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# ASSESSMENT OF THE USAID HEALTH POLICY INITIATIVE IQC AND TASK ORDER 1

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## ACRONYMS

A <sup>2</sup>	Analysis and Advocacy
ADS	Automated Directives System
AFR	Africa Bureau
AID/W	U.S. Agency for International Development/Washington, D.C.
ANE	Asia and Near East Bureau
ARV	Antiretroviral
CEDPA	Centre for Development and Population Activities
CSO	Civil Society Organization
CO	Contracting Officer
COTR	Contracting Officer's Technical Representative
CA	Cooperating Agency
DRC	Democratic Republic of Congo
DEMPROJ	Demographic Projection Model
E&E	Europe and Eurasia Bureau
FAMPLAN	Family Planning Model
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
FSRP	Field Support Review Process
Futures	Futures Group International
FY	Fiscal Year
GBV	Gender-based Violence
GH	Global Health Bureau
GH Tech	Global Health Technical Assistance Project
G/CAP	Guatemala/Central American Regional Program
HIDN	Health, Infectious Diseases and Nutrition
HS	Health Systems
HSS	Health Systems Strengthening
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPI	Health Policy Initiative
IGWG	Interagency Gender Working Group
IR	Intermediate Results
IQC	Indefinite Quantity Contract
LAC	Latin America and the Caribbean Bureau
LWA	Leader with Associates
LOE	Level of Effort
MC	Male Circumcision
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health

MH	Maternal Health
MH/CS	Maternal Health/Child Survival
MOH	Ministry of Health
MSM	Men Who Have Sex With Men
NACC	National AIDS Control Council (Kenya)
NGO	Nongovernmental Organization
OAA	Office of Acquisition and Assistance
OGAC	Office of the Global AIDS Coordinator
OHA	Office of HIV/AIDS
OVC	Orphans and Vulnerable Children
OPTIONS	Options for Population Policy
PLHIV	People Living with HIV
PEC	Policy, Evaluation and Communication
PHN	Population, Health and Nutrition
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PRH	Office of Population and Reproductive Health
PRSP	Poverty Reduction Strategy Paper
RDM/A	Regional Development Missions/Asia
RH	Reproductive Health
RHSC	Reproductive Health Supplies Coalition
RAPID	Resources for the Awareness of Population Impacts on Development
RFP	Request for Proposal
RTI	Research Triangle Institute, International
SOW	Scope of Work
SPER	Strategic Planning, Evaluation and Reporting
TA	Technical Assistance
TDY	Temporary Duty Travel
TOR	Terms of Reference
TO	Task Order
TO1	Task Order 1
TD	Technical Development
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	U. S. Agency for International Development
USAID/W	U. S. Agency for International Development in Washington, D.C.
VCT	Voluntary Counseling and Testing
WRA	White Ribbon Alliance
WHO	World Health Organization

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# EXECUTIVE SUMMARY

## INTRODUCTION

An assessment of U.S. Agency for International Development's (USAID) Health Policy Initiative (HPI) was conducted by a three-person team of consultants from the Global Health Technical Assistance Project (GH Tech) from late January to May 2009. The assessment's three tasks were to: (1) determine the effectiveness and efficiency of the multiple-award indefinite quantity contract (IQC) and Task Order 1 (TO1) procurement mechanisms in meeting policy and advocacy programming needs of the Global Health (GH) and Regional Bureaus and Missions; (2) assess the quality and progress of HPI/TO1 program implementation and satisfaction of GH Offices, Regional Bureaus, and Missions with the accomplishments of workplan objectives.

Started in 2005, HPI is a complex global project designed to improve the enabling environment in developing countries for health, primarily for family planning and reproductive health (FP/RH), HIV/AIDS, and maternal health (MH). There are five activity areas that address intermediate results (IRs) in the HPI results framework. These areas are policy and advocacy, leadership development, financing, multisectoral coordination, and evidence-based decision-making.

HPI covers the world geographically, working in 30 USAID-supported countries and in four regions. It implements diverse health policy and advocacy activities that address important health areas. Implementation of HPI has been challenging due to the procurement mechanisms, multiple contractors, numerous funding streams, ceiling constraints, and a time-consuming Field Support Review Process. Furthermore, the project works within a shifting environment for health policy and advocacy due to changes in the HIV/AIDS epidemic and levels and mechanisms of donor funding and uncertainties about health budgets in host countries.

## Procurement and Funding

A draft HPI request for proposal (RFP) for a single-award contract was issued on November 26, 2004, to solicit comments from interested parties. The final HPI RFP solicitation was issued as a multiple-award IQC with TO1 on March 4, 2005, with several subsequent modifications. In September 2005 four organizations became IQC holders: Abt, Chemonics, Futures Group International (Futures), and Research Triangle Institute, International (RTI). The contractor for HPI/TO1 is Futures. Most of the HPI work has been carried out under TO1. In addition to TO1, six other TOs have been awarded, four to Futures, and one each to Abt and RTI.

HPI/TO1 has two sources of funding: core and field support. Core support funds technical leadership and global policy and advocacy priorities (e.g., poverty and equity, stigma and discrimination, male circumcision to prevent HIV transmission, repositioning family planning, and contraceptive security). Core funds are also used to develop, test, and disseminate policy and advocacy tools and approaches. Field-support funds activities in host countries, including technical assistance in policy development and implementation, adaptation and application of policy and advocacy tools and approaches, and training of host-country personnel.

Two TOs were eventually awarded in FY 2007 and four in FY 2008. Mission technical and contracts staff reported that the transition from TO1 to separate TOs was generally smooth despite their initial resistance. An important purpose of having a multiple-award IQC was to promote competition. So far, four of the six TO contracts were awarded to the TO1 contractor, and one each was awarded to two other contractors.

Starting in 2006, HPI was the first project to be subject to the requirements of the Field Support Review Process (FSRP) even though the new review process was not officially introduced until 2007. GH/Office

of Acquisition and Assistance (OAA) provided limited information about the purpose of the new process and no training to USAID staff. This resulted in much confusion, especially among Mission Population, Health, and Nutrition (PHN) Officers and Contracting Officers (COs) and has created a heavy management burden not only on GH and Mission staff but also on the TO1 contractor.

### Recommendation

- If USAID continues the FSRP, the OAA should simplify the process, limit the management burden on the GH/HPI/TO1 Contracting Officer's Technical Representative (COTR) and management team, GH/CO, Mission PHN Officers and Contracting Officers as well as the HPI/TO1 contractor, and eliminate the large amount of duplication in the review process.

### HPI/TO1 Program Implementation

The project is on track to meet performance targets in HPI/TO1's monitoring plan, and in many areas it has already exceeded those targets. The technical, operational, and geographic scope of HPI has provided opportunities to employ health policy and advocacy tools developed by the project throughout the world. HPI/TO1 has contributed to global-health priorities in FP/RH, HIV/AIDS and MH through its core-funded technical leadership. It has developed many approaches, models and tools to inform the policy and advocacy process. Some of these are new models (costs of male circumcision) and others are existing models that have been enhanced and updated because they are still in demand. The policy models are powerful tools for increasing commitment and support for FP/RH, HIV, and MH services. These HPI/TO1 tools have advanced policy work in repositioning family planning, gender, poverty and equity, contraceptive security, and stigma and discrimination.

HPI/TO1 has been very effective in using its country experiences to inform the development of new tools and innovative approaches. Through advocacy, networking, and training activities, the project has expanded the number and variety of voices participating in the health policy and advocacy process. Training of health personnel in planning, budgeting, and advocacy skills has strengthened capabilities at different levels of government. However, such training continues to be in demand. The project uses its involvement in global policy dialogue and technical working groups to inform country work. This cross fertilization of experiences results in tools that are often cited for their ease of use and ability to demonstrate complex relationships in clear, simple ways.

HPI/TO1 has been very responsive to requests from the field and GH. However, the consistency and quality of project activities in the first two years of TO1 suffered due to organizational changes at Futures. Since then, the project has worked hard to move beyond that history and is poised to once again, provide consistently high-quality technical assistance.

The strongest testament to the need for policy and advocacy work and the general satisfaction of Missions and GH with HPI/TO1 is the continued high level of demand for its services. The majority of GH interviewees expressed satisfaction with HPI/TO1. They reported that it was in the top five of centrally managed projects that are requested to provide technical assistance to the field.

HPI/TO1 has followed a previous GH policy project's practice of setting up field offices with local staff. Missions found this approach very important since policy work requires knowledge of local people and institutions and a thorough understanding of the power relationships in a country.

Several respondents felt that the project was doing very innovative work, but they also expressed concern that information about project activities is not getting out to Missions and that lessons learned and best practices need to be disseminated. There was also concern expressed among all respondents that the project is doing lots of smaller activities at the community level and activities that might be better implemented by cooperating agencies (CAs) that do service delivery or training

and that it is moving away from its comparative advantage in policy work, especially at the higher policy level where it can have a greater impact.

#### Recommendations for the Final Year of HPI/TO1

- HPI/TO1 should improve collaboration with and the hand-off to service delivery and training CAs to ensure that policies are implemented.
- HPI/TO1 should continue capacity building of its local office staff to maintain and improve the consistency and quality of its policy and advocacy work.
- HPI/TO1 should work with GH to seek ways to inform Missions about HPI's work through communication channels such as the President's Emergency Plan for AIDS Relief (PEPFAR) "Notes to the Field."
- HPI/TO1 should identify lessons learned and best practices and develop and implement a dissemination strategy, including documenting approaches for building capacity in health planning and advocacy.



# I. INTRODUCTION

## PURPOSE AND OBJECTIVES OF THE ASSESSMENT

The United States Agency for International Development's (USAID) Bureau for Global Health (GH)/Office of Population and Reproductive Health (PRH)/Policy, Evaluation, and Communication (PEC) Division, and the Office of HIV/AIDS (OHA)/Strategic Planning, Evaluation and Reporting (SPER) Division commissioned this assessment of the USAID Health Policy Initiative (HPI) indefinite quantity contract (IQC) and Task Order 1 (TO1). USAID's HPI is a global project designed to improve the enabling environment for health, primarily for family planning and reproductive health (FP/RH) and HIV/AIDS. The project works toward this objective through policy and advocacy, leadership development, financing, multisectoral coordination, and evidence-based decision-making.

The assessment has two tasks:

1. Determine the effectiveness and efficiency of the multiple-award IQC and TO1 procurement mechanisms in meeting policy and advocacy programming needs of the Global Health (GH) and Regional Bureaus and Missions.
2. Assess the quality and progress of HPI/TO1 program implementation and satisfaction of GH Offices, Regional Bureau, and Missions with the accomplishment of workplan objectives.

## METHODOLOGY

The assessment was conducted from late January to mid-May 2009 by a three-person team of consultants hired through the Global Health Technical Assistance Project (GH Tech). Two team members have extensive experience in international public health, particularly in the areas of FP/RH and HIV/AIDS and USAID health assistance programs. The third member of the team has extensive experience in the design, management, and evaluation of USAID development programs and the procurement mechanisms used to support them.

The assessment team used both qualitative and quantitative methods. The qualitative information came from 90 interviews conducted either in person or by telephone (persons contacted, Appendix B). The groups of respondents included:

- USAID/W staff from GH and Regional Bureaus (30 including two from GH/OAA),
- USAID Missions and Regional Offices (30 staff from 23 countries, 11 of which were in Africa; 5 of the 30 were contracting officers),
- HPI IQC holders (18),
- Subcontractors of HPI/TO1 (5), and
- Partners and key informants (7).

To engage USAID Mission staff, the HPI Contracting Officer's Technical Representative (COTR) sent an e-mail to USAID Missions informing them of the assessment. The HPI management team selected a list of Mission technical and contracting staff who had experience with HPI and/or who would have useful thoughts about future health policy and advocacy needs. The initial e-mail to the Missions was followed by e-mails from team members requesting telephone interviews. Although it took several weeks to schedule and conduct interviews, the team succeeded having interviews with many Mission staff.

The team developed a standard core questionnaire with additional modules for different audiences (e.g., USAID HPI management team and Missions that had issued separate Task Orders) (Appendix C). The quantitative information was drawn from project reports and other documents (Appendix D for references).

The assessment reflects the feedback of many people who have worked with HPI. Overall, the response rate was very good with the exception of contracting officers. The assessment has several limitations. The sample of Mission respondents is skewed by region (most were from Africa) and by health area (most worked on HIV/AIDS) reflecting the geographic and technical distribution of HPI activities. Due to the diverse nature of HPI's work and the broad range of information being collected, some findings are based on a small number of respondents. In addition, it was difficult to interview Contracting Officers. There were 11 Contracting Officers on the contact list in the assessment's Scope of Work (SOW). Numerous efforts by e-mail and phone yielded only five interviews from four Missions. For this project, the work of field Contracting Officers only comes into extensive play when an IQC task order is issued in the field. Temporary Duty Travel (TDY) work or personnel transfers made it difficult to reach some of the Contracting Officers involved.

## **OVERVIEW OF HPI**

HPI is a five-year global project structured as a multiple-award IQC with a Task Order 1 (TO1). It began on September 30, 2005, and is scheduled to end on September 29, 2010. USAID awarded IQCs to four organizations or IQC holders: Abt Associates, Inc. (Abt), Chemonics International, Inc. (Chemonics), Futures Group International (Futures), and Research Triangle Institute (RTI) International. The multiple award IQC mechanism with TO1 was chosen to facilitate access by USAID Global Health, Regional Bureaus, and Missions to high-quality technical expertise in health policy and advocacy from different organizations. The multiple-award IQC has a ceiling of \$325 million.

The award for TO1 was issued at the same time that the multiple IQC awards were made. A consortium of six organizations received the award. These included the Futures Group as the lead contractor, the Centre for Development and Population Activities (CEDPA), the White Ribbon Alliance for Safe Motherhood (WRA), Cultural Practice, Social Sector Development Strategies, and Religions for Peace. The Futures Institute was added as a contractor in February 2007. TO1 has a ceiling of \$100 million.

The IQC mechanism allows for the issuance of additional TOs. Any of the four IQC holders is eligible to compete for them. Beginning in FY 2007, six additional TOs have been awarded by USAID country and regional Missions. A seventh TO is in the procurement stage.

## **Previous GH Health Policy Projects**

USAID's GH Bureau and its predecessors have been engaged in centrally-managed health policy work for a period of over 30 years. Prior to HPI, USAID's policy work had been implemented by several projects: RAPID I-IV (FY78-91), OPTIONS I-II (FY86-95), POLICY I-II (FY95-2005). There was a no-cost extension of POLICY II through June 2006. Given the focus of GH's work up to 1990, policies that affected FP and RH were emphasized; more recently a greater amount of funding has been provided for HIV/AIDS. The Futures Group has played a central role in providing technical assistance for health policy work over the three decades. Another important actor has been RTI, one the four HPI IQC holders and a subcontractor for all of the policy projects cited above.

## Strategic and Programmatic Scope of HPI

The project's objective is: "Improved enabling environment for health, especially family planning/reproductive health, HIV/AIDS, and maternal health." As such, HPI works in three of GH's major areas: PRH, OHA, and Maternal Health/Child Survival (MH/CS), a division within the Office of Health, Infectious Disease and Nutrition (HIDN). When requested by USAID, HPI project also addresses policy issues on diseases such as malaria and tuberculosis.

There are five intermediate results (IRs) in the HPI results framework (Appendix E). These are: IR1, Policy (health policies adopted and put into practice); IR2, Advocacy (public sector and civil society champions strengthened); IR3, Resources (health sector resources increased and allocated effectively and equitably); IR4, Multisectoral coordination (strengthened multi-sector engagement and host country coordination); and IR5, Knowledge (timely and accurate data used for evidence-based decision-making).

HPI is an extremely complex project. It covers the world geographically, works on important health areas, including FP/RH, HIV/AIDS, and MH, and implements a diverse set of health policy and advocacy activities. Its work is implemented by one of four IQC holders through seven Task Orders (TOs). The largest task order, TO1, is implemented by Futures. Of the six other TOs, four are implemented by Futures and one each is implemented by Abt and RTI.

HPI/TO1 has two main sources of funding, core and field support.

HPI/TO1's core support funds:

- Technical leadership by: (1) monitoring results of policy activities (as stated in the contract, "for the IQC as a whole"); (2) gathering lessons learned ("from all IQC contractors"); (3) developing a knowledge management and knowledge sharing strategy; and (4) disseminating lessons learned from host-countries and other cooperating agencies (CAs);
- Global policy and advocacy priorities including gender, poverty and equity, stigma, and discrimination among people living with HIV (PLHIV), repositioning family planning, and contraceptive security; and
- Development, testing, and dissemination of policy tools and approaches that are available to USAID Missions for application in developing countries.

HPI/TO1's field-support funds:

- Technical assistance in policy development and implementation in FP/RH, HIV/AIDS, and MH at national, regional, provincial, and local levels;
- Adaptation and application of policy and advocacy tools and approaches in host countries; and
- Training of host-country personnel from the public sector and civil society in policy development and implementation, advocacy and networking, costing of health services and resource allocation, and the use of data for decision-making.



## **II. EFFECTIVENESS AND EFFICIENCY OF THE MULTIPLE-AWARD IQC AND TASK ORDER ONE PROCUREMENT MECHANISMS IN MEETING POLICY AND ADVOCACY PROGRAMMING NEEDS OF USAID UNDER HPI**

### **PROCUREMENT PROCESS**

The original pre-solicitation document of what was known initially as the Policy Dialogue and Implementation Project (later renamed the Health Policy Initiative (HPI) Project) was issued for comment as a single-award contract. However, review of the comments received from CAs and further review by GH/OAA led to a change in the procurement mechanism from a single-award contract to a multiple-award Indefinite Quantity Contract (IQC). The switch to a multiple-award IQC procurement mechanism was made by GH/OAA to widen the number of bidders who might be involved in USAID's future health policy work. The budget of the overall IQC was set at \$325 million with a minimum guarantee for each IQC holder of \$100,000. The revised request for proposals (M-OAA-GH-POP-05-527) was issued on April 26, 2005.

A decision was also reached to compete the TO1 as part of the same solicitation. The HPI/TO1 budget was nearly \$100 million, and this level of funding had to accommodate both core and field-support needs.

Core funds from GH could support and provide leadership in key global-health policy and advocacy interests. Field-support funds from USAID Missions could buy into centrally-managed projects to fund host-country health policy initiatives. Field support has been used extensively by the GH for many years. Missions generally prefer this mechanism because it is an efficient way to program money. It also frees Mission staff from a management-intensive procurement process required by separate task orders and bilateral projects.

Contracts with the four IQC holders (Abt, Chemonics, Futures, and RTI) and the TO1 contract with Futures were executed on September 30, 2005. The predecessor project to HPI, POLICY II (also contracted to the Futures Group), was extended due to pipeline considerations because POLICY II had been asked to accept large PEPFAR obligations in FY 2005. This resulted in a nine-month overlap of the two projects.

### **STRUCTURE AND USE OF TASK ORDER 1**

A summary of HPI/TO1 activities supported by core funding through FY 2008 is presented in Appendix F1. FP/RH activities address the project's five IRs and the crosscutting technical issues that were spelled out in the contract. HIV/AIDS core activities cover all but one IR (multisectoral coordination) and all but one crosscutting issue (poverty and equity). In the area of MH, the advocacy activities of the White Ribbon Alliance (IR2) are funded.

A summary of HPI activities funded through field support and task orders is listed in Appendix F2. The number of funding sources is 35 from past and current Mission and regional accounts. The largest numbers of funding sources by health area are for HIV/AIDS (29 sources) and FP/RH (18 sources).

### **Field Support Review Process**

On January 8, 2007, USAID issued "An Additional Help to ADS Chapter 302, Field Support Action Process," for which the Office of Acquisition and Assistance (OAA) is the responsible office. This document defines a process: "To make it easy for all parties to perform their responsibilities for task

orders that accept Mission funding in a relatively simple and timely fashion...” While the source of such responsibilities is not defined in the document, at least one such source is found in the Foreign Assistance Act, Section 611 which states: “No agreement or grant in constituting an obligation in excess of \$500,000 shall be made if such an agreement or grant requires substantive technical or financial planning, until engineering, financial, or other plans necessary to carry out such assistance, and a reasonably firm estimate of the cost to the USG of providing such, has been completed...”

While HPI/TO1 predates the Field Support Action Process (hereafter called Field Support Review Process (FSRP) as it is referred to by GH staff), the TO1 contract incorporates the essence of this process for amounts in excess of \$500,000. As a result, the review process was applied to HPI/TO1 field-support funds beginning in FY 2006. The FSRP applies the same general parameters to amounts below \$500,000. The process requires review only by relevant field staff and the HPI/COTR and not by the USAID/GH/OAA Contracting Officer. The full process, for amounts above and below \$500,000, was applied to HP/TO1 in FY 2007 after the FSRP became part of the Automated Directives System (ADS).

According to GH/OAA staff, the full process was announced to USAID/Washington and field offices by Internet in February 2007. The new FSRP was considered to cover budgeting and activity planning, duties otherwise regarded as standard Agency practice. Thus GH/OAA did not provide any training and did not take other steps to assure that Missions and other responsible parties became familiar with the process.

Field support review guidelines were part of the TO1 contract, and so the HPI management team started providing guidance to field staff in 2006 sometime before the ADS guidelines were issued. The scope and level of effort of the FSRP for HPI/TO1 is substantial. In FY 2007, more than 28 scopes of work and independent government estimates were prepared, followed by contractor-generated work plans, budgets, and Mission checklists for these 28 field-support activities. The management burden for all concerned is considerable and takes place during the most management-intensive time of the year. While noting that much of the work involved processes that would have been carried out at any rate, Futures estimated that the additional burden on its staff in FY 2007 of this review and approval process—spread across 28 operating units, and involving both USAID and contractor staff—was 158 person-days of time.

Once the FSRP is approved, the TO1 contractor prepares a more detailed work plan and budget that are used in actual implementation of the agreed-upon task. Thus for any field-support review, there is considerable duplication since scopes of work, budgets, and work plans are being written three times. In addition, Missions sometimes ask for programmatic changes after the FSRP has been completed. Then the TO1 contractor has to redo the budget and work plan, adding an iteration to the process.

In theory, the review process could be carried out throughout the year as various pieces of field-support work are designed, budgets formulated, and funds identified and made available. In practice, the process has been largely confined to the last quarter of the fiscal year. One reason for confining the review process until late in the fiscal year is that actual budget numbers are generally not available until then. Without a budget in hand, there is too great a chance that the entire process, if done earlier in the year, would have to be redone when actual budgets are available. Another factor is the Agency’s interest in bundling work into a consolidated time frame in order to limit the impact on the limited GH technical and Contracting Officer staff. The TO1 contractor has noted that stretching the process out might also have the effect of creating more burdens on contractor staff throughout the year rather than the current concentrated approach. There appears to be little support from any party—USAID/W, Mission and contractor staff—in spreading the review process out.

Like many new processes, there was a learning curve required to implement it for all parties. Since many individuals are involved both in GH and the field (particularly in a project like HPI/TO1 that

operates in many Missions), there are inevitable delays caused by the press of other business or staff being away on TDY or leave. When the practical approach is to move the results of the whole field-support review for HPI forward as one package, these individual delays affect the entire process.

Over the last two fiscal years, GH, Missions, and Futures staff report that the review process may have eased somewhat as staff have moved up the learning curve and better templates have been developed. The interviews show that most GH and Mission staffs are now familiar with the requirements, but that a significant number still regard the process as cumbersome and difficult to handle given time constraints. A Contracting Officer in the field noted that the repeated need for movement of information and concurrences back and forth between the field and GH created inevitable delays. The funnel effect, as multiple Missions move the process forward to one GH/COTR and ultimately one GH/OAA/CO, creates a particular burden at the end of the fiscal year. GH staff finds it especially burdensome. The management burden also falls on the TO1 contractor staff. In sum, the FSRP is a multi-step, time-consuming process that does not seem to add obvious benefits to project management.

**USE OF OTHER TASK ORDERS AND MANAGEMENT OF THE IQC PROCESS**

**Other Task Orders to Date**

The first separate Mission TO was not developed until FY 2007. Since then, five additional TOs have been issued.

Missions that have issued their own TOs are: Regional Development Mission/Asia (RDM/A), Peru, South Africa, Vietnam, Guatemala/Central American Regional Program (G/CAP) and Tanzania (Table 1 below). Prior to issuing a TO, all Missions had ongoing, substantial health policy programs funded by field support under HPI, and most designed a TO’s SOW that builds directly on the existing program. Of the six extant TOs, all address HIV/AIDS policy and advocacy issues at varying levels of funding, two address FP/RH, and one addresses health-systems strengthening. Missions in the Democratic Republic of Congo (DRC) and Kenya have announced their intention to move to separate TOs in pre-solicitation documents.

TABLE 1. HPI TASK ORDERS 2-8			
TO #	Country/Region	TO Contractor	TO Contract Signed
2	RDM/A (regional)	RTI	9/07
3	Peru	Futures	11/07
4	South Africa	Futures	10/07
5	Vietnam	Abt	10/08
6	G-CAP (regional)	Futures	9/08
7	Tanzania	Futures	12/08
8	Kenya		

**Transition between TO1 and Other Task Orders**

All USAID technical and contractual field personnel interviewed who were associated with the six individual TOs noted that the transition from TO1 to other TOs was generally straightforward.

## Integration of TO1 and Other Task Orders

Most of the six task orders have been in existence about a year or less or are just now getting underway. Two others are still on the drawing boards. The HPI website has space for contractors of the separate TOs to report their work and findings. Since there has been little time for implementing activities, it is premature to see reporting on the new work, much less findings or lessons learned from the new TOs.

Two meetings were convened with the four IQC holders in 2005 and 2006 to discuss the status of implementation, the performance monitoring plan and branding requirements (organized by the by the HPI/COTR). TO1 held a Technical Development (TD) Week in spring 2008 to provide information on HPI country programs, innovative approaches to health policy, and core initiatives. Among those invited were HPI/TO1 field staff, IQC holders, and GH staff.

One concern about having a number of TOs under HPI is exchanging of information on findings, best practices, and lessons learned across the TOs. IQC contractors have noted that there is little money to support information sharing. Contracts for HPI note that core funds can be added to individual TOs for this purpose, but most Missions have not done so. Also, IQC contractors for the separate TOs have \$100,000 in their budgets that could be used for dissemination. At least one other GH/IQC/COTR manager, who attempted to add funds, could not find a way to make it happen. Another IQC manager said she found the integration issue no problem due to the close personal contacts between the staffs of the IQCs involved. As the number of individual TOs expands, information sharing will become more important.

### Findings

- The management of HPI is very complex given the wide dispersion of project resources by geography, health area, funding source, and funding mechanism.
- GH and Mission staff viewed the effects of the HPI/IQC with a TO1 contract from their different vantage points. Charts 1a, 1b, and 1c below list the opinions of each group, as gathered in interviews, on the benefits and constraints of the IQC mechanism on technical leadership, field support-funded activities, and use of Mission-funded TOs.

<b>CHART 1A. TECHNICAL LEADERSHIP</b>	
<p><b>Global Health Bureau</b></p> <ul style="list-style-type: none"> <li>• Core funds have supported innovative work to advance the policy agenda.</li> <li>• It is difficult to share lessons learned across TOs.</li> </ul>	<p><b>Missions</b></p> <ul style="list-style-type: none"> <li>• Missions want to support pilot testing only when it fits into their country strategy.</li> <li>• There is limited awareness of HPI's innovative tools and approaches at the country level.</li> </ul>

<b>CHART 1B. FIELD SUPPORT-FUNDED ACTIVITIES</b>	
<p><b>Global Health Bureau</b></p> <ul style="list-style-type: none"> <li>• TO1 ceiling is limited to \$100,000,000.</li> <li>• Project services need to be rationed.</li> <li>• Field support review process (FSRP) creates a heavy management burden, especially for the COTR and the CO.</li> <li>• There is no clear value added by the FSRP.</li> </ul>	<p><b>Missions</b></p> <ul style="list-style-type: none"> <li>• TO1 is very easy to access.</li> <li>• There were delays in Missions developing separate TOs until forced by the large size of program and the ceiling.</li> <li>• Field support review process is cumbersome and increases management burden.</li> <li>• There is no clear value added by the FSRP.</li> </ul>

<b>CHART 1C. MISSION-FUNDED TASK ORDERS</b>	
<p><b>Global Health Bureau</b></p> <ul style="list-style-type: none"> <li>• Development of TOs is management-intensive.</li> <li>• Mission-funded TOs limit policy impact of TO1.</li> <li>• Mission-funded TOs limit sharing of lessons learned and best practices.</li> </ul>	<p><b>Missions</b></p> <ul style="list-style-type: none"> <li>• Development of TOs is management-intensive, but Missions like management control.</li> <li>• Mission-funded TOs provide access to other CAs.</li> </ul>

- The Field Support Review Process is onerous for a thinly staffed agency even though it is logical in terms of FAA and ADS. The burden is especially heavy for the COTR and the Contracting Officer, and it is not an efficient use of the contractor’s time.

**Recommendations**

If USAID continues the FSRP, then the OAA should:

- Simplify the process given the severe staffing constraints of both GH technical and contract staff, which limit their capacity to handle the demanding review process. The review process is particularly onerous for GH technical staff, whose time is taken away from technical management of HPI/TO1, a large and complex project that is in great demand by Missions.
- Authorize that the review and approval duties for the FSRP be shared between the current COTR based in GH/PRH and staff in GH/OHA.
- Limit the burden of the FSRP, e.g., more extensive use should be made of templates, and an online training module should be developed by OAA for use by Missions COTRs and Contracting Officers and other appropriate staff.

- Eliminate the large amount of duplication in the FSRP and also monitor the implementation of the process to ensure that the information gathered is both useful and used. The first step in this monitoring effort is to request a memorandum from OAA detailing how the FSRP documents for HPI/TO1 have been used and what actions have been taken as a result of the information in those documents. This would enable OAA and GH to tailor the FSRP to more effectively and efficiently meet the needs of both offices.
- Find ways to integrate the FSRP process with other Agency-wide processes such as the annual budget reviews.

### **III. QUALITY AND PROGRESS OF HPI/TO1 PROGRAM IMPLEMENTATION AND USAID SATISFACTION WITH ACCOMPLISHMENTS**

HPI/TO1 is implementing a very diverse set of activities. These include core-funded work in the areas of FP/RH, HIV/AIDS and MH that advance Global Leadership priorities, including repositioning family planning, gender, poverty and equity, contraceptive security, and stigma and discrimination. The project also uses core funds to build the policy development and implementation knowledge base through monitoring of activities and dissemination of results. At the country level, HPI/TO1 has implemented activities funded by field support in 30 countries and four regional programs. It is currently active in 22 countries (Chart 2 on Policy to Action, HPI/TO1 approaches).

HPI/TO1 has done some very innovative work in the areas of policy implementation, poverty and health equity, strengthening contraceptive security for graduating countries, increasing use of longer term methods, increasing male engagement in FP/RH, and estimating costs of male circumcision. Many of its activities have been shaped by the legacy of POLICY II (2000-2005). POLICY II and HPI/TO1 overlapped for nine months. During this time, staff members were involved in the close out of POLICY II and did not fully turn their attention to the start up of HPI/TO1. In addition, many project activities have built upon earlier POLICY II work. This legacy provides HPI/TO1 with a very strong knowledge base and good relationships with partners in the field; however, it complicates attribution of results and project impact. Finally, HPI/TO1 has had to shift to a new way of conducting business from a single-award contract under POLICY II to a multiple-award IQC subject to the field-support review requirements under HPI/TO1.

Chart 2. HPI/TO1's Policy to Action Framework, HPI/TO1 Approaches, and Illustrative Examples



## **CORE-FUNDED ACITIVITIES**

### **Technical Leadership**

#### **Policy Models**

HPI/TO1 has continued updating, refining, and adding to the models developed under the previous policy projects. These include the Spectrum suite of models that are used to project needs for FP/RH, MH, and HIV/AIDS services; the Goals model; the Resource Needs Model; and the Workplace Policy Builder. These models have an excellent reputation in the field, are flexible and easy to use, and are important tools in advocacy and health-planning activities. Core funds have been used to update and incorporate new technologies into the models, as appropriate. A long-distance training module has been developed for the Demographic Projection Model (DEMPROJ) and is disseminated on the project's website. The Safe Motherhood Model, developed under POLICY II, was enhanced to help managers gain a better understanding of the impact of policies, budgets, and services on MH outcomes. This is a very useful tool that needs to be more widely disseminated and applied in the field.

The only completely new model that has been developed under HPI is the Male Circumcision (MC) model, co-funded and co-developed with UNAIDS. It is used to assess the cost of male-circumcision programs as part of strategic and operational planning for HIV prevention. The model estimates the cost and impact of MC scale-up in countries with high prevalence of HIV and low prevalence of male circumcision. The MC Decisionmakers' Tool Kit is being applied in thirteen countries.

HPI/TO1 is successfully using these models to inform the global policy dialogue. For example, HPI/TO1 collaborates with UNAIDS on a biannual basis to update the global epidemic estimates for HIV/AIDS. HPI is conducting an analysis of the cost of increasing contraceptive prevalence by one percentage point per year in a given set of countries. Since family-planning cost information has become outdated, HPI/TO1 is using this exercise as an opportunity to update the service-delivery cost data used as a basis for estimates in many of its models. HPI/TO1 has also informed national-level policymaking by applying the RAPID model to demonstrate the cross-sectoral impacts of rapid population growth. RAPID applications in Yemen, Mali, Rwanda, and Tanzania were highly praised for stimulating dialogue and increasing commitment for FP/RH at the national level.

#### **Poverty and Health Equity**

At the national level, HPI/TO1 has done innovative work to make FP/RH services more easily accessible to the poor and to improve equity. The project does this by using evidence to guide formulation of pro-poor policies and to help mobilize resources for the poor. The project also engages the poor in the decision-making process to build their capacity as advocates for culturally-appropriate programs that better meet their needs. For example, in Peru project work focused on including FP in health insurance schemes and cash-transfer education programs. In India HPI/TO1 assessed a voucher system for FP/RH and asked the rural poor to identify and address barriers to access. In Guatemala the project designed programs to improve outreach to indigenous communities. Finally, the project worked with refugees and internally-displaced persons to build their capacity to advocate for improved access to FP/RH services in Sierra Leone.

#### **Gender**

HPI/TO1 has continued POLICY II's work in integrating gender into programs by supporting the Interagency Gender Working Group (IGWG) and training program managers. The project has also developed innovative tools such as the Gender Integration Index and Gender-based Violence (GBV) Screening Tool for use by health care providers. The screening tool grew out of activities in Mexico and Thailand and has been successfully piloted and scaled up in both countries, while the Gender

Integration Index was applied in 10 HPI countries in 2007 to get a baseline score and will be repeated in 2010. HPI/TO1 has also done innovative work in addressing men's reproductive health and their role in family planning. This includes the Guide to Constructive Engagement of Men in Reproductive Health in Mali.<sup>1</sup>

HPI/TO1 has continued POLICY II's work in integrating gender into programs by supporting the IGWG and training program managers. The project has also developed innovative tools such as the Gender Integration Index and a GPV Screening Tool for use by health-care providers. The screening tool grew out of activities in Mexico and Thailand and has been successfully applied in Peru, Mali, Bolivia, and Guatemala. HPI/TO1 has also done innovative work in addressing men's reproductive health. This includes the Framework for Men's Reproductive Health and the Guide to Constructive Engagement of Men in Reproductive Health in Mali.

### Contraceptive Security

Since 2003, POLICY II, and now HPI/TO1, has been very active in advocating for secure supply of RH commodities. This work has included the Latin American and Caribbean Bureau (LAC) Contraceptive Security Initiative which has been particularly important as countries in this region are graduating from USAID commodity support. Under this initiative, HPI/TO1 has formed multisectoral committees that advocate for sustained provision of contraceptives by, for example, ensuring that there is a funded line item for commodities in budgets for national health plans and in national insurance schemes. These activities have been very successful in the Dominican Republic, and Peru. HPI/TO1 has also developed a RH Supplies Advocacy Tool Kit and trained people in its use in East and Southern Africa to raise awareness of the importance of ensuring continued provision of commodities. HPI/TO1 has also worked with DELIVER and UNFPA to develop and review plans for promoting contraceptive security at the biannual meetings of the Reproductive Health Supplies Coalition (RHSC). The 2007 RHSC meeting coordinated by HPI/TO1 was deemed especially productive because it gathered very good speakers and promoted a very fruitful exchange of information.

### Repositioning Family Planning

HPI/TO1 has done innovative work to increase support of and access to FP—referred to as repositioning family planning—through several endeavors. The project has increased donor funding for FP by highlighting the role it can play in poverty reduction and in helping countries achieve their Millennium Development Goals (MDG). HPI/TO1 has developed and made available on its website “Millennium Development Goal Briefs” for 32 countries across Africa, Asia and the Near East, and Latin America and the Caribbean. These briefs demonstrate how a relatively small investment in FP can reduce the costs of achieving the MDGs. HPI/TO1 also developed the guidebook, “Making FP Part of the PRSP Process,” and has succeeded in incorporating FP into the “Poverty Reduction Strategy for 2007-2011” in Mali. Including FP in these policy documents has leveraged additional donor resources to support services and increase access. HPI/TO1's work in Malawi is another innovative example of how advocacy that links FP with the MDGs can result in an increase in FP services. The health ministry approved operational policy changes that authorized community-based health surveillance assistants to provide injectables after it recognized the potential impact of the policy change on achieving the MDGs. HPI/TO1 has also promoted legislative reform for FP/RH by parliamentarians in Francophone Africa. And finally, the project has advocated for increased support of FP among religious leaders in Mali.

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<sup>1</sup> Under TO4, Futures is assisting in the development of a national strategy for Men's Reproductive Health in South Africa, which is complementing a core-funded initiative on addressing HIV and male circumcision in the context of a holistic approach to men's reproductive health.

## Advocacy and Strengthening Networks

HPI/TO1 has done important work in building capacity for advocacy, community outreach, and expanding advocacy networks.

*White Ribbon Alliance (WRA)* is the central component of HPI/TO1's work in maternal health. It consists of supporting the WRA, an extensive network with thirteen national alliances and individual and organizational members in 118 countries that advocate for strengthening MH interventions. The partnership between HPI/TO1 and WRA began under POLICY II and has continued as WRA has strengthened its capacity, broadened its donor support, and recently received very high-level support and interest in Britain. WRA provided an excellent example of how networks can advocate for improvements in quality of care through its program called "Social Watch" in India. This innovative work has been scaled up to 10 states in India. Similarly, in Tanzania, WRA created the "Play Your Part" DVD as an advocacy tool to be used with skilled health workers. Finally, HPI/TO1 trained 13 of the WRA members as part of its Africa campaign to build capacity for advocacy in Africa. These members then returned to their countries and used their strengthened capacity to advocate for improved MH services.

*Marginalized populations* have been another focus of HPI/TO1. The project has built capacity of marginalized populations to improve their access to FP/RH/HIV services and to strengthen their voices in the policy process. HPI/TO1 has worked with refugees and internally-displaced persons in Sierra Leone and developed the first regional network for PLHIV in the Middle East. The project has strengthened the advocacy capabilities of indigenous populations and developed the Reproductive Health Observatory through which advocates monitor the quality of RH services in Guatemala. The project has worked with the Global Forum on (Men Who Have Sex with Men) MSM to help with its strategic planning.

## Advocacy Tools to Address Stigma and Discrimination

HPI/TO1 has worked with PLHIV to strengthen their capacity to participate in the policy process directed at improving the quality of health services and reducing the stigma and discrimination surrounding HIV/AIDS. In conjunction with Family Health International and the East-West Center, the project developed the "A<sup>2</sup> Advocacy Training Manual" to develop skills for advocacy and community outreach, as well as more specific skills for using data for evidence-based decision-making. The project has contributed to country activities in China, Vietnam, and South Africa that have called attention to the need to strengthen privacy laws and reduced stigma and discrimination of PLHIV.

## From Policy Development to Policy Implementation

HPI has developed the "Policy Implementation Assessment Tool" and has pilot-tested it in Guatemala and India. This has resulted in the establishment of a national FP/RH policy monitoring board (an oversight mechanism) in Guatemala and updating of the state population policy in Uttarakhand, India.

## Operational Barriers to Service Provision and Integration of FP/HIV Services

HPI/TO1 organized a FP/HIV Integration Working Group workshop to gather CAs and other interested organizations to assess collective knowledge and provide recommendations. HPI/TO1 also coordinated a multi-donor meeting including USAID, WHO, UNAIDS, the World Bank, and various foundations to assess the research on operational barriers and develop a shared vision. During the meeting, participants discussed effectiveness of different FP/HIV integration interventions and shared existing programmatic experiences. The participants recommended revisions to the Integration Guidelines. The Integration Working Group also decided that the next Integration meeting will focus on policy. HPI/TO1's FP/HIV integration work on Kenya provided useful information to make the Integration Guidelines feasible and practical.

## **Program Monitoring and Dissemination**

HPI/TO1 has developed a very comprehensive Performance Monitoring Plan (PMP) to track the results of its wide range of activities. It was developed with input from the other IQC holders to track results of all TOs under HPI. In practice, it has been difficult to collect results from other TOs, even those implemented by Futures. This is because there are limited resources for compilation and dissemination of findings, best practices, and lessons learned. It should be noted that three of the separate TOs have been in existence for less than two years and three for less than one year, so it is too early to expect many results other than monitoring data. Another complication impeding the exchange of information is the fact that many of the activities in the field require reporting on indicators that feed into other evaluation efforts, such as those for the Country Operational Plans. This has created a heavy reporting burden that needs to be streamlined.

HPI/TO1 and the previous policy projects have developed a wealth of tools, tool kits, models, frameworks, and approaches that need to be disseminated and more widely applied in the field. The project faces the challenge of disseminating materials widely while ensuring that those who are using these materials are applying them appropriately. Current dissemination activities have included workshops, trainings, and dissemination events such as the 2007 event at the National Press Club. In addition, materials such as the MDG Briefs are available for download from the project website. To train its staff, POLICY II developed TD Weeks during which field staff were brought together to learn about models and tools and to exchange experiences in their application. Under HPI/TO1 one of these TD Weeks has been held (spring 2008) and a country director leadership training was held in the spring of 2009.

## **Benefits of Core Activities to the Field**

HPI/TO1 has used its core resources to develop many tools and approaches to inform the policy process. The project is very effective in using its country experiences to inform the development of these tools. It also uses its involvement in the global policy dialogue and in technical working groups to inform country work. This iterative approach results in the development of tools that are often cited for their ease of use and ability to demonstrate complex relationships clearly and simply. For example, the GBV tool percolated up from specific country experiences in Mexico and Thailand. And, the Gender Integration Index was developed centrally through experiences in the technical working group and then applied in the field.

Three core activities were specifically mentioned by interviewees as being in demand in the field. They include:

- Policy modeling,
- Reducing poverty and improving health equity, and
- Repositioning family planning.

## **Achievement of Core Work Plan Objectives**

HPI/TO1 has fulfilled core workplan objectives by implementing a wide variety of core-funded activities addressing reproductive health and HIV/AIDS. HPI/TO1's MH activities consist of the support to the White Ribbon Alliance and are very specific in nature. Work plans for FP/RH and HIV/AIDS activities are developed through a process in which HPI, including team members from Futures and all subcontractors, proposes activities that are consistent with USAID's global priorities as identified by technical leads. These plans are then proposed to missions for appropriate field application. GH staff identifies priorities in part through a system whereby "Champions," GH staff members who propose ideas for project activities, request project services. When HPI/TO1 receives approved requests from Champions, it has limited ability to turn them down if they do not fit within

an overall project strategic plan. Consequently, work plans for core funds are often very broad and not very strategic. In fact, several interviewees commented that the core-funded portfolio of activities lacked a strategic vision. This is largely due to the demand-driven nature of the workplan development. As the project moves into its last year, it will need to identify best practices and lessons learned and to disseminate this information.

**FIELD SUPPORT-FUNDED ACTIVITIES**

HPI/TO1 is on track to meet the targets for results established in its contract (Table 2). The project has implemented activities across all technical areas and in 30 countries. This has resulted in a very complex project that has succeeded in improving the enabling environment for health policy. HPI/TO1 has implemented very large programs addressing several of the IR areas in Ukraine, Vietnam, Peru, Mexico, Kenya, and South Africa. Of these countries, only Mexico and Kenya are still under TO1; the others have shifted their policy work from HPI/TO1 to separate TOs or to a bilateral program in the case of Ukraine. HPI/TO1 has achieved many results; however, as countries with substantial policy programs develop separate TOs, the ability of HPI/TO1 to account for and achieve results is diminished.

TABLE 2. PROGRESS TOWARD CONTRACT TARGETS FOR RESULTS THROUGH FY 2008				
Level	# of Indicators Required	Target	Achieved	Target Met/Exceeded
Activity Objective	4 of 5 IRs	8 countries	7 countries	
IR1	At least 1	12 countries	14 countries	X
	At least 2	10 countries	9 countries	
	At least 3	5 countries	7 countries	X
IR2	At least 1	12 countries	24 countries	X
	At least 2	10 countries	13 countries	X
	At least 3	5 countries	8 countries	X
IR3	At least 1	12 countries	17 countries	X
	At least 2	10 countries	5 countries	
	At least 3	5 countries	0 countries	
IR4	At least 1	12 countries	14 countries	X
IR5	Data used (5.2)	12 countries	14 countries	X
	Tools Applied (5.2)	5 countries	15 countries	X

The following highlights of country activities demonstrate the diversity of activities being done by HPI/TO1:

**Jordan** – HPI helped the government to form a multisectoral committee to identify solutions to HIV-related issues. HPI/TO1 assisted the committee to use the Policy Circle Methodology to identify three priority issues: (1) the high cost of medications, (2) distrust of healthcare facilities among PLHIV and

other vulnerable groups, and (3) the need for policies to address HIV-related stigma and discrimination. This is the first time that PLHIV have been engaged in the policy process in Jordan.

**Kenya** – HPI/TO1 has assisted the National AIDS Control Council (NACC) to decentralize its structures and strengthen its leadership and coordination capacity so that it can better coordinate the growing number of participants in the policy process. The project also developed the Greater Involvement of People Living with HIV guidelines to support the engagement of PLHIV in the policy process. Finally, HPI/TO1 has strengthened the capacity of civil society organizations (CSOs) and networks of PLHIV to participate in Joint AIDS Program Reviews and meetings of the Inter-Agency Coordinating Committee of the NACC.

**Vietnam** – Vietnam adopted the 2006 Law on HIV/AIDS Prevention and Control and HPI/TO1 assisted in the development of detailed implementation guidelines in 2007. These guidelines addressed antiretroviral therapies, therapies for opportunistic infections, palliative care, and methadone maintenance treatment. HPI/TO1 also helped establish the National Task Force on Harm Reduction, a permanent multisectoral body tasked with advising on the expansion of resources and programs to address prevention and treatment gaps. HPI/TO1 supported CSOs and PLHIV networks, including the country’s first PLHIV women’s group. Finally, HPI/TO1 helped establish HIV legal clinics and hotlines in five provinces.

**Peru** – HPI/TO1 supported the government in the decentralization of the national healthcare system. This included improving the role of the regional health directorates and establishing policies that promote citizens’ rights. In addition, the social insurance program was expanded to provide health care coverage to the poor and other vulnerable groups. Finally, HPI/TO1 developed a monitoring system for external cooperation projects and GBV training materials for local health providers. These materials have been adopted as the official training manual of the Ministry of Health (MOH).

### **Technical Quality and Responsiveness**

When asked to rank the technical quality of HPI/TO1 activities, staff from 15 of 20 Missions and one GH Bureau responded. On a scale of 1–5, their responses ranged from 3 to 5 with an average score of 3.9. Of the three Missions that gave the highest score, two have very comprehensive programs that benefit from the experience of a very strong local field presence. Of the four that gave the project the lowest rank of 3, the most common comment was “unevenness” in the quality of project work. Several Missions observed that under POLICY II, they received consistently high-quality work, good responsiveness, and rapid turnaround. They also expressed surprise that under HPI/TO1 they were not receiving the same consistently high quality of services.

Five Missions offered comments on the responsiveness of the project. Responses included: “very responsive” (1), “quite responsive” (1), “fairly responsive and communicated well” (1), “the project suffered delays” (1), and “not really responsive” (1). The respondent who felt that HPI/TO1 was very responsive observed that the project has assisted the Mission in organizing meetings at the last minute, sponsored workshop participants when requested, and organized a dissemination workshop of PEPFAR-developed guidelines. Two Missions commented on the ease of working with the COTR and her helpfulness and responsiveness in developing work plans and scopes of work.

Several Missions reported that there is not a clearly defined point at which policy work transitions into service delivery and at which HPI/TO1 hands the baton to service delivery or to training CAs. In addition, several Missions pointed out that national advocacy work is not always followed by regional and district activities. In some cases, Missions did not anticipate the need for follow-on activities at the regional and district levels. The need to support activities at lower levels in the health system will be more acute as more countries decentralize their health systems and shift decision-making to lower levels.

## Achievement of Field-Supported Work Plan Objectives

The majority of missions responded that HPI/TO1 achieved workplan objectives. However, some indicated that their workplan implementation had suffered from delays due to factors outside of the project's control. For example, one Mission indicated that objectives could not be achieved due to "external factors." Two African Missions noted that there were delays in project implementation resulting from the weaknesses of local partners. While they did not complain that HPI/TO1 did not achieve workplan objectives, five Missions raised concerns about the difficulty in agreeing on the workplan objectives. One of these questioned "are they meeting their own work plan or ours?" Another stated that the project was trying to be everything to everyone and that it had difficulty getting HPI/TO1 to prioritize activities. Two of these Missions commented that HPI/TO1 did not share the Mission's vision of project objectives and that the resulting advocacy activities reached a lower level of decisionmakers than the Mission had hoped. Consequently, in some instances, there was a sense that the activities did not have the anticipated impact.

## Most and Least Requested Activities

In the course of conducting this assessment, several activities were repeatedly cited for their *importance*. The first is the RAPID Model as a tool to conduct high-level policy dialogue and build commitment for FP among religious leaders and other key decisionmakers. The second is training of health-program personnel in planning, budgeting, and advocacy skills at regional and district levels of the health system as systems increasingly decentralize their decision-making. A third activity is comprehensive policy analysis to develop a more strategic approach to policy work.

Specific activities that were mentioned as being the *most requested* include the GBV screening tool, costing work conducted by The Futures Institute, and the advocacy tools developed for PLHIV. Feedback on the Safe Motherhood Model and the support to the White Ribbon Alliance was also very positive. One tool that was singled out for not being useful was the Orphans and Vulnerable Children (OVC) child status index. This comment was further clarified by noting the lack of clear direction given to this activity by GH/OHA and OGAC.

## ORGANIZATIONAL ISSUES

### Involvement of HPI/TO1 Subcontractors

There are six subcontractors under HPI/TO1, and they have been included in the project's work to varying degrees:

**The Futures Institute** has played a large role in the policy modeling work of the project.

**White Ribbon Alliance** provides access to active networks for MH advocacy. WRA staff has been satisfied with the working relationship and feels they have taken on as much HPI/TO1 work as they can handle.

**CEDPA** provides access to several thousand alumni (including women parliamentarians, leaders of nongovernmental organizations, and community activists) who have participated in leadership training programs all over the world for the past 30 years. CEDPA staff has not been engaged in HPI activities as much as had been envisioned, and their subcontract has not been funded to the level that had been anticipated. Even though CEDPA staff work at HPI headquarters and are included in decision-making and planning, they nevertheless have not been fully utilized. The staff understands the demand-driven nature of HPI's work and the fact that Futures' staff is out in the field but may not be promoting CEDPA's role as much as they could. CEDPA is looking for additional ways in which to bring its expertise into the work of HPI/TO1.

**Religions for Peace** provides access to an international coalition of representatives from the world's great religions and addresses stopping war, ending poverty, and protecting the earth. It was included in the development of guides for conducting advocacy work with religious leaders.

**Cultural Practice** has made very strong contributions to the innovative gender work conducted by HPI/TO1 and has done much of the gender training for the Interagency Gender Working Group (IGWG).

**Social Sector Development Strategies** has contributed to work on resource allocation and contraceptive security.

Subcontractors commented that Futures' organizational changes had a very negative impact on the work. However, they also commented that the current leadership has been very easy to access and has made significant effort to keep communication open. Finally, they observed that while transparency of decision-making can be improved, overall the working relationships are good and when problems arise, efforts are made to address them.

## **Staffing**

Missions commented that HPI/TO1 staffing is very uneven. There was unanimous praise for the quality of work of several of the senior project staff and high marks were given to staff that stayed with the project throughout Futures' organizational transitions. This praise, however, was then followed by frustration at the quality of work of other staff, including consultants and in-country staff. Missions' comments about the technical quality of staff varied greatly because the work that HPI/TO1 is being asked to implement varies so much from country to country. In one Mission activity, HPI/TO1 was asked to provide a staff person with a very specialized skill, and the Mission was dissatisfied with the level of expertise provided. In another country, the Mission specified that they were pleased with the skills of the technical expert provided. One Mission stated that the HPI/TO1 work was a success because the locally-hired staff person was at a very high level. However, another Mission reported that the locally-hired staff person was not at the appropriate level to do the work required.

The majority of Missions felt the HPI/TO1 staff collaborated effectively with other technical assistance, training, and service delivery CAs. In the three instances in which staff was not appropriate and had to be replaced, HPI/TO1 was cited for its responsiveness in resolving the problem quickly. Lastly in hiring technical consultants, two Missions in Southern Africa commented that they felt HPI/TO1 could use more regional experts to provide technical assistance (TA). In fact, HPI/TO1 is trying to use more regional expertise to conduct model-training and capacity-building activities.

Several missions noted that working with HPI/TO1 was difficult because of staff turnover. One Mission respondent had worked with five HPI/TO1 country managers. Lack of program continuity was compounded by the lack of a project director for 18 months and the appointment of three interim project directors. Clearly, the corporate upheaval suffered by Futures and the loss of several of its staff members has had a very negative impact on HPI/TO1. Respondents are very hopeful that the new project director and the new technical staff, once they are brought up to speed, will get HPI/TO1 back on track.

HPI/TO1 has followed POLICY II's practice of setting up field offices with local staff. All of the Missions that responded stated that this is a very important way to do business since policy work requires knowledge of local people, local institutions, and a thorough understanding of the power relationships in a country. The majority of Missions were pleased with the quality of local staff. One Mission stated that the policy change would not have occurred unless the HPI/TO1 local hire had been involved. There were two instances, however, in which Missions felt the staff was not at the

right level and they were hopeful that the replacements would be better. Training of local office staff in corporate policies and procedures is limited by lack of funding. HPI/TO1 uses several of its local office staff to train staff in other countries. This South-South technical assistance has been especially successful in the LAC region. Finally, there were several comments that indicated that the local HPI/TO1 offices relied too much on support from its Washington office. Several Missions commented that project activities were delayed because local staff felt they needed to wait for guidance from headquarters.

One general theme that was heard from many respondents both in GH and Missions was the concern that HPI/TO1 has spread itself too broadly and often stretched to do work that is beyond its purview. For example, in some instances respondents noted that HPI/TO1 was working in areas in which a service-delivery partner would be better placed. There was also concern that the project is not building the next generation of policy experts who will engage in policy modeling and maintain the level of credibility needed for high-level policy dialogue. One GH respondent asked “who will carry the work of these senior people into the future? Why isn’t Futures grooming mid-level staff to take their place?” Futures is attentive to this concern. It has a corporate commitment to recruiting, training, and developing the next generation of staff. Such efforts are often implemented through HPI/TO1. Sought-after expertise includes refining existing models; developing new models as needs are identified; and updating, adapting, and applying models as requested in the field. Appendix H describes efforts by Futures to groom the next generation of technical staff.

## **Management Systems**

The majority of Missions have expressed satisfaction with the timeliness and quality of HPI/TO1 management systems and reporting. A few Missions reported problems related to pipeline issues. Three countries experienced delays in the start of new HPI/TO1 activities because POLICY II was spending the remaining pipeline in its final phase. A new task order was delayed in one country because of the remaining pipeline.

Seven Missions reported that financial reporting had not been consistent because Futures had not accurately tracked the remaining pipeline, which significantly impacted program implementation. Two of these Missions noted that they could not believe that a firm as experienced as Futures could make such a mistake. Futures acknowledge the problems with financial reporting, which were related to corporate ownership changes, staffing transitions, and lack of leadership continuity.

## **Overall Satisfaction**

The strongest testament to the satisfaction of Missions and GH with the work of HPI/TO1 is the continued high level of demand for its services. The majority of GH interviewees expressed satisfaction with HPI/TO1. GH respondents reported that it was in the top five of centrally managed projects that are requested to provide technical assistance to the field. Several respondents felt that the project was doing very innovative work and expressed concern that lessons learned and best practices needed to be disseminated. There was also concern that the project is doing many smaller activities at the community level and not implementing higher-level activities that will have a greater impact.

Reporting on overall satisfaction of Missions is complicated by the wide range of responses. For example, one Mission said it was pleased with the performance of HPI/TO1 but frustrated with delays resulting from problems with host-country partners. The majority of Missions expressed satisfaction with the project. In the LAC region, most Missions were satisfied with the work of the project. In the Eastern Europe and Eurasia (E&E) region, there was satisfaction with the performance of HPI/TO1, but frustration with delays resulting from USAID approvals needed to pursue work in sensitive topical areas. In Asia, all but one Mission was satisfied with project performance. In Africa, just

under half of the nine Missions responding stated they were satisfied. One Mission stated it was too early in the work to give an opinion.

Several Missions characterized the HPI/TO1 work as “uneven” or “lackluster.” These responses were related to delays and staffing concerns that affected project startup and the quality of work. The new project director, who started in September 2007, took steps to address these concerns. These included strengthening technical leadership by adding three technical experts at the deputy level. Subsequently, Futures put in place several senior staff for the Africa region. This strengthened leadership is intended to improve the consistency and quality of project activities.

## Findings

- The operational and geographic breadth of HPI is very wide. This provides potential to employ health policy and advocacy tools developed by the project throughout the world and also to document health policy and advocacy best practices and lessons learned and to disseminate them worldwide.
- HPI/TO1 has done some very innovative core-funded work in the areas of policy implementation, poverty and health equity, strengthening contraceptive security for graduating countries, increasing use of longer term methods, increasing male engagement in FP/RH, and estimating the costs of male circumcision.
- HPI/TO1’s policy models are powerful tools for increasing commitment and support for FP/RH, HIV/AIDS, and MH services. These tools have contributed to increased contraceptive security in Latin America and increased donor and country support for reproductive health services in Malawi and Mali. They are also improving planning in health programs worldwide.
- HPI/TO1’s gender work has expanded the set of tools available to address the issue at the service-delivery level as well as in program design.
- Through its advocacy and networking activities, HPI/TO1 has expanded the number and variety of voices participating in the policy process.
- HPI/TO1 is very effective in using its country experiences to inform development of new tools and innovative approaches. It also uses its involvement in the global policy dialogue and technical working groups to inform country work. This cross-fertilization of experiences results in tools that are often cited for their ease of use and ability to demonstrate complex relationships in clear and simple ways.
- The following HPI/TO1 activities were cited as being important: (1) the RAPID Model as a tool to conduct high-level policy dialogue and build commitment for FP among religious leaders and other key decisionmakers; (2) training of health program personnel in planning, budgeting, and advocacy skills at regional and district levels of the health system as systems increasingly decentralize; and (3) comprehensive policy analysis to develop a more strategic approach to policy work.
- The most requested activities include the GBV screening tool, costing work conducted by The Futures Institute, and the Advocacy Tools developed for PLHIV. There was also very positive feedback on the Safe Motherhood Model and the support to the White Ribbon Alliance.
- HPI/TO1 has been very responsive to requests from the field and from GH. The consistency and quality of project work suffered under the organizational changes that occurred at Futures in its first two years. As of September 2007, a new project director has provided the leadership to move the project forward and is poised to provide consistently high quality technical assistance.

## Recommendations for the Last Year of the Project

- HPI/TO1 should improve collaboration with and the hand-off to service delivery and training CAs to assure that policies are implemented.
- HPI/TO1 should continue capacity building of local office staff to maintain and improve consistency and quality of the work.
- HPI/TO1 should identify lessons learned and best practices, and develop and implement a dissemination strategy, including documenting approaches for building capacity in health planning and advocacy.
- HPI/TO1 should work with GH to seek ways to inform PEPFAR Phase II so that:
  - Indicators for policy are developed and synchronized with HPI indicators, and
  - PEPFAR and Mission staff are informed of HPI’s work through communication channels such as “Notes to the Field.”



## **APPENDIX A. SCOPE OF WORK**

### **ASSESSMENT OF THE USAID HEALTH POLICY INITIATIVE IQC AND TASK ORDER 1**

#### **PURPOSE**

The purpose of this assessment is to provide the United States Agency for International Development's (USAID) 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 Initiative (HPI) multiple-award indefinite quantity contract (IQC) and Task Order 1 (TO1) mechanisms. The USAID Health Policy Initiative is a global project that seeks to improve the enabling environment for health, primarily for FP/RH and HIV/AIDS, through policy, advocacy, financing, multisectoral coordination, and evidence-based decision-making. The key tasks for this assessment are to: (1) determine the effectiveness of the multiple-award IQC and TO1 agreement mechanisms in meeting programming needs of the Global Health Bureau, Regional Bureaus and Missions and (2) assess the quality of program implementation and progress to date.

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, Missions, USAID contracting officers, HPI IQC holders, and other stakeholders and partners. Key findings and recommendations will serve to provide an overview of satisfaction with program implementation to date.

#### **BACKGROUND**

The USAID Health Policy Initiative (HPI) project, which is housed within GH/PRH/PEC, is a five-year, multiple-award IQC with a \$325 million ceiling under Order No.GPO-I-00-05-00040-00 (9/30/2005 – 9/29/2010). The USAID project management team includes a COTR and technical advisors from PRH and OHA. Four contractors qualified as IQC holders under the award and include Abt Associates, Chemonics, the Futures Group International (formerly Constella Futures), and the Research Triangle Institute (RTI International). Task Order 1 (TO1), with a ceiling of \$100 million, was awarded on September 30, 2005, to The Futures Group International consortium, consisting of The Futures Group International, the Centre for Development and Population Activities (CEDPA), the White Ribbon Alliance for Safe Motherhood (WRA), Cultural Practices, Social Sector Development Strategies, and Religions for Peace (formerly the World Conference on Religions for Peace). The Futures Institute was added as a key subcontractor in February 2007. TO1 can accept both core and field support funds and extends through September 30, 2010. All task orders issued under the IQC can be awarded for up to but not beyond five years, and depending on the date of issue, can extend up until September 30, 2013, three years beyond the base contract end date.

The objective of the HPI IQC and TO1 is to improve the enabling environment for health, with an emphasis on family planning and reproductive health (FP/RH), HIV/AIDS, and maternal health (MH) policies. The initiative also provides assistance to design policy responses to other infectious diseases, such as tuberculosis, avian influenza, and malaria. Working on health policy and implementation is challenging in developing countries where the capacity of governments, organizations, and individuals to advocate for, formulate, and implement policies may be limited. Building in-country capacity is therefore critical to all policy work. The overall objective is to be accomplished through the achievement of five intermediate results:

- **Result 1:** Policies that improve equitable and affordable access to high-quality services and information adopted and put into practice.
- **Result 2:** Public sector and civil society champions strengthened and supported to advocate successfully and sustainably.
- **Result 3:** Health sector resources (public, private, civil society) increased and allocated more effectively and equitably.
- **Result 4:** Strengthened multisectoral engagement and host country coordination in the design, implementation, and financing of health programs.
- **Result 5:** Timely and accurate data used for evidence-based decision-making.

HPI TO1 serves as the primary mechanism to support core-funded FP/RH and HIV/AIDS activities in policy dialogue and implementation. TO1 also supports a limited number of core-funded activities in maternal health, mainly through its support of the WRA. In addition to undertaking technical leadership activities, core funds are programmed to address technical and global leadership priorities for PRH and OHA. Core funds are also used to monitor overall HPI progress, to compile and disseminate knowledge and lessons learned across the IQC, and to share data and tools produced by all IQC holders.

Task Order 1 obligations to date, (FY 2005 through FY 2008) total approximately \$87 million. TO1 has received core funding from PRH, OHA, and HIDN, and field support from 27 countries and four Mission-based regional programs. The Africa, Asia and Middle East, Eastern Europe and Eurasia (E&E), and Latin America and Caribbean (LAC) Bureaus have also provided funds to HPI/TO1 to support regional activities in family planning and HIV/AIDS. Country-level strategies integrate activities across HPI's five intermediate results (IRs) to the extent possible, and in those countries receiving HIV funding, activities are programmed according to program components of the President's Emergency Plan for AIDS Relief (PEPFAR).

In late 2006, due to projected ceiling limitations for TO1, Missions were encouraged to look at issuing their own task orders to ensure continued programming at needed levels. In 2007, the RDM/A Regional, Peru, and South Africa Missions competed and awarded their own task orders. Two additional task orders for Vietnam and the LAC G/CAP Regional HIV/AIDS Program were awarded in September 2008, and three further awards from Missions in Sub-Saharan Africa are expected by the end of the 2008 calendar year. It was evident early on in the project that the collective country requests for field support would greatly exceed the capacity of the \$100 million ceiling. Programming and planning for several Missions, particularly those with higher buy-in needs, had to be adjusted to accommodate the TO1 buy-in limitation. All Mission task orders that have been issued or are planned represent transitions from an initial period of two to three years of field-support programming under TO1.

HPI/TO1 is the first GH project to be subject to the rigorous field-support review requirements mandated by the Office of Acquisition and Assistance (OAA). Completion of the review process is now a prerequisite for obligation of any field-support funds. This process includes submission of an independent cost estimate and scope of work by the Mission, development of a work plan and detailed budget by the contractor, and completion of a signed approval checklist by the Mission, contractor, and COTR. Each set of country documents must then be submitted to OAA prior to obligation of funds.

## **STATEMENT OF WORK**

The scope of work for the assessment team will consist of two main tasks:

### **Task 1: Determine the effectiveness and efficiency of the multiple-award IQC and Task Order 1 procurement mechanisms in meeting policy and advocacy programming needs of the GH Offices, Missions, and Regional Bureaus under the USAID Health Policy Initiative.**

Required outputs:

- Determination core and field support buy-in and the types of services requested under Task Order 1 and of task orders under the IQC;
- Assessment of the implementation and usefulness of the field support review process;
- Feedback on how well the field-support mechanism under TO1 has served the Missions and Regional Bureaus for meeting in-country programming needs;
- Assessment of the impact of the TO1 \$100 million ceiling on programming and issuance of task orders, including declined field support buy-in requests (by country, directive, and total \$ amount);
- Mission input on the issuance of task orders under the IQC, including the decision-making process for issuance of a task order; the impact of the HPI/TO1 ceiling; ease of use of the IQC mechanism; the time investment for issuing and awarding a task order; and satisfaction with task order mechanism; and
- Feedback on program transition from TO1 to Mission-issued task orders.

### **Task 2: Assess the quality and progress of HPI/TO1 program implementation and satisfaction of GH Offices, Missions, and Regional Bureaus with accomplishment of workplan objectives.**

Required outputs:

- Appraisal of the quality of technical assistance and timeliness of HPI TO1's work, for both Mission and core programs;
- Assessment of HPI/TO1 staffing and management;
- Assessment of degree to which core and FS workplan objectives have been achieved;
- Feedback on the most needed and successful approaches and services under HPI/TO1;
- Feedback on those approaches and services that have been less useful or successful; and
- Feedback on benefits of core activities in the field, including for supporting new initiatives and Mission programming.

## **SUGGESTED METHODOLOGY**

### **PRH/OHA Pre-Assessment Meetings:**

The assessment team will organize and hold a two-day preliminary planning meeting with the HPI Management Team to review and refine the assessment objectives and the proposed tasks comprising the scope of work. This meeting will allow USAID (and the partners) to present the team with the purpose, expectations, and agenda of the assignment.

In addition, the team will:

- 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; and
- assign drafting responsibilities for the final report.

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

#### **Data Collection Tools:**

The assessment team will assume responsibility for developing the interview questionnaires needed to fulfill Tasks 1-2 described in the scope of work. The data collection tools will be reviewed by the HPI management team prior to implementation to ensure their applicability in attaining the needed information.

#### **Document Review:**

The assessment team will be responsible for reviewing key project documents, including but not limited to the following:

- Contracts for the IQC, TO1, and Mission-issued task orders (TO #s 2–8);
- HPI IQC and TO1 Performance Monitoring Plan (PMP);
- ADS Field Support Review Requirements;
- TO1 annual work plans and semi-annual reports;
- TO1 management review and contractor self-assessment reports;
- Semi-annual reports from Mission-issued task orders; and
- Financial tracking documents.

Additional project-related information and technical reports can be found at the USAID Health Policy Initiative project website ([www.healthpolicyinitiative.com](http://www.healthpolicyinitiative.com)) and at the public USAID IQC website <http://ghiqc.usaid.gov>.

### **Key Informant Interviews:**

The assessment team will conduct in-depth, qualitative interviews with key USAID staff, stakeholders, and partners in person when possible, or if not, by telephone. Because the scope does not include visits to the field, information from Mission staff will be collected through telephone surveys.

Key informants should be drawn from but are not limited to the following:

- USAID Missions in countries with HPI field support or task orders,
- USAID Washington GH Bureau Offices (PRH, OHA and HIDN) and OGAC,
- Regional Bureaus (AFR, Asia and the Middle East, E&E, and LAC),
- OAA and Mission contracting officers,
- USAID Washington HPI project management staff (PRH/PEC and OHA/SPER),
- HPI/TO1 prime and subcontractor staff,
- HPI IQC contract holders, and
- Subject matter experts, outside stakeholders, and partners.

### **Task Order 1 Self-Assessment:**

Prior to initiation of the assessment, HPI TO1 will be asked to prepare and submit a self-assessment report, by January 15, 2009, to the AID/W HPI management team. This report will constitute one of the key TO1 documents to be reviewed as part of the assessment.

Note: Self-assessment reports will not be collected from contractors for Mission-issued task orders as those will not be evaluated under the scope of this assessment.

### **Data Analysis and Synthesis:**

The assessment team will need to review available documents and ensure that appropriate questionnaires are developed to obtain the needed information to complete Tasks 1–2. 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 and HPI/TO1:**

After submission of a draft report, the assessment team will be responsible for organizing and holding a set of debriefing meetings to share the assessment findings and recommendations. An initial, smaller debrief for review and discussion of the draft report will be held with the HPI management team and key PEC and SPER representatives. This will be followed by a broader debriefing for PRH, OHA, and O/GAC. A separate debrief should also be planned for The Futures Group International/HPI/TO1 for those sections of the assessment 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 HPI management team.

### **DELIVERABLES**

1. Two-day pre-assessment planning meeting.
2. Approved work plan, including assessment schedule and agreed-upon deliverables.

3. Development of data collection tools/ questionnaires.
4. Draft report – The assessment team will provide PRH with a draft report that includes all the components of the final assessment report. USAID will provide comments on the draft report to the assessment team leader within 10 working days of receiving the report. The contractor is then required to submit a final report within 10 working days after USAID provides its feedback on the draft report. The final report is to be submitted to PRH in electronic form.
5. Debriefing meetings.
6. Final assessment reports – The final assessment report should include, at minimum, the following: executive summary, scope and methodology used, important findings (empirical facts collected by evaluators), conclusions (evaluators’ interpretations and judgments based on the findings), and recommendations (proposed actions for management based on the conclusions. One edited and formatted final report for public release that omits any *procurement-sensitive* information will be submitted and five hard copies will be provided. The procurement-sensitive information will be submitted as a separate well-marked internal USAID memo.

### **DURATION, TIMING, AND SCHEDULE**

It is anticipated that the duration for this assessment will be approximately 10–11 weeks (estimated Jan 12 to April 3), which will cover implementation of the approved work plan and completion of all deliverables. This estimated schedule also includes a seven-day period for USAID/ PRH and OHA review of the draft report.

### **TEAM COMPOSITION**

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

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

1. 10–15 years 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 experience in the area of international health policy, including for family planning and HIV/AIDS in developing country settings.
3. Expertise is required for several of the following areas:
  - Health policy development and implementation,
  - Advocacy and capacity building for policy champions and civil society groups,
  - Financing and resource allocation,
  - Gender,
  - Health equity,
  - Human rights,
  - Data analysis and modeling, and
  - Health Systems.

4. For OAA and Mission Contracting Officer interviews: Experience with and knowledge of USAID acquisition and assistance mechanisms including single award contracts, Indefinite Quantity Contracts (IQCs), cooperative agreements and Leader with Associates awards (LWA), and the field support mechanism used by Missions for buy-in to central USAID/Washington programs.
5. Extensive experience with conducting evaluations, assessments, and questionnaire design.

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

1. An advanced degree in public health, health policy, economics, or other relevant course of study.
2. Excellent English language skills, both written and verbal.
3. Demonstrated knowledge of USAID policies, programs, and procedures.
4. Ability to effectively conduct interviews, in person or by phone.
5. 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 assessment, communicating with the USAID HPI management team, ensuring the quality of the questionnaire design and data collection process and writing, and editing the final the assessment report, including a version to be shared publicly that does not include any procurement-sensitive information.

## **RELATIONSHIPS AND RESPONSIBILITIES**

Overall Guidance: The USAID HPI management team will provide overall guidance to the assessment team.

PRH/PEC Contact: Mai Hijazi, Health Development Officer and COTR for the USAID/Health Policy Initiative, will serve as the official point of contact for the assessment team.

### **Responsibilities:**

- GH Tech will be responsible for logistics for travel and will also assist with setting up interviews and meetings as needed.
- GH Tech will work with the consultants to produce a report that will include content similar to what has been outlined in Annex 3; 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 that is not suitable for public distribution.
- Consultants will be responsible for coordinating and facilitating assessment-related visits, interviews, and meetings as needed.
- USAID will facilitate interviews by alerting interviewees about the assessment and by providing contact information to the team.
- A communication strategy will be developed jointly by USAID and the assessment team so that the parties who are contacted by the consultants hear a similar introduction and receive the same information about the project before interviews begin.

## **RESTRICTIONS**

The prime contractor, sub-contractors and any consultants are subject to the restrictions set forth in USAID CIB 99-17, under evaluation.

## **LIST OF BACKGROUND DOCUMENTS**

These will include but are not limited to:

1. HPI IQC Holder Contracts,
2. HPI/TO1 Contract,
3. HPI IQC and TO1 Performance Monitoring Plan,
4. HPI/TO1 Work Plans,
5. HPI/TO1 and IQC Holder Semi-Annual Reports,
6. HPI/TO1 Mission Reports,
7. HPI/TO1 Management Review,
8. HPI/TO1 Self Assessment Reports,
9. HPI/TO1 Technical and Programmatic Reports, and
10. USAID Health Policy Initiative Project Website ([www.healthpolicyinitiative.com](http://www.healthpolicyinitiative.com)).

## **APPENDIX B. PERSONS CONTACTED**

### **US DEPARTMENT OF STATE**

#### **Office of the Global AIDS Coordinator**

Michelle Maloney-Kitts

### **US AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)**

#### **USAID/Washington, D.C.**

#### **Office of Population and Reproductive Health**

Scott Radloff, Director

Ellen Starbird, Deputy Director

Jeff Spieler, Senior Scientist

#### **Policy, Evaluation, and Communication Division**

Elizabeth Schoenecker, Chief

Krista Stewart, Deputy Division Chief

Mai Hijazi, COTR, Health Policy Initiative

Shelley Snyder, Senior Policy Advisor

#### **Service Delivery Improvement Division**

Mary Ann Abeyta-Behnke, FP/HIV Integration Officer

Marguerite Farrell, COTR, PSP Project

Shyami De Silva, COTR, AIDSTAR 1

#### **Contraceptive Systems and Logistics**

Mark Rilling, Division Chief

Alan Bornbush, COTR Deliver Project

#### **Office of HIV/AIDS**

Robert Clay, Director

#### **Strategic Planning, Evaluation and Reporting Division**

Paul Mahanna, Division Chief

Gretchen Bachman, OVC

Katherine Kearns

Diana Prieto, Senior Technical Advisor

Billy Pick

Estelle Quain, Capacity

Scott Stewart, Health Systems Strengthening

Sara Wilhelmsen, former HPI management team member

#### **Office of Health, Infectious Diseases and Nutrition**

##### **Infectious Diseases Division**

Kamden Hoffman (Malaria)

##### **Health Systems Division**

Karen Cavanaugh, COTR Health Systems 20/20

##### **Maternal and Child Health Division**

Mary Ellen Stanton, Senior Reproductive Health Advisor

**Africa Bureau**

Ishrat Husain, Senior Health Advisor

**Asia and Middle East Bureaus**

Gary Cook, Team Leader, Senior Health Advisor

**Latin American and Caribbean Bureau**

Lindsay Stewart, Senior Advisor on HIV/AIDS and Family Planning

**M/OAA/Global Health**

Anne Quinlan, Division Chief

Dianna Radwan, Contract Negotiator for HPI

Braden Enroth (formerly Contracting Officer for G/CAP)

**AFRICA**

**Botswana**, Joan LaRosa, Director, PEPFAR Program

Dorothy Tlagae, HIV/AIDS/Health Program Assistant

**Democratic Republic of Congo**, Laurent Kapesa, HIV Program Management Specialist

**Ethiopia**, Anita Gibson, Team Leader, MCH

Premela Bartlett, MCH Specialist

**Ghana**, Susan Wright, RH/MCH Senior Advisor

**Kenya**, Bedan Gichanga, Health Management Systems Specialist, and Lynn Adrian, Office of Population and Health

Joseph McGee, Supervisory Regional Contracting Officer, East Africa

**Mozambique**, Nena Lentini, Health Program Manager

**Rwanda**, Justus Kamwesigye, Monitoring and Evaluations Program Manager

**RHAP (Southern Africa)**, Karin Turner, Chief, Office of Health

**Senegal**, Joshua Karnes, Health Officer, and Mater Camara, MD, Health Policy Advisor

**South Africa**, Nellie Gqwaru

Martin Fischer, Contracting Officer

**Tanzania**, Charles Llewellyn, Director Health and Population Office

Susan Monaghan, Team Leader PEPFAR Program

**Zambia**, Randall Kolstad, PHN Director

**ASIA**

**Bangladesh**, Lois Bradshaw, Health Officer (formerly RDM/A)

**Pakistan**, Susan Thollaug (formerly Peru), Chief Office of Health

**RDM/A (Bangkok)**, Nithya Mani, Health Development Advisor

Patrick Wilson, Contracting Officer

**Vietnam**, Ellen Lynch, Director Office of Population and Health

## **EUROPE AND EURASIA**

**Ukraine**, Oleksander Cherkas, Senior Social and Health Advisor

## **LATIN AMERICAN AND CARIBBEAN**

**G/CAP (El Salvador)**, David Brown, Contracting Officer, and Ileana Paraga, Acquisition Specialist

**Guatemala**, Isabel Stout, Health Officer

**Mexico**, Nancy Alvey, Health Program Director

**Peru**, Lucy Lopez, Program Manager and COTR/HPI TO3, Office of Health

Luis Rivera, Contracting Officer

## **MIDDLE EAST**

**Jordan**, Laura Slobey, Senior Public Health Advisor

## **IQC HOLDERS**

### **Abt Associates, Inc.**

Nancy Pielemeier, Vice President, International Health

Barbara Seligman, Principal Associate, International Health

Douglas Kerr, Director, New Business Development, International Health

### **Chemonics International, Inc.**

International Health Group

Betsy Bassan, Senior Vice President

Saul Helfenbein, Director

Ron Parloto, Director Africa

Lowrey Anne Gray, Manager Business Development

### **Research Triangle Institute International**

Jeffrey Sine, Deputy Director, Center for International Health, International Development Group

Jennifer Leopold, Program Development Coordinator, Center for International Health

### **Futures Group International**

Farley Cleghorn, Senior Vice President and Chief Technical Office

### **Health Policy Initiative, Task Order 1 Staff**

Sara Clark, Project Director - HPI/TO1 Director

Nancy McGirr, Deputy Director

Tom Goliber, Senior Fellow

Tito Coleman, Senior Advisor

Elizabeth McDavid, Deputy Director, Africa and MCH

Ken Morrison, Deputy Director, HIV

Suneeta Sharma, Deputy Director, FP/RH and ANE

Mary Kincaid, Senior Policy Advisor

## **HPI SUBCONTRACTORS**

### **Centre for Development and Population Activities (CEDPA)**

Carol Peasley, President

Ann Jorgensen, CEDPA HPI Director

### **Cultural Practice**

Debbie Caro, Co-Director

**The Futures Institute**

John Stover, President

**White Ribbon Alliance for Safe Motherhood (WRA)**

Theresa Shaver, President

**OTHER PARTNERS/KEY STAKEHOLDERS**

**Center for Global Development**

Rachel Nugent, Deputy Director, Global Health Program

**Gates Foundation**

Monica Kerrigan, Reproductive Health Specialist

**Global Health Council**

Maurice Middleberg, Vice President for Public Policy

**Hewlett Foundation**

Sara Seims, Director, Population Program

**Gates Institute for Population and Reproductive Health**

**Johns Hopkins Bloomberg School of Public Health**

Duff Gillespie, Professor and Senior Scholar

**Reproductive Health Supplies Coalition**

John Skibiak, Director

**World Bank**

Thomas Merrick, Program Advisor and Population Reference Bureau Visiting Scholar

## APPENDIX C. REFERENCES

### HPI/TO1 DOCUMENTS:

- Health Policy Initiative, Task Order 1 HPI/TO1), Contractor's Self-Assessment Questionnaire (January 23, 2009)
- HPI/TO1, Management Review Questions (February 28, 2009)
- HPI/TO1 Workplan, October 1, 2005 to June 30, 2007 (May 3, 2006)
- Performance Monitoring Plan, September 30, 2006
- Annual Report, September 30, 2005 to September 30, 2006
- Semi-Annual Report, Task Order 1, October 1, 2006 to March 31, 2007
- HPI/TO1 Workplan, July 1, 2007 to June 30, 2008 (September 26, 2007)
- Semi-Annual Report, Task Order 1, April 1 to September 30, 2007
- Semi-Annual Report, Task Order 1, October 1, 2007 to March 31, 2008
- HPI/TO1 Workplan, July 1, 2008 to September 30, 2009 (October 10, 2008)
- Semi-Annual Report, Task Order 1, April 1, 2008 to September 30, 2008
- HPI/TO1 Financial Reports
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- “Improving the Environment for Men’s Reproductive Health.” [www.healthpolicyinitiative.com](http://www.healthpolicyinitiative.com).
- Morrissey, Claudia S. and Linda Sanei, Evaluation of the White Ribbon Alliance for Safe Motherhood 1999–2007 (2007) produced for review by U.S. Agency for International Development through the Global Health Technical Assistance Project.
- HPI/TO2, Semi-Annual Report, Health Policy Initiative IQC (October 2007 to March 2008) (May 9, 2008) for RDM/A – China program.

#### **USAID DOCUMENTS:**

- Automated Directive System, Series 300, Acquisition and Assistance, particularly Section 302 covering USAID Direct Contracting, and Section 304 covering Selecting the Appropriate Acquisition and Assistance (A&A) Implementing Instrument.
- Federal Acquisition Regulations (FAR), Section 16.504, governing Indefinite Quantity Contracts, including the multiple award preference and the \$100 million ceiling on task orders with standards for exceptions to the rule.
- Foreign Assistance Act of 1961, as amended, Section 611 (policy on scopes of work and budgets for U.S. foreign assistance activities).
- Request for Proposals (RFP) No: M-OAA-GH-POP-05-527, Policy Dialogue and Implementation Project, issued by USAID Office of Acquisition and Assistance, April 26, 2005.
- Contract Types to Address Global Technical Leadership with Field Support and/or Cost Contributions, An Additional Help for ADS Chapter 302, Office of Acquisition and Assistance, revised April 26, 2006.
- Indefinite Quantity Contract for Services, Contract No. GPO-I-00-05-00040, issued to Futures Group by U.S. Agency for International Development, Office of Acquisition and Assistance (September 30, 2005).
- IQC Task Order 1, Contract No. GPO-I-01-05-00040-00, issued to Futures Group by U.S. Agency for International Development, Office of Acquisition and Assistance (September 30, 2005).
- Indefinite Quantity Contract for Services, Contract No. GPO-I-00-05-00026 issued to Abt Associates Inc. by U.S. Agency for International Development, Office of Acquisition and Assistance (September 30, 2005).
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- Indefinite Quantity Contract for Services, Contract No. GPO-I-00-05-00035 issued to Research Triangle Institute International by U.S. Agency for International Development, Office of Acquisition and Assistance (September 30, 2005).
- Field Support Action Process, An Additional Help for ADS Chapter 302, Office of Acquisition and Assistance.
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- HPI Task Order 1 Management Review, September–October 2007, Global Health Bureau, HPI Management Team, December 21, 2007.
- Innovations and Future Directions Survey for Global Health Partners – Data Summary, USAID Global Health Bureau, December 15, 2008.



## APPENDIX D. HPI ASSESSMENT INTERVIEW QUESTIONNAIRE

Not all questions listed here are specifically addressed in the accompanying report.

### USAID/WASHINGTON

#### Task 1:

1. How well has the field-support buy-in mechanism under HPI/TO1 served in meeting programming needs?
2. How useful are the field-support review requirements? How have they had an impact on how you program and carry out your work?
3. How has the TO1 ceiling affected your programming?

#### Task 2: Assess the quality and progress of HPI/TO1 program implementation and satisfaction with accomplishment of workplan objectives. (Use a five-point scale for questions asking for a rating. Five is the highest score.)

1. How well has HPI/TO1 served in meeting core-funded programming needs in technical leadership?
2. How would you rate the technical quality of HPI/TO1's work?
3. How would you rate staff qualifications?
4. How would you rate HPI/TO1's responsiveness to USAID Mission and Global requests and program priorities?
5. How well has HPI/TO1 met management and oversight needs? How timely are HPI/TO1 work plans, reports and activities? (Only for USAID/W HPI Management team: Has HPI/TO1 financial reporting been timely and accurate?)
6. Have the corporate and personnel changes at HPI/TO1 been an issue?
7. What are the most needed or successful activities? The least useful or least successful?
8. What kinds of policy activities would you liked to have done but could not do? Why couldn't they be done?
9. Are PRH and/or OHA core activities useful for supporting new initiatives and technical directives? Are they beneficial to in-country programming?

### USAID MISSIONS

General questions about your experience with the project and the quality of its work:

1. What has been your experience accessing the services under the HPI IQC? Were you aware of the range of services and contractors that you could access for services under the HPI Project?
2. Has HPI/TO1 been responsive to your mission's requests and priorities? Can you give an example?
3. Have you been satisfied with the work of the project and how would you rate the technical quality of HPI/TO1's work on a scale of 1–5, with 5 being excellent?
4. Did the project meet workplan objectives?

5. How would you rate the technical qualifications of the staff?
6. Did you feel that the project staff interacted effectively with the following groups:
  - a. host-country government representatives?
  - b. NGO's, networks, and other in-country partners?
  - c. other implementing agencies and/or other donor agencies working in country?
7. Do you think the project model of working with a local country director and local team has been effective? If so, why? If not, why not?

Now, here are some questions about your satisfaction working with the project and managing project activities:

1. Has HPI/TO1 completed workplans, reports and activities in a timely manner? If not, why?
2. (For missions with other task orders.) Has HPI/TO financial reporting been timely and accurate?
3. Do you think the support that you and the local project team have received from the HPI/TO1 Washington-based staff has been useful? Why? Or why not?
4. What impact have the field-support review requirements had on program implementation?
5. How has the HPI/TO1 ceiling affected your programming?

**If the Mission implemented a TO, then ask these questions. If not, skip.**

6. Why did you choose to issue a task order under the HPI IQC?
7. Did the transition from field support under TO1 to the task order go smoothly? If not, can you tell me what happened?
8. What are the differences in the quality of work and results between the services the project provides under field support and the Mission TO?

### **OAA CONTRACTING OFFICERS/MISSION CONTRACTING OFFICERS**

1. How well has the field-support buy-in structure worked under TO1? From the Contracting Officer perspective, what are the advantages of this structure and what are its disadvantages?
2. What has been your experience with implementation of the field-support review requirements? What are the benefits of this process? What are the associated costs? From the Contracting Officer perspective, is the process efficient in terms of time? Where do bottlenecks occur and what can be done to resolve them? Do the benefits outweigh the costs?
3. How is the field-support review information used by OAA given its contract oversight responsibilities?
4. What has been your experience with issuing task orders under the HPI IQC? What are the advantages and disadvantages to using this mechanism for a mission, or for a Washington unit, from a Contracting Officer's management perspective?

**If the Mission issued a TO then ask, if not skip.**

5. Has the transition from greater reliance on field support under TO1 to a greater number of mission-issued task orders been smooth? Has this process produced any organizational delays or problems for OAA staff?

6. Are there instances where, from your perspective as a Contracting Officer, it would make sense to recommend the use of a separate contract, rather than a TO, for work that you have seen carried out by missions under HPI?

### **HPI/TASK ORDER 1 (FUTURES CONSORTIUM)**

1. What has been your experience with core and field-support buy-in under Task Order 1? What are the advantages; what are the disadvantages? Is it efficient from a management perspective?
2. What has been your experience with completing the requirements for the FS review process? Have they had an impact on how you program and carry out your work: advantages and disadvantages? What is the associated management burden and cost? Do the benefits outweigh the costs? Is there a way to make the process more efficient?
3. What has been your experience in transitioning from field support under TO1 to Mission-issued task orders?
4. From your perspective as a manager, is putting a task order in place more efficient than undertaking tasks using field support, or vice versa?
5. Are there instances when you have felt that a separate bilateral procurement might make sense for a given activity you have been asked to implement under the IQC?
6. Does the TO1 project mandate (the IR structure) meet core and field-support programming needs? What works well? What does not? What is missing?

### **ALL HPI IQC HOLDERS (ABT, CHEMONICS, FUTURES, RTI)**

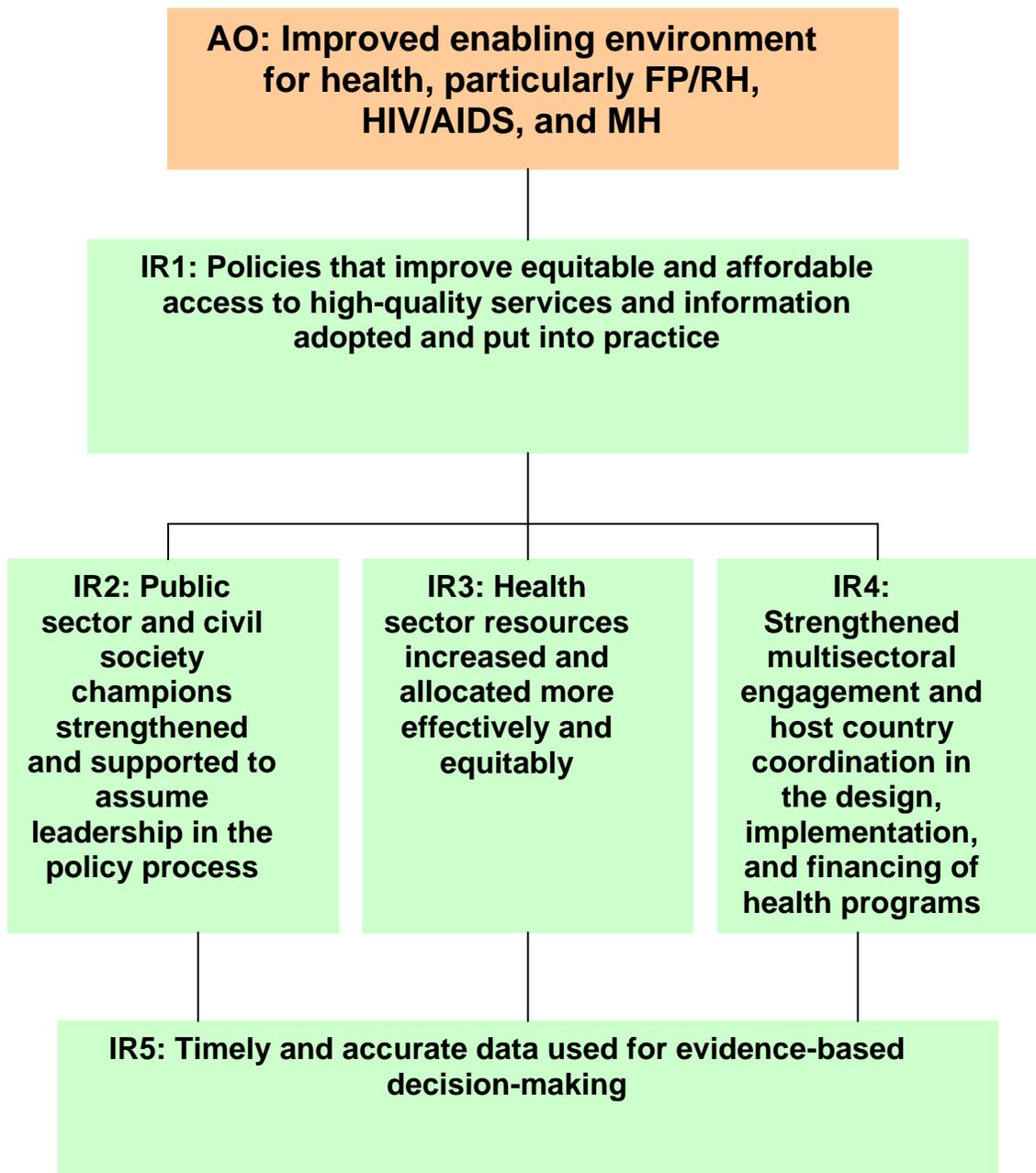
1. What has been your experience with the procurement process for Mission-issued task orders? Is it efficient in terms of timeliness? Where do bottlenecks occur and what can be done to resolve them? Are there parts of the process that could be improved? If so, how?
2. What has been your experience in carrying out programming under a Mission task order?
3. Given the volume of business that has come to your firm/consortium under this IQC, has using an IQC mechanism for HPI been worthwhile?
4. Have administrative processes associated with procurement for HPI services affected either positively or negatively the quality of the technical products produced by HPI?



## APPENDIX E. HPI RESULTS FRAMEWORK

HPI Results Framework.ppt  
(3/6/2007)

### HPI Results Framework, Task Order 1





## APPENDIX F1. SUMMARY OF HPI/TO1 CORE-FUNDED ACTIVITIES (AS OF SEPTEMBER 2008)

W = worldwide

RR = rapid response

TYPE	FP/RH	HIV/AIDS and PEPFAR	MH
<b>IR1</b>			
<b>Access</b>	GUATEMALA: access by indigenous pop.	W: policy implementation barriers analysis	
	W: policy implementation assessment tool	W: addressing operational barriers (gender)	
	MALI: barriers to limiting female genital cutting; male engagement	W: focus on OVC	
		W: male circumcision guidelines	
		W: post-exposure prophylaxis policy	
		AFR: task shifting — policy implementation	
<b>IR 2</b>			
<b>Advocacy</b>	MALI: religious institutions and FP	ANE: PLHIV leader capacity develop	W: White Ribbon Alliance: strengthening country-based MH advocacy
	FRANC-AFR: parliamentarians and FP	AFR: religious advocacy to end GBV	
	W: advocacy for securing RH supplies		
	UGANDA: policymakers & early marriage groups		
	NIGERIA: build leadership among the poor		
	GHANA: advocacy for financial reform (RR)		

TYPE	FP/RH	HIV/AIDS and PEPFAR	MH
<b>IR3</b>			
<b>Resources</b>	KENYA: application of models at sub-national level		W: identifying livelihoods for adolescent girls
			W: equity of access to ART
<b>IR4</b>			
<b>Multi-sector</b>	W: family-friendly workplace model		
	W: greater public-private collaboration on access to FP		
<b>IR 5</b>			
<b>Data</b>	W: investment needed to increase FP use by 1% per year	W: tools for HIV planning and analysis	
	W: contribution of FP to reach MDGs	W: costs—key PEPFAR interventions	
	INDIA: demo impact of FP	W: analysis of DHS data to scale up prevention	
	W: data for advocating delay in marriage	W: model—impact of TB control on HIV/AIDS	
	W: determinants of FP on maternal/neonatal outcomes	W: profile DOD's OVC programs	

**CROSSCUTTING ISSUES:**

<b>TYPE</b>	<b>FP/RH</b>	<b>HIV/AIDS and PEPFAR</b>
<b>Poverty &amp; Equity</b>	PERU: strategy to include poor	
	USAID: poverty and equity working group support	
	USAID: poverty and equity training	
	PERU: scaling up activities on FP/RH including the poor (RR)	
	APHA: presentation on pro-poor financing schemes (RR)	
<b>Gender Issues</b>	W: gender-based violence model	PEPFAR: strengthen services
	W: approaches to constructive men's engagement (CME)	USAID: integrate gender into USAID HIV programs
	USAID: gender working group support	
	AFR: presentation on CME (RR)	
<b>Stigma &amp; Discrimination</b>	USAID: support to working group—focus: training service providers	W: citizen monitoring model
<b>OTHER:</b>		
<b>FP-HIV/AIDS Integration</b>	KENYA: eliminate barriers to integration	
<b>Repositioning FP</b>	W: increase in donor funding by showing impact of FP investment on poverty reduction and MDGs	
	W: guidebook "Making FP part of PRSP Process	
	AFR REG: expand contraceptive methods available through community-based distributors and nurse auxiliaries	

TYPE	FP/RH	HIV/AIDS and PEPFAR
	MALAWI: advocacy for linking FP and MDGs; operational policy change by authorizing community-based health surveillance assistants to give injectables	
	MALI: FP in Poverty Reduction Strategy for 2007-2011; advocacy among religious leaders for FP/RH legislative reform	
<b>Communications</b>	New communications materials	New communications materials
	Conference participation	Conference participation
	Technical Development Week	Technical Development Week
	Website/database support	Website/database support
	Informational videos	Informational videos
	E-Learning/virtual training	E-Learning/virtual training

## APPENDIX F2. HPI FIELD SUPPORT AND TO ACTIVITIES BY COUNTRY AND FUNCTIONAL DISTRIBUTION THROUGH DECEMBER 2008

Region/ Country	FP/RH	PEPFAR or HIV/AIDS	MCH	Malaria/ TB	Asian Influenza	Infectious Diseases	Mission TO
<b>AFRICA</b>							
AFR BUREAU	C	C					
West AFR	P						
AFR RHAP		C					
Botswana		C					
DR Congo	C	C					
Ghana		P					
Kenya	C	C	C				To date not signed yet
Madagascar	C						
Mali	C	C	C	C			
Mozambique		C					
Namibia		P					
Rwanda	C	P					
Senegal	C						
South Africa		P (core) C		P			4
Swaziland		C					
Tanzania	C	C					7

C=current program

P=completed program

Country/ Region	FP/RH	PEPFAR or HIV/AIDS	MCH	Malaria/ TB	Asian Influenza	Infectious Diseases	Mission TO
<b>ASIA</b>							
ANE Bureau	P	C	P				
RDM/A - China		P (core) C	C				2
RDM/A - Mekong		P					2
India		C					
Indonesia		C					
Nepal		P					
Vietnam		C					5
<b>NEAR EAST</b>							
Egypt	P						
Jordan	C						
Yemen	C						

REGION/ COUNTRY	FP/RH	PEPFAR/ HIV/AIDS	MCH	MAL/TB	AI	INF DIS	Mission TO
<b>LAC</b>							
LAC Bureau	C						
LAC G/CAP		P (core) C					6
Dominican Rep.	C						
El Salvador		C					
Guatemala	C	C	C				
Haiti	P	P					
Jamaica		C					
Mexico		C					
Peru	P (core) C	P (core) C		P		P	3
<b>E&amp;E</b>							
E&E Bureau		C					
Ukraine		P		P	P		



## **APPENDIX G. TRAINING THE NEXT GENERATION OF COMPUTER MODELING EXPERTS**

### **BY THE FUTURES GROUP INTERNATIONAL**

In 2007, Futures Group convened a task force to look across the company to strengthen and build on modeling capabilities. We identified several levels of expertise required: familiarity with the applications of models, application of specific models in developing countries, training in the application of models in developing countries, and refinement of current models and development of new models. We have developed several standard practices to make sure that we address the various needs as described above.

One of the specific ways we keep abreast of issues that cut across the programs is through an economic modeling working group. It is currently chaired by Suneeta Sharma and includes all HPI staff working on models, consultants or staff of Futures Group International or the Futures Institute, as well as experts from other projects across the company, notably Measure Evaluation. We bring in outsiders whose work has caught our attention to speak with this group or, as appropriate, to the whole staff. New techniques are examined for their applicability to the types of problems we work on and new applications, for example in the Family Planning Model (FamPlan), are shared with those who model HIV/AIDS costing. The working group meets intermittently but about every five or six weeks.

We established that the entire technical staff should be familiar with the application of models. In order to accomplish that aim we have carried out periodic half-day training where junior and non-specialist staff members are introduced to the models and the circumstances under which they are applied, to the documentation, and are shown how to access the software. This training is carried out every four to five months when new staff members have joined the project. We also conducted in-depth training during our technical development week. Two such sessions can be viewed on the HPI Intranet under the video archives section. One-on-one and intensive hands-on training is made available as needed. In addition, we have developed a virtual-learning application to introduce DemProj, the projection model that underlies many of the other models in the Spectrum Suite of Policy Models. See: <http://www.healthpolicyinitiative.com/index.cfm?id=software&get=Spectrum>

Over the years we have discovered that training in the application of models is not really appropriate unless and until the staff member will actually be involved in applying the model. Not all staff is able to carry out this step, but we have seriously and consciously recruited the “next generation” among recently-minted demographers and economists so that there is a pool of people who can. In this case, training is arranged one-on-one or two over several days using data and assumptions appropriate to the targeted country. This training takes place five or six times a year. A recent example is the request by the Guatemala Mission for application and training in the Safe Motherhood Model; this was carried out by Ellen Smith, demographer, with just-in-time training by Futures Institute. Similarly, so that Rachel Sanders could assist in carrying out antiretroviral (ARV) costing, she was trained by Futures Group staff member, Nalinee Sangrujee, and earlier by Gayle Martin. Part of the on-the-job training is a deliberate and consistent pairing of junior staff with more senior colleagues, and this is the policy for all technical missions sent out to the field.

After successful country applications, staff is then able to teach counterparts and colleagues how to apply the models and, after a few repetitions, become master trainers themselves. This may be even a smaller group since not all are equally talented as trainers. However, members of this more seasoned group of modelers are able to suggest new applications and refinements to the models.

One of the outstanding characteristics of the Futures Group in carrying out its policy projects over the years is that we have developed models to respond to specific needs. It has not been an academic exercise whereby a model is developed with such stringent data requirements that researchers are looking for places to apply it. I think of the two World Bank models that have been often cited as more rigorous alternatives to some of the Futures Group products: the Bachue model and the “bottlenecks” model. The vision to see the potential of a modeling solution and the expertise to carry it out in a simple enough fashion that it can be widely applied are not often paired together! This skill is at the pinnacle of the skills matrix. Here we agree with the evaluation team that we have not found the next John Stover!

Our policy is to recruit in order to keep the pipeline full of the various levels of expertise. However, since demand is uneven, it is not always possible to (1) retain mid-level staff in the face of competition for their skills and (2) keep skills honed at times when demand is low. Therefore, we concentrate on the entry level and try to have two or three junior-level quantitatively-oriented policy analysts deployed at all times, and keep an eye out for mid-level people who can contribute.

In conclusion then, Futures Group recognizes the key role data-based policy applications, especially models, have played in its successful policy work over the years and our identity with that “branding.” We have therefore attached high priority to recruit, train, deploy, and support staff to maintain and expand that competence.

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

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