in Kenya.

Summary of Emerging Trends

In each HPP policy work area, emerging issues were raised by respondents representing multiple stakeholder groups.

For example, in **policy development**, many in Missions, government partners, and donors saw a need to update or reinforce policies, in both current areas (e.g., FP/RH, HIV/AIDS, MH) and new areas, such as UHC and prevention of NCDs. Many also cited the need for policies to make health services *more equitable*, e.g., by improving access of adolescents to behavior change communication (BCC) and FP/RH services and of other underserved populations through community-based distribution; and by raising quality of care standards for health facilities. Staff in HPP, the consortium, country offices, and government also urged more *integration* of health services in the field.

As for **health financing**, the concern most often mentioned was for greater country investment to enhance a country ownership of health programs, reduce donor dependence, and ensure health program sustainability in an environment of transitions (e.g., graduation from certain types of donor financing). Many also expressed a closely related need for HPP assistance in health program costing and strategic planning so that ministries can better plan for transitions.

In the **advocacy** area, many country teams and government partners stressed the need for both continuing and new efforts to build up civil society groups to be forceful advocates for health funding and services and to hold governments accountable for fully implementing what they have committed to. Many respondents also noted the importance of identifying pro-health champions within parliaments and equipping them with the data they need to advocate effectively for more investment in health.

For **governance**, decentralization and devolution were most often mentioned as emerging issues. These changes involve a large number of complex policy, financing, and governance issues. Stakeholders look to HPP to help countries effectively understand and plan for the myriad changes necessary, such as establishing health systems and structures throughout the country.

Future Directions

A clear sign of respect for HPP and its work was the thoughtfulness evident in responses about what could be done during the rest of this project or in similar future programs. Respondents identified a number of major areas that needed attention

Time

Extend the time period of policy projects: Many respondents said the project was too short for developing policy. For governments wanting to complete a major policy change, such as devolution of national authority to counties or putting in place national public-private-partnerships (PPPs) HPP is ending too soon. Missions explained that cutting policy projects into

five-year chunks leaves both Missions and USAID exposed when trying to honor their commitments to host governments, especially as USAID encourages country ownership.

USAID officials in Washington explained that OAA did not approve agreements lasting longer than five years, though the team was unable to meet with the OAA representative. However, GH/PRH recently launched an agreement for research that has an option to go beyond five years because, like the policy process, the research process may take longer.

Make HPP more efficient: Respondents also called for more efficient use of the time the project has, e.g. more flexible SOWs to meet the needs of changing policy environments and faster reviews and clearances.

Information and Communication

Disseminate more information to potential clients: Potential Mission and Washington clients need to know what HPP can do and its capacity to take on new activities and funding. They also need to understand its tools and approaches.

Provide information on policy development: What is needed generally is a better understanding of policy development and what needs to be tracked. One Mission official noted the need for those within USAID and elsewhere to understand that policy work is not just media and fact sheets but requires interpersonal interaction.

Consortium

Review the needs of the consortium: Futures Group would like to review the roles of all consortium members and their working relationships within HPP. The two newer consortium members may need to be viewed differently in future activities. PPD ARO feels they have benefited from the relationship, but would like to learn more about how to expand its activities with other organizations. WRA would also like to expand, but not by having more HPP activity within its program. Instead, a model in which HPP MH leads and WRA work together for a Mission or region was suggested.

Other Suggestions

Finally, both from the field and Washington, including HPP senior staff, it was suggested that more focus and staff time be added on both existing and new areas of activity. It was suggested that HPP give

- New emphasis to leadership development, country technical exchange, study tours, how to use new technologies, how to better tap the private sector to meet national health goals, and “implementation science,” i.e., how to use research findings to inform policy.
- More staff in sustainability, finance, costing, and stakeholder engagement.
- More thought to core-funded programs, such as the strategy for use of these funds and how core-funded activities affect and are accepted by the field.
- A more strategic approach to what the project does, e.g., finance for policy development as opposed to just finance, and equity as a possible focus.
- Consideration to bringing in new partners.

V. CONCLUSIONS AND RECOMMENDATIONS

Following are the evaluation team's major conclusions and recommendations for USAID, HPP and future designers:

CONCLUSION 1: PROJECT APPROACH

HPP is widely known for commendable work in expanding evidence-based decision-making and action in global health using a collaborative, country-centered approach that relies heavily on local expertise. Within local policy environments HPP provides soup-to-nuts assistance in developing policy and moving policy into action, often successfully. HPP meets project and Mission objectives using innovative technical approaches in policy, advocacy, finance, and governance.

HPP's four technical approaches are accompanied by work on cross-cutting issues: capacity building, women, reduction of stigma and discrimination, and M&E. Capacity building is discussed in a separate conclusion. HPP's M&E strategy is comprehensive in that it includes the framework for M&E of HPP, including the PMP, and for assistance to field programs. The evaluation of HPP work is beginning. Gender and reduction of stigma and discrimination are both important areas of HPP work in their own right.

Recommendation 1: Continue the good work HPP is doing.

CONCLUSION 2: CAPACITY BUILDING

USAID's Global Health Bureau mandates capacity building in all its projects. HPP has a framework to address capacity building at the individual, institutional, and systems levels, and a technical director for capacity is one of its four key personnel positions. All HPP country programs have capacity building incorporated into the SOW in a way that does not crowd out intended policy work, and various core activities have capacity-building elements. As field and international staff interact with in-country partners, they demonstrate commitment and skill in transferring skills. Individual and institutional capacity building is measured through the PMP.

The project has also furthered capacity building in the policy arena by creating a suite of 16 resource guides for key competencies with facilitator and scoring guides; these have been used in Guatemala and Afghanistan and tested in Kenya. Yet there has not as yet been a full court press on implementing the framework described in HPP's Mid-term Self-Assessment.¹⁹ The project needs to request Mission or core activity funds to take on capacity-building work; there is no line item in its budget directed to those activities.

Recommendation 2: Continue addressing capacity building as HPP has, and evaluate its work. If USAID chooses to incorporate more capacity building into future projects, to do so will require both more staff and resources and top-level commitment of Missions and host governments.

¹⁹ HPP Mid-term Self-Assessment, p 2.

CONCLUSION 3: TOOLS AND MODELS

HPP develops and uses tools and models to analyze, guide, and give credibility. It makes a good faith effort not just to use tools and models themselves but also to train people in-country how to use them, and in some cases how to adapt them to new situations. HPP does not, however, train people to be modelers, which makes sense. It has created a large library of models and tools already in the public domain, including models users can access to answer real-life questions related to management and policy development. Highlights have been the use of models in Malawi and Ukraine to bring disparate groups together to analyze decision options and come to consensus; for the first time the government of Malawi chose to fund FP commodities through the national budget. The evaluation team also supports use of dashboards for decision-makers, as in Guatemala, as a powerful way to present information to political leaders.

Recommendation 3: Continue this work and improve upon its models and tools to ensure valid and reliable results; and continue to make them more user-friendly and make it easier to transfer capability and use.

CONCLUSION 4: HPP PROJECT MANAGEMENT

The evaluation team interviewed both the outgoing and incoming project directors, all the deputy and regional directors, and many of the technical directors. All were highly qualified and well-motivated, and each had many years of experience in their areas of responsibility. Although the sheer number of senior managers may seem large, the changes in HPP's management structure were warranted by the need for firm and consistent leadership of a growing portfolio of activities spread over a large number of technical and cross-cutting areas. For example, the new regional director roles, staffed by experienced senior professionals with extensive country experience, should improve the quality of country backstopping. It is important, however, to fill the position of technical director for capacity promptly.

HPP field staff also had some ideas for improvement of HQ support. One immediate need identified by the Kenya country team director and corroborated by others was for additional HQ health financing expertise to complement the leadership and technical support already available in costing. The new director is experienced in HCF and will be reviewing needs in this area.

Recommendation 4: Hire and clearly articulate the role of a technical director for capacity development. Also consider the need for additional senior HCF backstopping at headquarters. AOR should formally introduce new senior staff to relevant GH office directors and GH front office.

CONCLUSION 5: QUALITY OF COUNTRY TEAMS

Country teams observed and interviewed demonstrate the requisite skills and experience to provide complex policy assistance. Directors have the experience to operate within the national and subnational policy environment without political affiliations of their own. The teams demonstrate the creativity and flexibility needed to be effective in changing policy environments and are committed to country-led approaches. These characteristics are especially effective when shared by a Mission, as was observed in Kenya where the Mission and the country team agree on how best to engage with the government.

Country teams appreciate international TA for both technical and administrative activities and the examples of international TA given to the evaluation team added value to the country teams' assistance. It is commendable that the majority of TA comes from local staff and experts; in recent months, 75% of country labor came from in-country staff, supporting HPP's goal of building local capacity by focusing USAID's resources on local ownership. In Afghanistan and Ethiopia, where LOE information does not indicate an excessive level of TA, Missions were nevertheless concerned about having too much international TA as they strive to focus on in-country expertise.

Recommendation 5a: The AOR should discuss with Missions in Afghanistan and Ethiopia their concerns about too many outside experts.

Staff turnover and new staffing needs in the field are not a concern for most, but the Guatemala team could benefit from an additional staff member in data systems. And the West Africa Regional Office believes that though HPP has an excellent coordinator, he needs more dedicated support from country consultants. This program operates on a modest budget. Organizationally, Malawi is concerned that the WRA is not well integrated with Mission activities.

Recommendation 5b: HPP should review the staffing needs for Guatemala and the West Africa Region and the WRA relationship with the Mission in Malawi, and take appropriate action.

CONCLUSION 6: IN-COUNTRY STARTUP AND WORK PLANS

HPP's participatory assessment process helps designers understand the policy environment and the capacity of potential partners and allows its staff to begin building working relationships. However, startup is slowed by the time it takes for work plan drafting, reviews, and USAID clearances. After being developed in the field, work plans are reviewed and augmented by HPP HQ experts in such areas as M&E, gender, stigma reduction, and capacity building before they are finalized for the Mission and AOR—a process that the evaluation team believes could be completed by a senior HPP staff member, such as the M&E director or delegate.

Further, country office experience with work plans suggests more flexibility would be useful. The Guatemala team follows an annual work plan process where the plan is developed for a Mission and Washington audience, yet the country office works off an operational plan on a GANTT chart. In Kenya, the 64-page 2012–15 work plan contains specific components for two tranches of funding, many of which need to be modified or changed to meet Mission priorities and respond to a fluid policy environment where government is devolving authority to counties. Neither country approach is useful to the project. HPP reports it is working on simpler formats for work plans, and both HPP and the AOR are watching how long the process takes. This will help, however, in cases where Missions are adding requirements that are not value-added, the AOR, HPP and Missions need to work together to find solutions.

Recommendation 6: HPP and the AOR should continue to adhere to their timelines and limit the number of reviewers for work plan drafting and clearance. The AOR should contact Missions with excessive work plan requirements to discuss possible alternatives to meet requirements.

CONCLUSION 7: FIELD IMPLEMENTATION

Missions are pleased with and are effectively using the field support mechanism to address their needs for specialized expertise, country-led policy development and implementation, and flexibility in programming in fluid policy environments. There are no pipeline problems in the field.

Missions value HPP's responsiveness and the quality and timeliness of its work; even in countries with slow startups, implementation is smooth. Both Missions and field partners point to numerous project successes, usually many in each country. As good examples of successes, the evaluation team noted kick-starting devolution in Kenya, the multisectoral information systems for decision-making and public transparency in Guatemala, and the closer collaboration between the public and private sector in health in Afghanistan.

On the operational side, HPP HQ provides useful TA for the country work and much-appreciated backstopping on program and financial issues. Nevertheless, USAID and HQ reporting requirements are burdensome due to the review process and are not sufficiently flexible to demonstrate successes. The clearance process for review of project reports takes too long and there are too many reviewers, and there have been instances where reviewers contradict each other. These hold-ups, combined with required Mission and OGAC reporting, detract from implementation.

Recommendation 7a: HPP should amend the clearance process for both routine (e.g., quarterly) and technical reports to minimize the number of reviewers and put time limits on reviews.

Country teams are responsive to program reporting needs and work to adapt information to the formats required, but the formats do not lend themselves to the detail needed to explain, e.g., the intricacies of how in Guatemala, different national and regional NGO consortia were able to move beyond advocacy to become watchdogs for policy implementation and appreciated by government as valued participants in health, education, and social development. Nor does routine reporting pick up the nuances of political maneuvering that HPP's collaborative, evidence-based approach must operate within or, for example, how HPP has helped position the health sector in Kenya as a leader in devolution. For the evaluation team, this raises an obvious question: what is the purpose of a progress report that does not *substantively* report on progress? Indicators and budget figures are important and the team appreciates the sensitivity of writing explicitly about some policy issues, but progress reports also need to include enough text to convey the country context, the achievements, and the challenges that help readers rightly understand what all the numbers mean. This may require some rethinking of the basic format/content guidelines for routine reports, or perhaps use of routine reports to update only one aspect of a country program at a time. This is important as the HPP comes to an end and there is need for a thorough understanding of what the project did and did not accomplish and why.

Recommendation 7b: HPP should consider how to amend routine reporting (e.g., quarterly report) formats to ensure more complete reporting of complex country activities.

CONCLUSION 8: IMPLEMENTING CORE ACTIVITIES

HPP's core activities portfolio contains a wide range of operational and economic research, modeling, investigation of new approaches to policy development, and building conceptual frameworks. Most activities are dedicated to work in a specific GH area—RH, HIV, or MH—and program priorities in each sector influence what the core activities will be, e.g., the RAPID/Women–Population, Health, and Environment (PHE) work or costing of prevention of mother to child HIV transmission. All these activities contribute to the field of policy development, yet the universe of activities appears to lack strategic focus, partly because core funding comes from various accounts and HIV subaccounts.

The core program is hampered by what appears to be inefficient interaction with some of the PEPFAR TWGs, slow obligation of HIV and more recently MH funds, and dependence on Mission participation in research or pilots.

PEPFAR TWGs review HPP's core submissions to USAID's OGAC HQ Operational Plans (HOPs) as an initial step in the PEPFAR review process. Bureaucratically the process is fairly straightforward, but HPP finds that both it and its HIV PMT members are having to engage with the TWGs outside that process, and HPP management reports cases of having OGAC funding but not being able to proceed without TWG approval. Given how the HOP process is supposed to work, this is unacceptable.

Recommendation 8a: The AOR, HIV PMT members, and HPP should review the plan vs. the reality of PEPFAR TWG in decision-making related to core funding and as appropriate share experience and concerns with senior staff in PRH, OHA, and possibly OGAC.

Garnering Mission participation for core-funded research and pilot activities is a long-standing issue for core-funded programs. If Missions do not see the benefit of a core activity for their country or program, it is difficult even with extra funding to push an activity in. One alternative is for core planners to build an activity around something started in the field that needs more work, such as the activity to provide costing elements to FP GAP analysis completed in Ethiopia and Nigeria. However, for new topics, such as devolution or government budgeting for FP or HIV, a more inclusive approach may be more effective. Convening a topical workshop or an online network of interested parties within government, NGOS, and Missions to exchange experiences, hear from policy practitioners, and design field follow-on that is more operational and less research oriented would allow core-funded activities to both study key policy issues and expand program experience. It appears that this approach is being discussed on the RH side of the project already.

Recommendation 8b: As the core portfolio is amended, the AOR and HPP should consider moving away from traditional operations research and pilot activities toward opportunities to expand policy experience and innovations through more consultative approaches that include Missions and local partners.

Finally, the evaluation team has a specific concern about the important core-funded work on Linking Health Policy with Health Systems and Health Outcomes: A Conceptual Framework.²⁰

²⁰ Hardee, K., Laili Irani, Ron MacInnis, and Matthew Hamilton. 2012. *Linking Health Policy with Health Systems and Health Outcomes: A Conceptual Framework*. Washington, DC: Futures Group, Health Policy Project.

The framework was drawn up with thoughtful input from HPP experts and has been disseminated at international meetings and in brown-bag meetings at USAID Washington. At present, HPP is looking for countries to test it, is expecting to have it published in a peer-reviewed journal, and is considering other dissemination options. This work should be a service to the entire policy development community. However, coming from a single project, the evaluation team is concerned that this could still be an invisible contribution. As field studies begin, it is important to secure wider review and acceptance and more visible champions for the framework beyond those in HPP.

Recommendation 8c: HPP should consider ways to improve the trajectory of work underway on the conceptual framework, such as opening it up to wider international review and participation as the work moves to the field.

CONCLUSION 9: MANAGING GLOBAL PARTICIPATION

In global initiatives like FP2020, USAID, other donors, and host government officials appreciate HPP's expertise in analysis and modeling on policy, resource gaps, and resource mobilization and on how to fine-tune policies and move them to action. HPP's global and field partners also see it as a very collaborative partner. HPP is using this expertise in important global FP and HIV initiatives.

Yet HPP leaders felt out of the loop with how USAID is engaged in these global initiatives and the seminal meetings that often initiate global calls to action. USAID respondents agreed and noted that within GH, internal coordination on engagement is minimal. GH should therefore take a page from the State Department playbook when managing participation in global health initiatives, including having the right people doing preparatory work, having USAID be clear on the objectives it wants to accomplish, galvanizing USAID staff and their partners, and remembering that USAID partners are an extension of USAID. Furthering this process might include consultation and coordination with other national and international agencies and NGOs.

Recommendation 9: GH should create a more participatory and objective-driven model for global leadership initiatives. In the interim, GH should review USAID participation in global health initiatives with a view to fine-tuning its engagement.

CONCLUSION 10: USAID FIELD MANAGEMENT

USAID Missions are pleased with their working relationships with the AOR, and the feeling is mutual. AOR and the program analyst are effective at handling both routine project issues (e.g., incremental funding, travel) and handling special problems. The timeliness of clearances seems to be the only exception, and that has improved and continues to be addressed.

Missions and especially HPP country offices would like the AOR to travel to see programs firsthand, especially in Guatemala and Kenya. Guatemala did have a visit from the GH AA that visibly raised the morale of the country team, and Kenya has invited the GH AA to a regional meeting on HCF that HPP is working on with the World Bank. The evaluation team understands that the AOR is considering some travel and suggests these two countries for visits based on the complexity and innovations in their programs, as well as the importance of HPP to their governments.

Recommendation 10: The AOR should visit HPP programs in Kenya and Guatemala, if possible within the next six months.

CONCLUSION 11: PROJECT-USAID COMMUNICATION

Communication between HPP HQ and the USAID management team is a work in progress that both sides report they are committed to. Set meetings have been established and dashboard instituted to track progress. Quarterly country or technical focus meetings were established for more in-depth discussion and a dashboard format is being used for updates. On the USAID side, the PMT has drawn up a list of its responsibilities, and the project director and AOR meet regularly. Respondents on both sides noted there are too many people talking to too many people, and a few felt out of the loop, reportedly for such reasons as insufficient clarity about who is working on what or who to contact, the lack of a complete organogram for HPP, too many reviewers, and the PEPFAR TWG issue. It also seems to the evaluation team there may be too many people on the PMT, which may be contributing to the problem of delays in reviews and approvals. The HPP Midterm Self-Assessment explains how activities are staffed and why there would not be a static organogram below the senior staff level.

Recommendation 11: HPP and the PMT should review the accuracy of short contact lists for key HPP and PMT members about every six months and then use the lists.

CONCLUSION 12: MARKETING TO THE FIELD AND WASHINGTON

The July 2013 revision of the HPP KM strategy sets out a comprehensive plan to capture, analyze, and disseminate information on the project, the work it does, and the field of policy development. Internal audiences are considered an audience for KM work and can be “useful ambassadors for the project.” The evaluation team agrees and believes it is time to implement that part of the strategy. HPP needs to market its services more effectively. A Mission that does not know what the project can do is unlikely to ask for its assistance. One Mission manager interviewed did not know what HPP has done in health finance, a technical advisor in Washington suggested looking at another project’s web site for ideas on how to improve HPP’s, and, an OGAC colleague suggested setting up occasional briefings for OGAC.

Because USAID AORs need to approve the use of project funds for dissemination activities and a company cannot use USG funds to market itself, there is hesitancy even about project-related dissemination. Technical advisors from two similar projects felt the AORs for their projects have been able to come up with effective methods of disseminating information in ways that involve the AOR without taking undue AOR time. HPP and their AOR can do the same.

Recommendation 12: Future projects of this type should implement a plan to educate Missions and Washington counterparts on approaches to policy development, project experience, and work products. HPP should be documenting its accomplishments and legacy to serve as a guide for communicating its experience.

CONCLUSION 13: LOCALIZATION

HPP is well-known not only for its work in policy, advocacy, finance, and governance but also for evidence-based policy analysis and development, collaboration, and the use of local expertise. Many who work with the project also note that it is flexible, responsive, collaborative, and client-centered and has a country presence. USAID Missions and host governments say that HPP takes a genuine country-led approach to its work, and staff in HPP country offices—who are all local or regional—demonstrate that the expertise resides in-country. An alternative to

HPP is to have a local institution do the same kind of work. Some work is being done in Kenya to develop a local center of excellence along these lines, but it will likely be deferred in favor of more immediate needs in the next Mission plan. At present, donors may find it easier to use local entities than the government, which may be interested but lack contracting mechanisms or sufficient budgets. Nevertheless, given the long time frames for policy work, the need for understanding local policy environments, and the GHI emphasis on capacity building, it is important to work on local entities with characteristics like HPP.

Recommendation 13: In coming years, USAID should consider supporting the emergence of local entities that can provide health policy development services.

CONCLUSION 14: HPP EMERGING ISSUES

Few of the numerous emerging issues listed in the final section of this report are outside the capacity of HPP. Yet certain streams of activity articulated seem particularly relevant to the field work and analytical expertise available under this project, and to health policy development, such as

- *Transition*, e.g., country graduation from GFATM and PEPFAR support, devolution, decentralization; and
- *Equity*, e.g., in relation to reduction of stigma and discrimination, populations at risk, gender, youth, and human rights.

HPP has extensive experience with topics in these two streams, as well as newer areas emerging. The first stream keeps attention on policy with a big P, an apt role for a policy development project. The second stream better articulates an equity element, which is already an HPP comparative advantage, while adding new elements (e.g., civil rights, youth).

Two other areas on the immediate horizon are special challenges (some might say elephants in the room), both of which HPP could unpack from a policy standpoint and where it could provide useful contributions.

- Initial work on planning, costing, financing, and equity for UHC (another equity issue); and
- Doing initial analysis and modeling on the growing importance of NCDs in the developing world, and how USAID and other donors should engage on this issue.

Recommendation 14: GH should consider including transitions, equity, UHC, and NCD as technical topics for future programs of this kind.

ANNEX I. SCOPE OF WORK

Global Health Technical Assistance Bridge Project GH Tech

Contract No. AID-OAA-C-13-00113

SCOPE OF WORK

September 9, 2013

I. TITLE: EVALUATION OF THE HEALTH POLICY PROJECT (HPP)

Contract: Global Health Technical Assistance Bridge IV Project (GH Tech)

II. PERFORMANCE PERIOD

The assignment will begin on/about November 18, 2013 and conclude on/about February 21, 2014. The place of performance includes Guatemala and Kenya (pending Mission agreement) with special remote attention to Afghanistan.

III. FUNDING SOURCE

Cross-Bureau Cooperative Agreement: Office of Population and Reproductive Health, Office of HIV/AIDS, Office of Health, Infectious Disease and Nutrition (Maternal Health Section).

IV. PURPOSE OF ASSIGNMENT

The purpose of this performance evaluation is to provide the United States Agency for International Development's (USAID's) Bureau for Global Health (GH)/Office of Population and Reproductive Health Office (PRH)/Policy, Evaluation and Communication (PEC) Division and Office of HIV/AIDS /Strategic Planning, Evaluation and Reporting (SPER) Division with an independent assessment of USAID's Health Policy Project (HPP) Cooperative Agreement, and more specifically to:

- Evaluate the project's technical approach and client satisfaction, including satisfaction of GH Offices, Missions, and Regional Bureaus and other clients/partners with progress toward achieving work plan objectives;
- Assess how the Project's management structure, processes, and staffing patterns have helped or hindered progress toward achieving project goals;
- Assess the quality and progress of HPP in program implementation; and
- Provide recommendations that can be feasibly incorporated into the management and implementation of future projects. Assess options for how the highest-priority recommendations can be implemented. Identify current and emerging trends in policy, advocacy, financing, and governance that the Project is encountering.

The assessment will gather and synthesize information from multiple sources, including the GH Bureau Offices (PRH, OHA and Health, Infectious Disease and Nutrition (HIDN), the Office of the Global AIDS Coordinator (OGAC), Regional Bureaus, and Missions, USAID contracting officers, HPP/Futures, HPP consortium partners, and other key stakeholders.

V. BACKGROUND

The USAID Health Policy Project (HPP) is a 5-year cooperative agreement with a \$250 million ceiling, under award number: AID-OAA-A-10-00067. The project prime awardee is Futures Group International; the award also includes a consortium of partners: PLAN International (formerly known as the Centre for Development and Population Activities [CEDPA]), Population Reference Bureau (PRB), RTI International, Futures Institute, White Ribbon Alliance (WRA), and Partners in Population and Development Africa Regional Office (PPD ARO). The project can accept both core and field support funds (which may be funded from any source). HPP was awarded on September 30, 2010, and runs through September 29, 2015.

The USAID project management team includes technical advisors from PRH and OHA and input from HIDN (MCH). The Agreement Officer's Representative (AOR) resides within the GH/PRH Division of Policy, Evaluation and Communication (PEC).

The objective of HPP is to strengthen developing country national and subnational policy, advocacy, financing, and governance for strategic, equitable, and sustainable health programming. HPP strives to promote well-informed and active participation in policy development through effective leaders and program managers and efficient use of resources. While the project focuses on family planning and reproductive health, HIV and AIDS, and maternal health, it also includes health systems strengthening and program integration.

Core-funded activities include policy analysis, health systems strengthening, health governance and financing, capacity building in advocacy, and advancement of global knowledge-sharing through the following illustrative approaches:

- Development and application of tools and methodologies for informed decision-making and strategic planning;
- Identification, validation, and dissemination of promising practices to strengthen good governance and effective policy processes;
- Provision of strategic information to USG and in-country partners;
- Development, piloting, and transfer of models to project programmatic impacts and to assess FP/RH, HIV/AIDS and MCH program resource allocation needs;
- Advancing approaches for improved monitoring and evaluation of policy implementation;
- Development of training programs and curricula to promote individual and institutional capacity building and identification of avenues for regional institutionalization and transfer of training capacity.

In-country programming funded with field funding supports the broader goals of health systems strengthening and effective program integration by building individual and institutional capacity for critical areas of good governance and leadership at national and subnational levels. Technical assistance includes the following illustrative approaches:

- Policy implementation and financing/resource allocation;
- Advocacy and policy communication;
- Strengthened multisectoral coordination and stakeholder/civil society participation;

- Use of data and monitoring and evaluation for informed decision-making and strategic planning;
- Increased transparency and financial accountability;
- Strengthened key country and regional institutions to support long term capacity development.

HPP also strives to support partner countries to address the cross-cutting elements of 1) promotion of health equity, 2) significance of gender issues, 3) reduction of stigma and discrimination, 4) effective monitoring and evaluation of project activities, and 5) sustainability of skills with institutional and individual capacity building.

HPP's overall goal of strengthening developing country national and subnational policy, advocacy, and governance for strategic, equitable, and sustainable health programming is addressed through the following five results in close relationship to the cross-cutting issues:

- **Result 1:** Individual and institutional capacity for stewardship, policy development, implementation, and financing
- **Result 2:** Individual and institutional capacity for advocacy, accountability, leadership, and ownership
- **Result 3:** Individual and institutional capacity for strategic data use, analysis, and evidence-based decision making
- **Result 4:** Increased multisectoral coordination for advancing health elements, systems strengthening, and program integration
- **Result 5:** Advanced development and dissemination of models, tools, and global best practices

HPP serves as one of the primary mechanisms to support core-funded FP/RH and HIV/AIDS activities in policy dialogue and implementation. HPP supports a limited number of core-funded activities in maternal health, mainly through its support of the White Ribbon Alliance.

This mid-term project evaluation should follow the GH Guidelines for Management Reviews and Project Evaluations (2007), as well as the Agency's new evaluation guidelines (2011). In addition, the evaluation should take into account relevant USG/USAID initiatives, policy developments, and reform efforts, such as the USG Global Health Initiative and PEPFAR Blueprint, which are linked to the Agency's commitment to the Paris Declaration's aid effectiveness.

VI. SCOPE OF WORK (SOW)

The scope of work for the assessment team will consist of three main tasks. The approximate distribution of LOE for the team is indicated in parentheses.

Task 1: Assess the project's technical approach in achieving project objectives. Assess the quality and progress of HPP in program implementation, and how the Project's management structure, processes, and staffing patterns have helped or hindered progress towards achieving project goals and results. (40%)

Illustrative Approach:

- Assess the project's technical approach, including in-country work with missions, governments, and other donor and partner organizations, and the use of consultants in the field.
- Assess how the project's organization, staffing, management, and interface with the USAID HPP management team have helped or hindered the progress of the project.
- Assess the quality of technical assistance and timeliness of HPP's work for both Mission and core programs.

Task 2: Measure client satisfaction, including satisfaction of GH Offices, Missions, Regional Bureaus, PEPFAR and OGAC in-country teams, and other clients and partners with progress toward achieving work plan objectives. (40%)

Illustrative Approach:

- Satisfaction of USAID Missions and other partners with inputs and progress toward project goals to date.
- Feedback on benefits and challenges of implementing core activities in the field, including supporting new initiatives and Mission programming.
- Feedback on how well the field-support mechanism serves Missions and Regional Bureaus for meeting in-country programming and technical needs.

Task 3: Provide recommendations that can be feasibly incorporated into the management and implementation of future projects. Assess options for how the highest-priority recommendations can be implemented. Identify current and emerging trends in policy, advocacy, financing, and governance that the project is encountering. (20%)

Illustrative Approach:

- Assessment of key informant opinions regarding
 - *Whether current objectives are the right ones to achieve the project's strategic objectives. Are there more important ones to consider?*
 - *Highest priorities for adjustments in the management and implementation of the current project approach.*
 - *Emerging issues and challenges in policy, advocacy, financing, and governance that can be addressed within the current project at the global, regional, and country level.*
- Illustrative Interview Assessment Questions
- Illustrative questions are categorized based on Task 1-3: Technical Approach and Client Satisfaction, Management Structure and Staffing, and Emerging Trends and Future Directions. It is expected that the evaluation team will develop a complete interview assessment questionnaire in concert with the HPP management team.

Task 1: Technical Approach, Management Structure, Staffing, and Implementation

1. HPP seeks to strengthen and institutionalize local capacities.
 - What have been the achievements to date?
 - What challenges has it faced?
 - Are efforts meeting the needs of stakeholders?
2. Describe the current mix of HPP activities, including long-term technical assistance, short-term technical assistance, training, organizational development, monitoring and evaluation, research, and communications.
 - Are these adequate to achieve the project’s objectives?
 - What other types of activities should be considered?
3. Where there are HPP country offices, do you think the project management model of working with a local country director and a local team has been effective? Why or why not?
 - Has the composition of the local staff been adequate to implement HPP activities?
 - How would you rate the technical quality of the work? The management?
 - What, if any, have been the obstacles in hiring and retaining local staff with sufficient technical expertise?
 - What has been the relationship between Futures HQ and the local Futures country teams, and how has that affected project progress?
4. How are Futures headquarters staff and regional consultants being used in the program implementation process? Is there sufficient headquarters staff with appropriate technical expertise?
 - What have they contributed (for example, in terms of technical quality, timeliness, engaging with local partners)?
 - How could they be used more strategically?
5. Have HPP consortium organizations been adequately involved in the implementation and decision-making process?

Task 2: Client Satisfaction

1. How efficient and effective have Futures, partners, and the USAID management team been in their respective roles?
2. What do you expect HPP to provide in terms of country-level improvements and capacity building for policy, advocacy, financing, governance, and gender?
 - What have been outstanding successes to date?
 - Where have there been significant shortcomings or failures?
 - What lessons have been learned?

3. What do you expect from HPP in terms of global leadership, knowledge building and collaboration?
 - What are the global leadership strengths to date?
 - What are the global leadership weaknesses or shortcomings, and how may these be improved?
4. How would you rate HPP's responsiveness to your Mission's requests and program priorities?
 - What has been your experience accessing and receiving services from HPP?
 - How responsive and timely has the project staff been to needed adjustments?
 - Has HPP completed work plans, activities, and reports in a timely manner?

Task 3: Emerging Trends and Future Directions.

1. If the project were starting anew, what would you change, both structurally and substantively?
2. What existing gaps and future technical directions need to be addressed in the follow-on that are not currently being addressed within HPP?
3. Are the structure and framework of the program and activities conducive to achieving the objectives and desired results? Why or why not?

If you were the head of HPP/Futures or the USAID AOR, what would you change about this project?

Process

The evaluation team will have to propose an appropriate evaluation methodology, including sample sizes for both quantitative and qualitative data collection, tools, and steps for data collection and analysis, which will be reviewed and agreed by USAID before conducting the evaluation.

The evaluation team will follow sound accounting procedures and be prudent in using the resources of the evaluation. The evaluation team will also follow a participatory and consultative approach ensuring close involvement of the Government, relevant program partners, and beneficiaries.

The evaluation team will have home-based preparation for reviewing different documents and reports related to the program and developing the evaluation tools. The team will also have field work to collect relevant data/information through

1. meetings and discussions with stakeholders and the representatives of the program partners and beneficiaries; and
2. visiting program sites.

Prior to the start of data collection, the evaluation team will develop and present, for USAID review and approval as part of the work plan, a data analysis plan that details but is not limited to how focus group interviews (if deemed appropriate for the evaluation) will be transcribed and

analyzed; what procedures will be used to analyze qualitative data from key informant and other stakeholder interviews; and how the evaluation will weigh and integrate qualitative data from these sources with project performing monitoring records to reach conclusions about the effectiveness and efficiency of the HPP projects and program.

It is anticipated that the evaluation team would have completed preparation (literature review and development of evaluation tools) prior to the field mission. The team shall use the time during the field mission to collect and analyze data/information and consolidate main findings before conducting the debriefing meeting and final review workshop with stakeholders to present the preliminary results.

The information collected will be analyzed by the evaluation team to identify correlations and determine the major issues. Data will be disaggregated, where possible, by gender to identify how program inputs are benefiting disadvantaged and advantaged groups.

Interviews and Site Visits

The evaluation team will conduct in-depth interviews and focus group discussions, at a minimum, with the following organizations/staff:

- HPP consortium partners
 - Futures Group
 - PLAN International
 - Futures Institute
- Partners in Population and Development Africa Regional Office (PPD ARO)
 - Population Reference Bureau (PRB)
 - Research Triangle Institute (RTI)
 - The White Ribbon Alliance for Safe Motherhood (WRA)
- USAID Missions in countries with HPP field support
 - Afghanistan (special focus)
 - Caribbean Regional
 - Dominican Republic
 - Ethiopia
 - Guatemala (travel – case study)
 - India
 - Jordan
 - Kenya (travel – case study)
 - Malawi
 - Mozambique

- Tanzania
- West Africa
- USAID Washington GH Bureau Offices (PRH, OHA)
- Regional Bureaus (AFR, Asia and the Middle East, E&E, and LAC)
- OAA and Mission contracting officers
- USAID Washington HPP Management staff (PRH/PEC and OHA)
- OGAC
- HPP subaward and subcontract holders
 - African Men for Sexual Health and Rights (AMShR; West Africa & core activities)
 - Afghanistan Private Hospitals Association (Afghanistan)
 - Afghanistan Social Marketing Organization (Afghanistan)
 - NCPD (Kenya)
 - ISDM (Guatemala)
 - NIHFWS (India)
 - PHE (Ethiopia)
 - Futures Group Global Outreach (multiple countries)
- Subject matter experts, outside stakeholders, and other identified partners
 - Gates Foundation
 - UNFPA
 - FANTA II
 - IPPF

Proposed provinces for the site visits are:

- Guatemala City, Guatemala, and sites where NGO/civil society partners are working
 - Nairobi, Kenya, and sites where partners are working

The team is expected to visit sites as outlined in the suggested schedule.

The evaluation team may be accompanied by a staff member from USAID/[Washington, Kenya, or Guatemala], as appropriate, to observe interviews and field visits. A list of interviewees and key stakeholders will be provided by USAID prior to the assignment's inception.

VII. METHODOLOGY

The primary methodologies for this performance evaluation will include: (1) document review and (2) in-depth key informant interviews. Focus group discussions, surveys, and direct

observation will be methodologies open for discussion at the PRH/OHA pre-evaluation meetings. The specific methodologies for each of the evaluation areas are identified and described below; however, where feasible, methods should be combined to address multiple questions at once.

A select set of countries with moderate to high M&E and resource investment has been selected for in-country case study evaluation. These countries are Guatemala, Afghanistan, and Kenya (pending Mission agreement). The evaluation team will consult with and receive approval from the USAID management team as to the selection of additional countries for evaluation by remote means.

PRH/OHA Pre-Assessment Meetings and All Staff Meeting

The evaluation team will organize and hold a preliminary half-day team planning meeting (TPM) with the HPP/USAID Management Team to review and refine the assessment objectives and the proposed tasks comprising the scope of work. Prior to the meeting, the evaluation consultants will be expected to have read all background material. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. The meeting will be comprised of HPP/ USAID Management Team, HPP Futures Management, and Futures Partner Consortium representatives and will be used to further discuss the assessment and scope of work.

In addition, the team will work with USAID to

- Clarify team members' roles and responsibilities;
- Review and clarify assessment questions;
- Review and finalize the assignment time line and share with USAID;
- Agree on and prepare preliminary drafts of data collection methods, instruments, tools, guidelines, and analysis;
- Review and clarify any logistical and administrative procedures for the assignment;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Develop a preliminary draft outline of the team's report;
- Assign report-drafting responsibilities for the final report.

The evaluation team will develop a detailed work-plan, tools, and timeline for approval by the USAID management team prior to commencement of the evaluation. Expected deliverables with associated due dates will also be agreed upon at the TPM. While the evaluation is underway, the evaluation team will also be responsible for periodically contacting the USAID management team to provide updates on progress and address any issues that may have come up.

Data Collection

The evaluation team will work collaboratively with the USAID management team to develop a detailed work-plan as well as a data collection strategy, including data collection instruments. The evaluation team will assume responsibility for developing the interview questionnaires

needed to fulfill Tasks 1-3 described in the scope of work. The data collection tools will be reviewed by the USAID management team prior to implementation to ensure their applicability.

The evaluation team will conduct in-depth, qualitative interviews with key USAID staff, stakeholders, and partners in person when possible or if not by telephone. Information from Mission staff may be collected through in-person interviews in case study country visits as agreed upon by the USAID management team, and by telephone surveys.

Key informants will be identified by USAID and Futures and will receive final approval by USAID. They will be drawn from but are not limited to the following:

- USAID Missions in countries with HPP field support
- USAID Washington GH Bureau Offices (PRH, OHA)
- Regional Bureaus (AFR, Asia and the Middle East, E&E, and LAC)
- OAA and Mission contracting officers
- USAID Washington HPP Management staff (PRH/PEC and OHA)
- HPP consortium partners
- OGAC
- HPP sub award and subcontract holders
- Subject matter experts, outside stakeholders, and other identified partners.

HPP Self-Assessment

Prior to initiation of the evaluation, HPP will be asked to prepare and submit a self-assessment report to the HPP/USAID Management Team. The evaluation team will assume responsibility for developing the self-assessment guide.

Data Analysis and Synthesis

The evaluation team will need to review available documents and ensure that appropriate questionnaires are developed to obtain the needed information to complete Tasks 1–3. Information/data should be collected to provide sufficient detail to answer key questions and inform the design process for the follow-on agreement. Once the data collection process is complete, results will be carefully compiled and analyzed to identify significant findings and recommendations.

Debriefing meetings with PRH/OHA/HIDN and HPP

After submission of a draft report, the evaluation team will be responsible for organizing and holding a series of debriefing meetings in Washington to share the findings and recommendations.

- An initial, smaller debrief for review and discussion of the draft report will be held with the USAID management team and key PEC representatives.
- This will be followed by a broader debriefing for PRH and OHA.

- A separate debrief should also be planned for The Futures Group International/ HPP for those sections of the evaluation that are relevant to project performance.

Based on comments to the draft report and input provided at debriefing meetings, a final report will then be completed and submitted to the USAID Management team.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Team Composition

A two- to three-member evaluation team is proposed; one of the members is to be designated as team leader. The evaluation team should have substantial demonstrated knowledge in health policy and advocacy; in international public health in the fields of family planning and HIV/AIDS; in USAID and PEPFAR policies, procedures, and procurement mechanisms, and in conducting project evaluations.

Collectively, team members will need to have the following skills and experience:

1. 10–12 years of experience in international public health, including the areas of family planning and HIV/AIDS. Additional experience in the areas of maternal health, child survival, and infectious disease would be beneficial.
2. 7–10 years of experience in the area of international health policy, including family planning and HIV/AIDS in developing country settings.
3. Expertise is required for several of the following technical areas:
 - Health policy development and implementation
 - Advocacy and capacity building for policy champions and civil society groups
 - Financing and resource allocation
 - Gender
 - Health equity
 - Data analysis and modeling and
 - Health systems
4. Extensive experience with conducting evaluations, assessments, and questionnaire design.

In addition each member should have the following skills and experience:

- An advanced degree in public health, health policy, economics, or other relevant course of study.
- Excellent English language skills, both written and oral.
- Demonstrated knowledge of USAID policies, programs, and procedures.
- Ability to effectively conduct interviews, in person or by phone.
- Ability to interact and communicate effectively with a diverse set of professionals.

The team lead will have the required skills and will be responsible for organizing and carrying out the evaluation, communicating with the HPP/USAID management team, ensuring the quality of the questionnaire design and data collection process and writing, and editing the final assessment report, including a version to be shared publicly that does not include any procurement-sensitive information.

Level of Effort

An illustrative table of the LOE is found below.¹ Dates may be modified based on availability of consultants and key stakeholders, and amount of time needed for field work.

Activity	Team Leader	Team Member	Illustrative POP (depending on start date)
Document review/	5 days	5 days	November 18– 21
Draft workplan/Creation of instruments	5 days	5 days	November 25– December 2
Half-day kick-off meeting	1 day	1 day	November 21
Remote data collection– Afghanistan	3 days	3 days	December 3–5
Data collection and travel– Guatemala	7 days	7 days	December 7–13
Data collection and travel)– Kenya	8 days	8 days	December 14–21
Data analysis	5 days	5 days	January 6–10
Report writing	5 days	5 days	January 13–17
Debriefings in Washington/ Draft I due	3 day	3 day	January 21–23
USAID responds with comments on draft 1	n/a	n/a	January 24
Team revises draft 2	1 day	1 day	January 27
USAID provides technical sign-off	n/a	n/a	January 28
Edit/format/508/print report	n/a	n/a	January 29–February 18
Assignment end			February 21
Total LOE	42	42	November 11–February 21

*A six-day work week is approved only for periods of international travel to accommodate travel/ work days.

This amended SOW provides 11 (5 in the previous period, plus 6 in the extension) additional days of LOE per consultant for report writing and revision, 3 days to travel to DC for a second debriefing, and 1 to prepare an internal memo to USAID, for a total of **57 LOE days** per consultant.

(Please note: Five days of LOE were added to the consultants’ LOE, shifting costs from editing, formatting and printing the report during the assignment’s initial period of performance.)

¹ LOE schedule amended February 12 to account for additional travel and schedule changes.

Revised Timeline:

Team submits draft #2	4 days	4 days	Feb 24
USAID final Review Technical sign-off by 2/27)			Feb 25 - 27
Internal Debrief with USAID	3 days	3 days	Dates TBD
Draft Internal Memo	1 day	1 day	March 20
Edit/Format/508	2 days	2 days	Feb 28 – March 20
Submit final edited, formatted report	n/a	n/a	March 21
Additional LOE	10 days	10 days	February 22– March 21

* **NOTE:** This assignment was initiated in late November 2013. At the kick-off meeting with USAID a methodology was agreed on that included: document review, open-ended interviews and written questions to Futures Group (prime recipient of the project). As part of the open-ended interviews, respondents will be assured that their responses are private, yet typed notes from the in-depth interviews will kept by GH Tech. Other options identified in the SOW were not taken.

The LOE for the project was changed twice during the assignment. Once to cover the costs of the methodology used, and a second time, when the Global Health Technical Assistance Project was extended, to allow the consultants to finalize the report and provide briefings to USAID/W and the prime recipient. As a result, LOE for two consultants was raised from 42 to 57 days each, and the number of meetings in Washington DC (noted in LOE chart below) increased from 2 to 5.

Deliverables to be provided to USAID on three (3) flash drive to provided Evaluation Program Manager: Guideline Questions for in-Depth Interviews, Questions for Futures Group; Answers from Futures Group; Power Point Presentations (one used with the project management team and Futures Group leaders, and a second used for a general GH audience); Final Report. As Interview notes will be provided in typed form to GH Tech. Additionally, the project's Agreement Officer's Representative (AOR) will also receive a memorandum with information redacted from the Final Report.

LOGISTICS

GH Tech will be responsible for all international travel, consultant logistics, and assisting with in-country consultant travel arrangements, as necessary.

The USAID management team will provide overall direction to the evaluation team; identify key documents and key informants; and liaise with USAID Missions to ensure logistical support for field visits prior to the initiation of field work. The USAID management team shall be available to the team for consultations regarding sources and technical issues, before and during the evaluation process.

The evaluation team will be responsible for scheduling and arranging all meetings and key informant interviews, as well as arranging overseas and in-country travel as necessary.

DELIVERABLES AND PRODUCTS

The team will prepare the following deliverables; all deliverables will require final approval by USAID/Washington.

- *Data sets.* All data instruments, data sets, presentations, meeting notes, and final report for this evaluation will be presented to USAID on three (3) flash drives to the Evaluation Program Manager. All data on the flash drive will be in an unlocked, editable format.

- *Final work plan and data collection instruments:* The evaluation team will prepare a detailed work plan in response to SOW requirements and evaluation questions. The detailed work plan should identify the countries for site visits and individuals and stakeholders for in-depth interviews and should include each of the proposed data collection instruments (i.e., structured interview guides, surveys, observation forms, etc.). A draft of the detailed work plan and data collection instruments should be submitted to the USAID Management Team for input prior to finalization.
- *Draft report:* This report should describe the findings from the technical evaluation as well as findings related to the big picture and overarching issues spanning both the Management Review and the evaluation. The report should separately and comprehensively address each of the objectives and questions listed in the SOW as well as the findings, interpretations, conclusions, and recommendations which should be clearly supported by the collected and analyzed data. Findings should be presented graphically where feasible and appropriate using graphs, tables, and charts. The final report should make recommendations for future action, including recommendations that may be relevant to the implementation of the second half of the existing project as well as for the redesign of future projects in technical and managerial aspects. The report should not exceed 40 pages in length (not including appendices, list of contacts, etc.). The final report should contain an executive summary, table of contents, main text including findings, conclusions, and recommendations. Annexes should include the Scope of Work, description of the methodology used, lists of individuals and organizations consulted, data collection instruments (questionnaires, discussion guides, etc.) and bibliography of documents reviewed. The executive summary should accurately represent the report as a whole and should not exceed two pages.
- *Final report:* After receiving the draft version of the report, USAID will have 10 days to respond with one set of comments. The team will then have one week to revise the report and submit it to USAID. An electronic version of the edited, formatted, and 508-compliant final report should be submitted to the USAID Management Team along with 15 hard copies. The report will be released as a public document on the USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) in accordance with GH Tech Bridge contractual requirements.
- *Final debrief presentation:* The final report is to be accompanied by a PowerPoint presentation that aims to debrief selected stakeholders of the results and recommendations stemming from the mid-term evaluation. A draft of the final presentation should be submitted to the USAID Management team prior to finalization.

USAID Criteria to Ensure the Quality of the Evaluation Report

The report shall follow USAID branding procedures. An acceptable report will meet the following requirements as per USAID policy (ref: the USAID Evaluation Policy):

- The evaluation report should represent a thoughtful, well-researched, and well-organized effort to objectively evaluate what worked in the project, what did not, and why.
- The evaluation report shall address all evaluation questions included in the SOW.

- All modifications to the SOW, whether to technical requirements, evaluation questions, evaluation team composition, methodology, or timeline need to be agreed upon in writing by the AOR.
- The evaluation methodology shall be explained in detail and all tools used in conducting the evaluation, such as questionnaires, checklists, and discussion guides will be included in an Annex in the final report.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the valuation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.)
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or the compilation of people’s opinions. Findings should be specific, concise, and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

Reporting Guidelines

The final report should be a comprehensive analytical evidence-based evaluation report:

- Detail and describe results, effects, constraints, and lessons learned from HPP Futures partners and other stakeholder-supported activities.
- Identify gaps in HPP control and pandemic preparedness and prevention, including programmatic, leadership, funding, and geographic gaps.
- Review current USAID-funded programs’ goals and objectives and their applicability in the context of host government and other stakeholder objectives and activities, and the political context within the evaluated countries.
- Evaluate level of coordination among USAID partners, host governments, and other stakeholders.
- Evaluate level of sustainability/replication/adaptation of USAID-funded activities.
- Provide recommendations and lessons learned on aspects related to factors that contributed to or hindered attainment of program objectives, sustainability of program results, innovation, and replication.

The annexes to the report shall include:

- The evaluation SOW
- Any “statements of differences” regarding significant unresolved difference of opinion by funders, implementers, and members of the evaluation team

- All tools used in conducting the evaluation, such as questionnaires, checklists, survey instruments, and discussion guides
- Sources of information, properly identified and listed
- Disclosure of conflicts of interest forms for all evaluation team members, either attesting to a lack of conflict of interest or describing existing conflict of interest.

Data Quality Standards

To be useful for performance management and credible for reporting, USAID Mission/Offices and Missions should ensure that the performance data in the PMP for each DO meet five data quality standards (abbreviated VIPRT). When this is not the case, the known data limitations and plans to address them should be documented in the indicator reference sheet in the PMP. Note that the same data quality standards apply to quantitative and qualitative performance data.

a) Validity. Data should clearly and adequately represent the intended result. While proxy data may be used, the DO team must consider how well the data measure the intended result. Another key issue is whether data reflect a bias such as interviewer bias, unrepresentative sampling, or transcription bias.

b) Integrity. Data that are collected, analyzed, and reported should have established mechanisms in place to reduce the possibility that they are intentionally manipulated for political or personal reasons. Data integrity is at greatest risk of being compromised during data collection and analysis.

c) Precision. Data should be sufficiently precise to present a fair picture of performance and enable management decision-making at the appropriate levels. One key issue is whether data are at an appropriate level of detail to inform management decisions. A second key issue is what margin of error (the amount of variation normally expected from a given data collection process) is acceptable given the management and resource decisions likely to be affected. In all cases, the margin of error should be less than the intended change. For example, if the margin of error is 10 percent and the data show a change of 5 percent, the USAID Mission/Office will have difficulty determining whether the change can be attributed to USAID activity or is a function of lack of precision in the data collection and tabulation process. USAID Missions/Offices should be aware that improving the precision of data often has time and financial resource implications.

d) Reliability. Data should reflect stable and consistent data collection processes and analysis methods over time. The key issue is whether different analysts would come to the same conclusions if the data collection and analysis processes were repeated. USAID Missions/Offices should be confident that progress toward performance targets reflects real changes rather than variations in data collection methods. When data collection and analysis methods change, the PMP should be updated.

e) Timeliness. Data should be timely enough to influence management decision-making at the appropriate levels. One key issue is whether the data are available frequently enough to influence the appropriate level of management decisions. A second key issue is whether data are current enough when they become available.

For further discussion, see USAID Information Quality Guidelines and related material on the Information Quality Act in **ADS 578** and at http://www.usaid.gov/about_usaid/.

RELATIONSHIPS AND RESPONSIBILITIES

This evaluation will be a participatory external review, in the sense that the GH Tech evaluation team will work collaboratively with the USAID management team throughout the duration of the evaluation.

The evaluation team will consult with the USAID management team regarding the methodology, approach, and data collection instruments but will be primarily responsible for data collection, analysis, and report writing.

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

USAID will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- *SOW*. Respond to queries about the SOW and/or the assignment at large.
- *Consultant Conflict of Interest (COI)*. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- *Documents*. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.
- *Communication*. A communication strategy will be developed jointly by USAID and the evaluation team so that the parties who are contacted by the consultants hear a similar introduction and receive the same information about HPP before interviews begin.
- *Local Consultants*. Assist with identification of potential local consultants, including contact information.
- *Site Visit Preparations*. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs. USAID will facilitate interviews by alerting interviewees about the evaluation and by providing contact information to the team.
- *Report Assistance*. Work with the consultants to produce a final report; this version of the report will only be distributed within USAID. GH Tech will also work with the consultants to produce a second version of the report that does not include procurement-sensitive information.
- *Lodgings and Travel*. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation). Be responsible

for approving travel and approving selection of key informants and assist with setting up interviews and meetings as needed.

During Field Work

- *Mission Point of Contact.* Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team's work.
- *Meeting Space.* Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- *Meeting Arrangements.* Approve the selection of key informants and assist the team in arranging and coordinating interviews and meetings with stakeholders.
- *Facilitate Contact with Implementing Partners.* Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and anticipated meetings.

After Field Work

- *Timely Reviews.* Provide timely review of draft/final reports and approval of deliverables.

CONTACT PERSONS

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Health Development Officer, HPP AOR
USAID/Washington
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Guatemala Mission: Yma Alfaro
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Kenya Mission: Sheila Macharia
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IX. COST ESTIMATE

GH Tech will provide a cost estimate for this activity.

X. DOCUMENTS REVIEWED

- Guidelines for Management Reviews and Project Evaluations, Bureau of Global Health, 2007
- USAID Evaluation Policy, 2011
- RFA Request for Applications
- Project Proposal
- Cooperative Agreement
- HPP Management Review
- Financial tracking documents and financial reports
- Project Strategies
- HPP KM Strategy
- HPP Gender Strategy
- HPP Evaluation Strategy
- Project work plans (core and field)
- Project Annual and Semiannual Reports
- HPP Performance Management Plan (PMP)
- SOWs for field-funded activities
- Trip reports
- Participant evaluations of trainings
- Community of practice meeting notes/records
- Capacity building and training curricula
- Management review data (interview transcripts) and final report

- USG Global Health Initiative (GHI) Strategy
- Country case studies, GHI/health strategies and frameworks (Guatemala, Afghanistan and Kenya)

Additional project-related information and technical reports can be found at the USAID Health Policy Project website (<http://www.healthpolicyproject.com/>).

ANNEX II. PERSONS INTERVIEWED

USAID MANAGEMENT TEAM

Linda Cahaelen, AOR, Health Policy Project (HPP). GH/PRH/PEC

Samantha Corey, HPP Program Analyst, GH/PRH/PEC

Mai Hijazi, HIV Activity Manager, GH/OHA

Britt Herstad, HIV Activity Manager, GH/OHA

Emily Roseman, HIV Activity Manager, GH/OHA

Debra Armbruster, MCH Technical Advisor, GH/HIDN/MCH

HEALTH POLICY PROJECT HEADQUARTERS

Suneeta Sharma, incoming Director

Sarah Clark, outgoing Director

Nancy McGirr, Senior Deputy Director

Ron MacInnis, Deputy Director for HIV

Carol Miller, Director for Field Support, Africa

Tito Coleman, Director for Field Support, Latin America

Nancy Yinger, Director M&E

Karen Hardee, former Deputy Director for RH/FP

Laura McPherson, former Director for Field Support

Polly Mott, Focal person for Guatemala

HPP CONSORTIUM MEMBERS

Steven Forsythe, Futures Institute, Costing/Modeling

Amy Sunseri, PLAN International (formerly CEDPA), Civil Society

Sue Richedei, PLAN International (formerly CEDPA)

Lalli Irani, Population Reference Bureau, M&E

Taylor Williamson, Research Triangle Institute, Governance

Mande Limbu, White Ribbon Alliance for Safe Motherhood (WRA), Maternal Health

Patrick Mugira and Diana Nambatya, Partners in Population & Development-Africa Regional Office (PPD-ARO)

OTHER U.S. GOVERNMENT AND STAKEHOLDERS

Ellen Starbird, Director, GH/PRH

Carmen Tull, GH/PRH/SDI

Jodi Charles, GH/OHS

Temitayo Ifafore, GH/PR

Marissa Leffler, GH/CAII

Kristina Yarrow, USAID Asia Bureau

Kaite Qutub, USAID Asia Bureau

Liz Shoenecker, former GH/PRH/PEC Division Chief

Tonia Potea, Senior Advisor for Key Populations, OGAC

Nathan Heard, Health Analyst, Office of the Geographer, U.S. Dept. of State (OGAC embed)

Andrew Mitchell, Advisor for Systems Strengthening and Human Resources, OGAC

Amy Tsui, Gates Foundation, Advancing Family Planning

Margot Fahnestock, Hewlett Foundation

Helena Choi, Hewlett Foundation

Dylis Mc Donald, Technical Director, Caribbean HIV/AIDS Alliance

AFGHANISTAN

Christina Lau, USAID Afghanistan, OSSD

Mohammad Iqbal Roshani, USAID Afghanistan, OSSD

Dr. Omarzaman Sayedi, Team Leader, HPP Afghanistan and FGGO lead

Dr. Abdul Qadeer Qadeer, Director General, Policy, Planning and International Relations, MoPH

Mohammad Saber Perdes, Acting Director for Health Economics and Financing Directorate, MoPH

Dr. Sayed Mohammad Shafi Saadat, Director for Directorate of Private Sector Coordination, MoPH

Mohammad Khan Zamani, Head of PPP Unit, MoPH

Dr. Hamrah Khan, Director of Gender Directorate, MoPH

Abdul Khaliq Zazai, CEO, Afghanistan National Medicine Services Organizations (ANMSO)

Dr. Aziz Amir, President, Afghanistan Private Hospitals Association (APHA)

Victoria Parsa, President, Afghanistan Midwifery Association (AMA) /Organization of Afghan Midwives (OAM)

Mohammad Ebrahim Heidar, Executive Director, Afghanistan Social Marketing

GUATEMALA

Erik Janowsky, Director, Health and Education Office, USAID Guatemala

Yma Alfaro, Activity Manager for HPP, USAID Guatemala, OHE (Health)

Juan Luis Cordova, Alternate Activity Manager for HPP, USAID Guatemala, OHE (Education)

Herminia Reyes, Director, Health and Education Policy Project (HEPP), and FGGO lead

Lorena Moreira, Director of Information Systems, HEPP

Marisela de la Cruz, Senior Family Planning Advisor, HEPP

Miriam Castaneda, Senior Advisor for Education, HEPP

Marlyn Marin, Director for M&E, HEPP

Suzette Higueros, Director of Operations, HEPP

Susana Palma, Senior Associate for Policy, HEPP

Dr. Brenda Campos, National Center for Epidemiology, Ministry of Public Health & Social Assistance (MoPH)

Vinicio Varrentor, National Center for Epidemiology, MoPH

Dr. Enrique Rodriguez, Advisor, MoPH

Dr. Roberto Santiso, Senior Technical Advisor for Family Planning, MoPH

Cynthia de Aguila, Minister of Education

Alfredo Garcia, Administrative Vice Minister, Ministry of Education (MoE)

Evia Hernandez, Planning Director, MoE

Nidia De Vega, former Planning Director, MoE

Julio Orellana, Deputy Director of Statistics, Planning Unit, MoE

Esteban Francisco Andrino, Vice Minister for Policy, Ministry of Social Development (MIDES)

Enrique Oregel, Planning and Evaluation Group, MIDES,
with unit members Ramiro Nochez, Luis Alvarado, Evelyn Lopez Morales

Dr. Mira Montenegro, Executive Secretary, Observatorio de Salud Reproductiva (OSAR)

Consuelo Esquivel, Board Member, Red de Mujeres por la Construcción de la Paz (REMUPAZ)
with nine representatives of member organizations representatives, and three youth volunteers

Dr. Rebecca Guizar, Representative of Legal Petition for Health and Development of Women;
Member, Commission on Contraceptive Security and Commission on Multisectoral Maternal
Health

Dr. Elsa Martinez, President, Guatemalan Association of Women Physicians); Member,
Commission on Contraceptive Security and the Commission on Multisectoral Maternal Health

Raquel Zelaya, Executive Secretary, National Campaign for Education

Belia Meneses, Legal Representative, Synergos

Julio Zelaya, President and General Director, The Learning Group

Mariano Sanchez, Mayor, Municipality of Concepcion Chiquirichapa, Quetzaltenango

Noemi Recancoj, Coordinator, National Red for Indigenous Women for Health, Nutrition & Education (ALIANMISAR), Participant, National Council on Food Security led by the Vice President

Mario Rodriguez, National Coordinator for Red for Men for the New Masculinity

Field visit to Quetzaltenango included Q&As with 20 Red members at a training program on family planning

KENYA

Barbara Hughes, Director, Office of Population and Health (OPH), USAID Kenya

Bedan Gichanga, Health Systems Management Specialist, OPH, USAID Kenya

Maria Francisco, Chief Health Systems Strengthening, OPH, USAID Kenya

Rene Berger, Chief HIV/AIDS, OPH, USAID Kenya

Jerusha Karuthiru, RH/FP Specialist, OPH, USAID Kenya

Stephen N. Muchiri, Director, HPP Kenya

Aaron Kivuva Mulaki, Health Systems/Public Administration Advisor, HPP Kenya

Robinson Kahothu, Senior Policy Advisor (Health Economics), HPP Kenya

David Kuria Mbote, Senior Policy and Advocacy Advisor, HIV, HPP Kenya

Thomas M. Maina, Senior Health Finance Advisor, HPP Kenya

Daniel N. Mwai, Effectiveness & Efficiency (E2) Advisor, HPP Kenya

Monica Wanjiru, Communications Advisor, HPP Kenya

Dr. Ruth Kitetu, Lead Policy Reform Department, Policy and Planning Directorate (PPD), Ministry of Health (MOH)

Elkana N. Ong'uti, Chief Economist, PPD, MOH with

Geoffrey Kimani, Deputy Chief, PPD, MOH

Terry Wastiri, Economist, PPD, MOH

Torn Mirasi, Economist, PPD, MOH

Dr. S.K. Sharif, Director for Public Health, MOH

Regina Ombam, Head Strategy, National AIDS Council (NACC), MOH

Dr. Irene Mukui, Lead Care and Treatment Component, National AIDS and STI Control Program (NAS COP), MOH

Dr. G.N.V. Ramana, Lead Health Specialist, Africa Region, World Bank

Dr. Heide Richter-Airijokik, Principal Advisor, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

Dr. Joanne Ondera, Program Advisor, Healthcare Finance, GIZ

OTHER USAID MISSIONS

Petros Faltamo, USAID/Ethiopia

Jennifer Knight-Johnson, USAID/Jamaica

Veronica Chirwa, USAID/Malawi

Susan Perez, USAID/West Africa Regional

OTHER FUTURES GROUP GLOBAL OUTREACH LEADS (FGGO)

Dr. Bhupinder Aulakh, India

Olive Mtema, Malawi

Dauda Sulaiman, Nigeria

Dr. Andriy Huk, Director and Senior Technical Advisor HPP, along with consultants Lena Truhan and Oleg Semeryk

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ANNEX IV. GUIDELINE QUESTIONS FOR IN-DEPTH INTERVIEWS

(38 questions)

January 10, 2014

Task I (18)

I.1.1. Do the technical approaches used in the project—e.g., policy development, advocacy, finance, and governance—help achieve project objectives/Mission objectives?

I.1.2. How has HPP strengthened and institutionalized local capacities?

I.1.3. Is there an emphasis on individual or institutional capacity building?

I.1.4. The use of modeling and tool kits appears to play a visible role in HPP. In what ways do you see these models and tool kits as an important part of capacity building?

I.1.5. When the HPP Cooperative Agreement began, finance and health systems strengthening were not key areas of activity. What was the evolution of adding this work into the project?

I.1.6. How does HPP coordinate with other donors at the global, regional, or county level? Are there examples of cofinancing?

I.1.7. What were the major steps in project startup and who was involved? What were the challenges and how were they addressed?

I.1.8. At the country level, after you complete an assessment, how do you determine which activities will be pursued? Are there standardized approaches? To what extent are approaches tailored to the local setting?

I.2.1. How has the current staffing structure been helpful, or not, in project implementation?

I.2.2. We understand that HPP is undergoing changes in key senior leadership of the project. Does Futures Group plan to maintain the current management structure, or do you envision any changes at this time? [now asked generally]

I.2.3. Have HPP consortium organizations been adequately involved in the implementation and decision-making? What have been their strengths and weaknesses?

I.2.4. What types of TA are most requested by Missions? By in-country partners?

I.2.5. What is the mix of Futures headquarters staff and regional consultants for the project? Is this the right mix for meeting local capacity building? What is the quality of the consultants?

I.2.6. How do you work and interface with the AOR (or Futures, or Mission staff)?

I.2.7. Have you had pipeline issues with HPP?

I.3.1. What is the breakdown of TA provided by U.S.-based experts vs. that provided by regional or country experts? What is the rationale used to make these choices? [not used—turned into a written question]

1.3.2. What assistance approaches—e.g., country offices, short-term consultants, embedded staff, and mentors—do you find to be the most useful? What about XX makes it useful?

1.3.3. How are assignment decisions for TA made? How are local country team members involved? How is the quality of the work of TA reviewed?

Task 2 (13)

2.1.1. What are HPP's comparative advantages?

2.1.2. How well is HPP meeting your needs? What have been important successes to date? Where have there been significant shortcomings? How did the project address shortcomings?

2.1.3. Is the HPP project responsive to [your] requests and program priorities?

2.1.4. Does HPP complete work plans, activities, and reports in a timely manner? Is HPP managed in a manner that facilitates work in the field?

2.1.5. How is project implementation progressing? What project inputs are important for implementation and what has been the quality of these inputs?

2.1.6. Has the project management model of working with local country directors and local teams been effective? Why or why not?

2.1.7. Has the skill mix of the local staff been adequate to implement HPP activities? What, if any, have been the obstacles in hiring and retaining local staff with sufficient technical expertise?

2.1.8. How do Futures HQ and the local HPP country teams work together and communicate?

2.2.1. What is the strategy for use of core activities in the HPP project and under what circumstances are core activities initiated? Examples? What are the challenges in implementing core activities?

2.2.2. Are there situations where core funds are used to fund field activities? How often does this happen? What is the rationale for this?

2.2.3. How has HPP contributed to global leadership, knowledge building, and collaboration? What are the project's global leadership strengths? Shortcomings? How might they be improved?

2.3.1. How does the field-support mechanism serve Missions and Regional Bureaus for meeting in-country programming and technical needs? What are some of the benefits and challenges you've experienced in using this mechanism?

2.3.2. Are there other options for accessing HPP or HPP-like services that could be better?

Task 3 (7)

3.1.1. What do you view as the important health policy priorities in the coming years?

3.1.2. Is HPP addressing these priorities? What existing gaps and future technical directions need to be addressed that are not currently being addressed by HPP? In your experience how long does it take to address these key priorities?

3.2.1. Are the structure and framework of the program and activities conducive to achieving the objectives and desired results? Why or why not?

3.2.2. What are some of the important design questions that should be addressed in future programs of this kind?

3.3.1. What are emerging issues in health policy priorities in the coming year?

3.3.2. What are current challenges in health policy, advocacy, finance, and governance?

3.3.3. What are other emerging policy issues in health over the coming years?

ANNEX V. QUESTIONS FOR HPP SELF-ASSESSMENT

HPP Evaluation

Questions for HPP Self-Assessment

December 16, 2013

1. What approaches does HPP use to strengthen and institutionalize local capacities of government and nongovernment entities? Which of these approaches have been the most effective and why? Please specify the type of capacities—as well as the level of government and/or type of organization.
2. Has the project's use and development of toolkits and models been effective in furthering the project's goals? How are they used to address/approach the cross-cutting areas under HPP, as well as the four main focus areas (policy, financing, advocacy, and governance)?
3. What are the key elements of country program startup (note: these can be listed) and on average how long does it take? What are some of the difficulties in startup? Are there solutions for these difficulties that could be instituted, and by whom?
4. What are the challenges you find in starting and then implementing a core activity? How could some of these challenges be mitigated?
5. In general, what have been the successes and challenges in working with the project management team in USAID/WASHINGTON and Mission teams?
6. Is a cooperative agreement an appropriate mechanism for this kind of project? What mechanism changes would you suggest to improve project implementation? Is the broad scope of the project an advantage or a disadvantage, in the field and in core?
7. Please describe the project's reporting and management system. How do you find the matrix management system used by HPP headquarters— where people have a vertical line of reporting, but where they are involved with a number of activities managed outside their organizational unit— helps with project implementation? What are the downsides? Please provide the names of HPP management and technical staff working on each current core activity as well as country programs in Guatemala, Kenya, and Afghanistan.
8. In the ever-changing global development realm (which is currently FP2020, AIDS-Free Generation, and Ending Preventable Maternal and Child Deaths), what do you feel are HPP's comparative advantages, specifically in technical expertise?
9. Please provide a breakout for 2013 by country showing the percentage of TA/LOE provided by headquarters staff, in-country staff and consultants, and others.
10. Please provide pipeline information for each fiscal year: 1. Core funding received, 2. funding office, and 3. pipeline as of the end of that FY. Please provide the same information for each field support activity for each year: 1. FS funding received, 2. funding office/Mission, and 3. pipeline. Feel free to use an existing chart with this information if one is available.

11. Please briefly discuss future areas of work that you think should be addressed by USAID in both field and core work. What trends are you seeing in both FP/RH and HIV/AIDS? Should one of the current primary work areas...policy, advocacy, financing, governance...be given more focus than currently afforded? Less? What about the cross-cutting areas? Are there new areas that you would suggest USAID invest in?
12. Is there anything else you would like to share with the evaluation team?

ANNEX VI. HPP TECHNICAL STAFF WORKING ON CURRENT CORE ACTIVITIES AND SELECTED FIELD PROGRAMS (LAST 6 MONTHS OF 2013)

Copied from HPP Self-Assessment 2014, Table b (Q8)

Core Activity	Activity Manager	Other US Staff
<i>Common Agenda Activities</i>		
C1. Developing and Integrating Sustainable Capacity-building Plans, Approaches, and Tools	Nancy Yinger	Anne Jorgensen
C2. Advancing Policy and Advocacy Approaches for Vulnerable Populations, including Women and Girls, Poverty, Youth, and Other Factors Associated with Social Exclusion	Rudolph Chandler	Sarah Alkenbrack Suneeta Sharma
C3. Measuring the Impact of Policy Interventions	Laili Irani	Karen Hardee
C4. Enhancing Sharing of Best Practices and Knowledge Management, including Collaboration with Knowledge for Health (K4H) and AIDS Support and Technical Assistance Resources (AIDSTAR)	Beth Robinson	Sarah McNabb Tom Fagan Pol Klein Cameron Hartofelis
C5. Providing Technical Leadership on the Women, Girls, and Gender Equality (WGGE) Principle	Jennifer Pendleton	Beth Rottach Susan Settergren
C6. Identifying “Next Generation Policy” Processes/Tools through Technical Coordination, Technical Assistance to Global and Regional Policy Networks, Consultation, and Evidence Building	Dara Carr	
C7. Monitoring and Evaluation Support to HPP	Nancy Yinger	Mona Steffen Rachel Kiesel Andrew Zapfel Laili Irani Dara Carr
<i>FPI/RH-Specific Activities</i>		
P1. Informing High-level Dialogue, Strengthening Leadership, and Sharing Best Practices for Promoting Family Planning in Africa	Elizabeth Leahy Madsen	Karen Hardee Nichole Zlatunich
P2. Repositioning Family Planning in West Africa	Modibo Maiga	Don Dickerson
P3. Creating a Near-term Advocacy Platform for Family Planning with Near-term Economic Modeling	Ellen Smith	Aparna Jain Alexander Paxton Nancy Yinger

Core Activity	Activity Manager	Other US Staff
P4. Providing Evidence to Meet the Contraceptive Supply Challenge (Reproductive Health Supplies Coalition)	Margaret Reeves	Elizabeth L-Madsen Karen Hardee Randolph Chandler Nichole Zlatunich Joni Waldron Rachel Kiesel Bethany O'Connor
P5. Putting Integrated Health Action Plans into Practice at the Decentralized Level	Taylor Williamson	Karen Hardee Aparna Jain
P6. Empowering Women Leaders for Country-led Development	Sue Richiedei	Amy Sunseri Anne Jorgensen Karen Hardee Nancy Tian Kate Mangino
P7. Enhancing the Spectrum System of Models	Bob McKinnon	Randolph Chandler Bill Winfrey John Stover Imelda Feranil
P13. Demographic Dividend	Elizabeth Leahy Madsen	Scott Moreland Bernice Kuang
P14. Support for Global Advocacy for Family Planning H2H	Rudolph Chandler	
P15. Building Capacity for Evidence-based Advocacy to Promote Smart Integration of FP	Kristen Savard	Mande Limbu Lauren Bland Lisa Bowen R Angels (WRA) S Stanton (WRA)
P17. Reducing Stigma and Increasing Adolescent Access to Contraception	Laura Nyblade	Aparna Jain Anne Jorgensen Laurette Cucuzza U Tatsia (PLAN) M Stockton (PLAN)
P18. FP2020—Country Follow-up	Jay Gribble	Karen Hardee Margaret Reeves Mariela Rodriguez Suneeta Sharma
P19. RAPIDWomen—PHE	Scott Moreland	Alexander Paxton
P20. PAC Compendium Update	Sara Pappa	Laili Irani

Core Activity	Activity Manager	Other US Staff
P21. Food Nutrition Pop Model	Ellen Smith	Phonda Smith Reshmi Naik Jill Hagey S Mehta (PRB) Jason Bremner
P23. Rethinking CPR/TFR Relationship (NEW)	Ellen Smith	Bernice Kuang
P24. Costed Implementation Plans (NEW)	Nichole Zlatunich	
P25. Strengthening Accountability – CSOs (NEW)	Erin McGinn	Mariela Rogdriguez Kay Wilson
P26. Strengthening Accountability – MOH (NEW)	Taylor Williamson	
P27. FP Effort Scores (NEW)	Ellen Smith/Bernice Kuang	John Ross
P28. HTSP Dissemination and Advocacy (NEW)	Margaret Reeves	
<i>MH-Specific Activities</i>		
M1. Promotion of Respectful Care at Birth	Mande Limbu	Lisa Bowen Ray Mitchell
M2. Promotion of the Profession of Midwifery	Mande Limbu	Lisa Bowen Ray Mitchell
<i>HIV-Specific Activities</i>		
H1. PFIP Policy Matrix Monitoring and Evaluation	Nicole Judice	Andrew Zapfel Ron MacInnis
H2. Supporting the Rollout and Implementation of the Policy and Enabling Environment Components of the New PEPFAR IDU and MSM Guidance	Kip Beardsley	Ryan Olson
H5. Enhancing Evidence, Capacity, and Tools to Reduce HIV-related S&D in Healthcare Settings	Laura Nyblade	Ryan Olson
H6. Implementing Efficiency and Effectiveness Targets in Scale-up for HIV Programs: Identification of Best Practices and Country-level Pilot	Arin Dutta	Nicole Perales Ricardo Silva Annie Chen
H7. Supporting Country-Led Initiatives to Strengthen HIS	Anita Datar	Priya Iyer
H9. Support for What Works for Women and Girls	Sara Pappa	
H10. MSM Policy and Advocacy	Darrin Adams	David Kuria Mbote
H11. GBV Program Quality (NEW)	Sarah Alkenbrack/ Susan Settergren	

Core Activity	Activity Manager	Other US Staff
H12. Country Ownership (NEW)	Dara Carr	Taylor Williamson Derek Brinkerhoff
H13. PMTCT Costing (NEW)	Sarah Alkenbrack	
H14. Peds Costing (NEW)	Joni Waldron	
H15. VMMC Costing	Katherine Kripke	
H16. VMMC – Lesotho (NEW)	Katherine Kripke	
H17. ICT Key Pops (NEW)	Darrin Adams	
H18. GIS Mapping (NEW)	Anita Datar	Ron MacInnis Taryn Couture

Country Program	CFP	Other US Staff	Local Technical Staff
Afghanistan	Megan Bishop	Katie Sears Wu Zeng Joe Ichter Laili Irani Karen Hardee Beth Robinson Ken Morrison Rachel Kiesel Anne Jorgensen Amy Sunseri Xiaoping Tian	Omarzaman Sayedi Mohammad Yousuf Jabarkhil Christine Kim Rahila Juya Heela Barakzai Hamrah Khan* Mohammad Shafi Sadaat* Khan Mohammad Zamani* Mohammad Jamshid Payam* Abdul Azim Musamem Mohammad Osman Fahim* Janaqa Shams Hashimi* Ahmad Reshad Osmani* Anosha Qiyamee* Mohammad Younus Zawoli* Shuhrat Munir* Sayed Mohammad Karim Alawi* Mir Najmuddin Hashimi* Ajmal Behzad* Mohammad Samim Soroush* Najibullah Naimi* Jan Ali Faizi* Enayatullah Modasser* Emal Masood* Sayed Sajid Khyber Khishki Mohammad Rasool Farhad Barai Mohammadullah Alishungi* Allah Dad Marufkhail Qiamuddin Sabawoon*
Guatemala	Polly Mott	Mona Steffen Beth Robinson Justin Fugle Amy Sunseri	Herminia Reyes Miriam Castañeda Marisela de la Cruz Lorena Moreira Susana Palma Marlyn Marin Juan Carlos Villatoro Edwin Canu Saul Gomez Orly Lam Edgar Mendez Sonia Son Yadira Coti Claudia Cucul Juana Lorenzo

Country Program	CFP	Other US Staff	Local Technical Staff
			Silvia Maldonado Apolonia Pascual Nicolasa Puac Juan Carlos de Leon Lucas Esteban Marco Galvez Oliveri Garcia Humberto Gonzalez Gilda Rivera Telma Suchi
Kenya	Laura McPherson Nicole Judice Arin Dutta	Beth Robinson Taylor Williamson Annie Chen Nicole Perales Jennifer Pendleton Nancy Yinger Derek Brinkerhoff Anne Jorgensen	Stephen Muchiri Robinson Kuhuthu Monica Wanjiru Thomas Maina Tom Oneko Daniel Mwai Aaron Mulaki David Mbote Sandra Erickson Caroline Njoroge

Employee is funded by HPP but seconded to the MOPH.

ANNEX VII: PARTNER INVOLVEMENT IN HPP ACTIVITIES (2013)¹

Partner	FT Staff	Part-time	Activities
Futures Institute	Katherine Kripke	R. Chandler S. Forsythe Biyi Adesinyi Bob McKinnon Peter Stegman	Core: C2, P7, P14, H15, H16 Field Programs: Botswana, Malawi, South Africa, Tanzania, Swaziland, Lesotho, Mozambique
Plan International USA/ CEDPA	Anne Jorgensen Amy Sunseri	Sue Richedei Jason Fugle Xioaping Tian	Core: C1, P6 Field Programs: Afghanistan, Ethiopia, Guatemala, Kenya, Mozambique, AME Regional
RTI International	Laura Nyblade Taylor Williamson	Derek Brinkerhoff ½ staff person TBD	Core: P5, P17, H3, H4, H5, P26 Field Programs: Caribbean, DR, Kenya, Ghana
PRB	Laili Irani	Rhonda Smith Jason Bremmer Reshma Naik	Core: C3, C5, C7, P21 Field Programs: Afghanistan, Jordan, Kenya
WRA	Mande Limbu	Kristen Savard Lisa Bowen Betsy McCallon	Core: M1, M2, P15 Field Programs: Afghanistan
PPD ARO		Dr. Jotham Musinguzi Patrick Mugirwa Diana Nambatya	Core: P1

¹ HPP Mid-term Self-assessment, pp. 20–21.

ANNEX VIII: CONFLICTS OF INTEREST

Disclosure of Conflict of Interest for USAID/GH Consultants

Disclosure of Conflict of Interest for USAID/GH Consultants

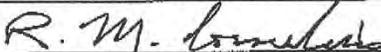
Name	Constance A. Carrino
Title	Independent consultant
Organization	GH Tech Bridge 4
Consultancy Position	
Award Number (contract or other instrument)	Contract Number: AID-OAA-C-13-00113
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	For GH Tech, I participated in an evaluation of maternal and child health programs for USAID Afghanistan in 2011. Implementing agencies included BASCIS, JHU, and MSH.
I have real or <u>potential</u> conflicts of interest to disclose.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>If yes answered above, I disclose the following facts:</p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	<p>#5</p> <p>As shown on my CV, since retiring from USAID, I have consulted for URC, Save the Children, and ARD Tetra Tech.</p> <p>As a senior manager within USAID, I've probably worked with every organization that might be evaluated by GH Tech.</p>

2

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	<i>CN Casino</i>
Date	<i>9/27/2013</i>

Disclosure of Conflict of Interest for USAID/GH Consultants

Name	Richard Cornelius
Title	International Consultant, Population and Public Health
Organization	GH Tech Bridge 4
Consultancy Position	
Award Number (contract or other instrument)	Contract Number: AID-OAA-C-13-00113
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Health Policy Project Futures Group, PLAN, CEDPA, PRB, RTI, and others Award # AID-OAA-A-10-00067
I have real or potential conflicts of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>If yes answered above, I disclose the following facts:</p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	
<p>I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.</p>	
Signature	
Date	11/19/2013

For more information, please visit
<http://www.ghtechproject.com/resources>

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