



NGO Networks
for Health

**Report of the
Final Evaluation of Umoyo Network Malawi
USAID Grant # HRN-A-00-98-00011-00**

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Acronyms and Abbreviations

ADRA:	Adventist Development and Relief Agency
AHS:	Adventist Health Services, Malawi
AIDS:	Acquired Immune-Deficiency Syndrome
BCI:	Behavior Change Initiative
CBDAs:	Community Based Distribution Agents
CBO:	Community Based Organization
CHAM:	Churches Health Association of Malawi
CHBC:	Community Home Based Care
CS:	Child Survival
DAPP:	Development Aid from People to People
DFID:	Department for International Development
FP:	Family Planning
GOM:	Government of Malawi
HBC:	Home Based Care
HIV:	Human Immune-Deficiency Virus
ID	Institutional Development
LQAS:	Lot Quality Assurance Sampling
MACRO:	Malawi AIDS Counseling and Resource Organization
MANASO:	Malawi Association of National AIDS Service Organizations
M&E:	Monitoring and Evaluation
MANET+:	Malawi Network of People living with HIV/AIDS
MOHP:	Ministry of Health and Population, Malawi
NAC:	National AIDS Commission, Malawi
NAPHAM:	National Association of People Living with HIV/AIDS in Malawi
NGO:	Non-Governmental Organization
NSO:	National Statistics Office
PLWHA	Persons Living with HIV/AIDS
PSI:	Population Services International
PVO:	Private Voluntary Organization
QOS	Quality of Service
RFA:	Request for Applications (by USAID)
RH:	Reproductive Health (includes family planning, safe motherhood and the prevention and treatment of sexually transmitted diseases)
SOW:	Scope of Work
STAFH:	Support to AIDS and Family Health
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection
USAID:	United States Agency for International Development
VCT:	Voluntary Counseling and Testing



Final Evaluation of Umoyo Network

1. Introduction

This report documents the summative evaluation of Umoyo Network, Malawi, a USAID-funded project aimed at providing funding and technical assistance to Malawian NGOs working in reproductive health and HIV/AIDS. According to the consultant's SOW, the purpose of the evaluation is *'to document the accomplishments of Umoyo Network against its original objectives and to establish:*

What are the strategies that Umoyo Network utilized with the Sub-Grantees that have worked to improve and expand services and strengthened the organizations overall? Looking at these strategies – if they worked, why did they work? If not, why?

What kind of unintentional events have helped or hindered the achievements of the goal?'

The evaluation was conducted in two short inputs, one in early December 2002 and the second in March 2003. The full SOW is given in Appendix 2.

2. Methodology

This evaluation is based on the following:

- discussions with Umoyo Network staff, USAID Mission HIV/AIDS Team Leader and Program Director of National AIDS Commission (NAC)
- informal discussions with staff and volunteers at DAPP, TSA, and Malamulo Hospital
- meetings and one phone interviews with managers of MANASO, AHS, and NAPHAM, and the Program Director of the National Aids Commission
- an analysis of project documentation – including selected consultant reports, MIS data in quarterly and annual reports, the 2001 Mid Term Evaluations - a review of the reports of, and discussions with, the evaluators of the Quality of Service (March 2003) and the Institutional Development Program (November 2002), and in the case of the ID Evaluation, participation in his debriefing session with Umoyo Network staff.

The word 'sub-grantee' suggests that Umoyo Network is primarily a disbursement mechanism for USAID funds. Over the last 3 years the 'sub-grantees' have come to see themselves more as 'local partners' of the Network, (and receive much



more than funding from it): we therefore refer to them as local partners throughout.

This report was commissioned as a 'Final Evaluation' of Umoyo Network for the period of the first contract awarded by USAID to Save the Children US (SC) from 1999 to June 2003. During the research it became clear that every stakeholder involved sees the Network continuing in some kind of form well beyond that date. This evaluation report is therefore written more as a kind of 'mid-term evaluation of a continuing project, and it makes recommendations for any further phase of funding from USAID.

3. Project Background

UNICEF estimates that more than 300,000 people are estimated to have died of AIDS-related illnesses since the first case in Malawi was reported in 1985.¹ Today around 9 per cent of the 10.6 million population, or about one million people, are believed to be infected with HIV. But efforts to prevent and treat HIV/AIDS are hampered by severe poverty, increasingly frequent food shortages, and a severely under-resourced and under-staffed government health sector. USAID has therefore been active in finding ways of meeting this considerable challenge for over 11 years.

Umoyo Network emerged out of the Support to AIDS and Family Health or STAFH Project, which was funded by USAID from 1992-2001 and included grants for 24 local NGOs. As a result of this project USAID/Malawi felt it needed to make a far greater investment in technical and institutional capacity building if funding to local NGOs in the health sector was to be really effective. In 1999 it therefore invited NGO Networks for Health to make a proposal that would *promote sustainability through a phased marriage of grants management, capacity building, and network development*. This proposal was consistent with the key Strategic Objectives of USAID - the *'increased adoption of measures that reduce fertility & risk of HIV transmission, including improved child health services'* and *'Behaviors adopted that reduce fertility & HIV/AIDS & improve child health'*. Umoyo Network's own goal was initially defined in the initial SOW in May 1990 as *'to promote & support the development of networks in order to improve the scope & quality of service delivery mechanisms'*

Given this very brief history, three issues require comment. First Umoyo Network's three activities (grants management, capacity building, and network development) are complementary, but each activity requires a specific set of skills. Initially there were difficulties in making this 'phased marriage' work well, and the annual report for 2000 said that *'grants management & network development are separate activities requiring different types of staffing, phasing of activities, & support systems'* While the ID Evaluation suggests that, from the perspective of local partners, these different activities were in the end able to

¹ UNICEF *State of the World's Children* (2002)



combine more successfully, there were definitely initial uncertainties, which are referred to below.

Secondly, Umoyo Network is remarkable for its large and diverse number of stakeholders. NGO Networks for Health was a global health partnership program supported by USAID through a consortium of 5 US-based PVOs, and its major focus was to build the capacity of these PVOs to provide quality FP/RH/CS and HIV services. Save the Children US (SC) became the lead agency, and both its US and Malawi offices support the management of Umoyo Network. USAID/M as the sole donor has always had an important monitoring role. Within Malawi, the government (in particular the MOHP and the National Aids Commission) and local partners have a strong interest. This multiplicity of stakeholders has made the management of Umoyo Network an extremely complex and multi-faceted task, and lends support to a recent finding from USAID's Bureau of Global Health that *any new activity with PVOS/NGOs should have a fairly simple, straightforward design and avoid overly complex mandates.*²

Thirdly, at least initially, there were discernible differences in the priorities of some of these stakeholders, with NGO Networks tending to emphasise networking as a priority, including an initial emphasis on setting up a Resource Centre in Blantyre, while USAID and SC have always given the highest priority to effective capacity building. The Strategic Objective in the initial Results Framework quoted above reflects these mixed agendas as it tries to link the anticipated improvement in services *with the enhanced capacities of PVO/NGO Networks*. This appears to refer to the expansion of NGO Networks as a Washington-based global project rather than to the capacity of local NGO networks.

As a result of these overlapping agendas the first year was difficult, with changes in staff both in Umoyo Network and NGO Networks for Health. Some staff who worked for Umoyo Network at this time felt that the involvement of NGO Networks for Health and their frequent consultancy inputs were a 'distraction'. In particular local partners initially had to cope with far more demanding systems for financial disbursement and M & E than they were used to, and these partners felt they were spending too much time collecting data, and too little on implementation: one ex-member of staff said that in the first year *60% of our time seemed to go into data collection and evaluation*.

The absence of an overall Log Frame or clear Results Framework for Umoyo Network itself has probably complicated the overall management of the project. For instance Darcy Ashman noted *an internal sense of confusion* (about project goals) but added that it *has not appeared to affect the external performance of the project*³. Both Darcy Ashman and the ID Evaluation conclude that the

² USAID –Bureau of Global Health/Office of Population & Reproductive Health *Enhancing PVO & NGO Partnerships in Family Planning & Reproductive Health* (Sept 2002)

³ Network Development Report – Darcy Ashman, NGO Networks for Health Dec 2001.



underlying uncertainties about project goals have not seriously hampered the work, but they have probably made it a harder project to manage, monitor, report on, and evaluate.

One early challenge for the project was to reach its own definition of a 'Network'. The word 'Network' is itself a little ambiguous as the term is now widely used to cover a range of technical and institutional relationships. A consultant from NGO Networks, Darcy Ashman reviewed this issue in December 2001 and posed the question: *Is Umoyo Network itself a network that promotes networking – or is Umoyo Network basically a USAID project that promotes networking, among other goals?* She concluded that *it is more of the latter – a project that promotes service delivery, capacity building, and networking in HIV/AIDS and RH.*

From these early uncertainties Umoyo Network has consolidated its activities round its initial assumption *that improved programme delivery by the NGOs would follow after the organizational capacity building, and that networking or networking development function ... was intended to follow after the grant management mechanism was established.*⁴

The original hypothesis on which the Umoyo Network was based was that *'enhancing PVO/NGO capacity to provide FP/RH/CS/HIV services and strengthening PVOs/NGOs will result in a significant and sustainable increase in the quality, access, and use of health information and services.'* This hypothesis contained some implicit assumptions about how effectively even strong NGOs can operate without government support, especially in relation to clear government policies and standards, an improving (rather than declining) government health service, a sufficient supply of test kits, drugs and FP supplies, and an availability of appropriately trained staff. All of these are frequent constraints mentioned in the mid-term evaluations, and remain challenges requiring advocacy at the time of this evaluation. (See recommendations on advocacy below)

In accordance with national policies, Umoyo Network has always aimed at the integration of FP, RH, treatment of STIs, with HIV/AIDS related services, and has employed staff with specialist knowledge of these sectors. Though this integrated approach made sense to the established mission hospitals, those local partners that had been founded specifically in response to the HIV/AIDS epidemic saw it as far less relevant.⁵ This commitment has meant that the Network is aiming to offer its local partners a wide range of both institutional and technical support – including grants management, inputs on governance and management, as well as technical advice on FP/RH/STI's, HIV/AIDS, and VCT. Rick James has evaluated the impact of this capacity-building work from the local partners'

⁴ Darcy Ashman (2001)

⁵ *Needs Assessment of the Status of Integration of HIV/AIDS, STI, & Reproductive Health Services achieved by Umoyo sub-grantees, Malawi.* (Ruminjo & Wohlfahrt for ENGENDERHEALTH April 2002)



perspective, and the Executive Summary of his report is included in Attachment 2.

4. Findings

4.1 Grants management

While capacity building has grown to be the major focus of the work, grants management remains of vital importance. In the whole period of funding (4 years from June 1999) the Network has spent \$7.7million in total, of which almost \$4.5 million is in the form of sub-grants to the 11 different Network members. In addition \$102,372 has been distributed in 43 small grants to local organizations. This is a fairly labor intensive scheme as 316 proposals were received in total, and there has never been an evaluation of its impact. (See recommendations). However there is strong anecdotal evidence that this kind of small scale funding is very helpful, and the NAC is now building on the Network's experience in setting up its own small grant's scheme. An example of this is seen in the case of Ubale (or 'Friendship') Network described in the box below:

Ubale Network, Blantyre: an example of how networks can work with minimal funding

The Ubale Network is a group of small CBOs, all run by volunteers, who look after orphans in and around Blantyre to enable their carers to go to work. This network has grown from 6 CBOs in 2001 to 34 in March 2003. Umoyo Network has helped with a total of only \$5,836. This money has been used to raise the profile of the Network with the Dept of Soc Welfare and other Government Departments, and it has also paid for the Network to undertake a Needs Assessment of CBOs involved in the care and support for Orphans in. Following a recent Fundraising Workshop run by Umoyo Network they mobilized more than 60 volunteers to clean the grounds of offices, factories and shops in return for food and cash donations.

4.2 Umoyo Network's impact at community level

4.2.1 LQAS as an Evaluation tool

The major way in which Umoyo Network's impact at community level has been assessed has been by means of LQAS surveys. Before reviewing the information provided by these surveys it is necessary first to assess the strengths and weaknesses of the LQAS approach itself. This is especially important in that LQAS 'came with the contract': over the course of the project the LQAS methodology has been successfully transferred to Umoyo Network's partners and in the long term it may well represent the most significant contribution made by NGO Networks to the whole project. One local partner told the ID Evaluation



that at first the LQAS was *'derailing the operations of NGOs and people were very unhappy. But the beautiful baseline data produced was very illuminating, and we changed our program design on the basis of this data'*. The strengths and weaknesses of the LQAS appear as follows:

LQAS strengths:

- The data generated has been tested and has been found to be reliable
- The use of small samples makes it relatively cost effective
- Local partner organization staff are able to undertake the data collection, analysis and report writing
- It is now popular with local partners, who after up to 3 survey 'rounds' are now able to conduct their own surveys, and (according to the CB evaluation) are increasingly using it for their own decision-making. The sub-division of areas into different 'supervision areas' is especially useful for disaggregating overall performance.
- It offers useful data for comparison of impact across different local partners

LQAS weaknesses

- It is a quantitative approach: there is a need to supplement it with more qualitative analysis – a gap addressed in the participatory Mid Term Evaluations
- It puts more focus on attitudes and behaviour at the community than on changes in the capacity of local partners, so is only a partial answer to either the local partners' or Umoyo Network's overall evaluation needs (see below)
- It has absorbed a relatively large amount of the time of M & E staff at the expense of other M & E methods, especially in the first 2 years. As the Mid-Term Evaluation Report for AHS (July 2001) said *a shortfall of the focus on LQAS is that no attention has been given to AHS own monitoring system and evaluation systems at headquarters and at the health centers.*
- There have been some problems with the analysis of the consolidated data which has been sent to Washington for analysis with delays in production of reports and there has to date been far too little feedback of the results of this analysis either to the local partners or to Umoyo Network itself. This whole arrangement appears to Umoyo Network staff as 'extractive' and hardly seems designed to build local analytical capacity.

The conclusion of this evaluation is that the LQAS methodology should be maintained, since it represents an investment in time and effort, and the approach has been successfully transferred to local partners. There would be very high training costs and a risk of losing valuable data if a new contractor were to come in after June 2003 with a different approach. Consistency and continuity are key principles in this kind of capacity building work, and whatever the outcome of the current RFA exercise it would be useful for as many partners as



possible to undertake further LQAS surveys, using those questions relevant to their particular programmes.

However in any future project an *annual* LQAS survey should be optional, and the next survey should be done by most partners after a further 2 years of funding as part of a broader mid-term review process. The analysis of the results should be done as far as possible by the local partners themselves, with assistance where required from Umoyo Network's M & E Department.

While the LQAS should be one important component of any future programme, there is also a need for more outcome and impact indicators, as noted by the MIS report that saw *'a need for better communication & definition of core indicators between Umoyo Network and Sub-grantees to give more comparability from one sub-grantee to another'*.⁶

4.2.2 Summary findings of LQAS surveys for August/September 2002

As requested in the SOW, a preliminary study was made of the recent LQAS surveys. It should be stressed that no statistical analysis was undertaken. In all cases the local partners have done some initial analysis of their own, and though it will be interesting to see the results analysed using statistical packages⁷, the reports and more recent discussions with Rick James in the Institutional Evaluation make it clear that in most cases partners have already drawn useful conclusions from the data. These conclusions are summarized in the following table:

Agency	Key findings
NAPHAM	Overall: positive results except in respect of condom use..... Level of HIV Awareness high, but <i>"there is no behaviour change among Malawians;</i> Increase in use of condoms minimal amongst youth & men but apparently higher amongst women. Both availability & knowledge of how to use condoms has increased; Few people going for HIV Tests; but big increase in no. of youth who report going for an HIV/AIDS test No change by either men or women about awareness of support groups for home based care; Increase in awareness of both youth & women (but not men) re signs of STIs <i>'Big & Professional People'</i> found to be more resistant to taking HIV tests, acknowledging their HIV status, and more reluctant to join NAPHAM

⁶Sub-grantee NGOs Management Information Systems – Documentation Report – September 2002

⁷ Final Report due on 30th May 2003



<p>DAPP –1 Blantyre/ Chiradzulu Dists</p>	<p>Overall: men appear to have better knowledge of HIV/AIDS issues than women & youth Lack of knowledge about specific ways in which parents can reduce or prevent mother to child transmission of HIV. Fall in condom use from 35% in BS to 24% overall, and from 46% in BS to 33% now for youth (but 41% of respondents claim to use condoms in extra-marital sex) Only 40% aware of support groups for home based care (cf NAPHAM) Need to expand VCT services Decrease in stigma and increase in knowledge of positive living for those with HIV.</p>
<p>DAPP-2 Lilongwe</p>	<p>Big increases in HIV/AIDS awareness; high awareness of mother/child transmission of HIV/AIDS; No increase in use of FP by either men or women. Low rate of condom use (max 15% all men; 25% youth, 10% women) Only 20% of women & 30% of men aware of support groups for home based care Low knowledge of STI's other than AIDS Low % of respondents going for VCT</p>
<p>Malamulo Hospital</p>	<p>Major improvements found in quality of post-natal care & female awareness both of STIs, HIV & FP issues. <i>“100%” of both males & females (15-49)...knew how they can avoid contracting HIV/ AIDS & STI's”</i> Trends in condom use ambiguous but remain at about 20% for men, have fallen from 15-10% for women. Low awareness (27%) amongst men of HIV mother-child transmission Major declines in many key indicators between 2nd & 3rd LQAS surveys explained by loss of key staff in 2001-2.</p>
<p>Ekwendeni Hospital</p>	<p>High awareness & use of FP (70% of women), with 60% of women seeking antenatal care Over 70% of both men & women know signs/symptoms of STI's. Over 90% of women aware of HIV/AIDS & HIV test, but only 25% use condoms. 60% of men (claim to) use condoms – a high figure that may need checking!</p>
<p>Adventist Health Services</p>	<p>National programme run from 19 clinics: differences in performance between different areas noted; 50% of men (much higher rate than other NGOs) use condoms but 99% know where to obtain them; % of women using modern FP methods has fallen from 69% in May 2001 to 38% now, while % of men using same methods has remained stable at 54%. Big increase (from 45 – 76%) in mothers of babies under 11 months prepared to go for immunization</p>



MACRO	Programme covers Lilongwe, Blantyre, Mzuzu. (Results not yet analysed on a % basis & no comparison made with previous surveys) – but survey shows low awareness of support groups; low awareness of STIs; low condom use
World Alive Ministries ICOCA Project	Strong awareness of VCT; only 50% knowledge of support groups; amongst men: high awareness of HIV/AIDS, but lower awareness of STIs as they affect women; condom use at 45-50%; women: increasing awareness of HIV/AIDS; big variation between areas in relation to use of FP; increasing awareness of STIs, VCT & HIV tests, & but only 20% use condoms compared with 25% in 2000 Youth: (not covered in previous surveys; 2002 LQAS being used as baseline) generally high awareness both of STIs & HIV/AIDS; condom use 40-50%; Follow up Quarterly Qualitative Assessment planned
Salvation Army	High awareness of HIV/AIDS by both youth, men & women; but more women than men aware of existence of support groups; <i>'FP & condom indicators show that both men & women can demonstrate knowledge of appropriate family planning methods, but they are not being used'</i> Over 90% of youth do not take part in traditional, high risk, cultural practices, still only 20-35% of youth use condoms; lack of knowledge re. Mother-child transmission of HIV.

4.2.3. Comments on LQAS findings

The above results show the familiar gap between knowledge and attitudes, which in general appear to be improving, and people's behaviour in relation to avoiding the risk of HIV/AIDS infection, which has shown less progress over the last two years. This gap between reported changes in knowledge/ attitudes and actual changes in practice is a well known phenomenon: educated people in all countries are aware of the health hazards involved in excessive drinking or smoking, but there is often a very long time lag before (if at all) they alter their practice.

How useful is condom use as a proxy indicator for behavioural change? First it is unrealistic to expect people to be entirely truthful about their own sexual practices, and over time respondents are likely to adjust their answers to meet what they define as the interviewers' expectations. Even so the answers given in relation to condom use which suggest condoms are used on average only about 35% of the time are remarkably consistent across all the agencies.⁸ On the optimistic side there is a far higher rate of condom use in areas covered by Umoyo Network's partners than national MDHS figures which suggest that only 14% of men and 5% of women used a condom during their last sexual

⁸ The exception is the figure of 60% quoted in the LQAS survey undertaken by Ekwendeni Hospital



encounter.⁹ Aggregate condom use will always be a less useful indicator than condom use amongst those groups most at risk –especially youth, sex workers, and other people in temporary and extra-marital relationships. It might therefore be useful if future LQAS surveys were to focus less on general condom use, but focus more on the key behavioural indicators identified by USAID – condom use with non-regular partners, the increased age of sexual debut, and a reduction in the number of sexual partners.

From the perspective of an overall impact assessment, many of the factors that inhibit behavioural change are outside the control of Umoyo's local partners. These include inadequate investment in education, chronic poverty, increasing food insecurity, high levels of migration to towns, and a lack of job opportunities, especially for women. Against this difficult background even the modest improvements recorded in this LQAS should be seen as major achievements.

These LQAS findings need to be compared with the summary results of the participatory mid-term evaluations conducted between July and November 2001, which reviewed more qualitative issues. These showed some improvements in services, especially by the CBDA's, and the introduction of VCT services, but they also documented some common challenges – especially weak integration of RH at the level of service delivery; too limited a focus on youth, insufficient transfer of training knowledge within partner organizations, and inadequate behavioural change strategies and IEC materials to support them.

Since the MTEs a needs assessment of integration has been carried out, with training for service provider managers in integration and in facilitative supervision, and a follow up of action plans will take place in April 2003. There has been a TOT in youth friendly services and the NGOs included this in their workplans this last year; all have been awaiting the national sexual and RH behaviour change strategy and many more IEC materials have been supplied. Rick James has raised transfer of training knowledge within the partner organizations and Umoyo staff plan to address this by the development of organization capacity building plans in the next funding.

One consistent finding of both the LQAS surveys and the mid-term reviews is that the integration of RH, FP, and HIV/AIDS services (one of Umoyo Network's objectives) will only assist those people who are reached by these integrated services. These evaluations point up the need for more outreach work to at-risk groups like youth who do not often come to RH or FP clinics; and this in turn suggests a need for any future project to have a larger budget to support local partners with transport (especially motor bikes) to support this kind of outreach work.

⁹ Quoted in USAID's *Request for Applications – increased availability & quality of HIV/AIDS related support services through NGOs-November 2002*



4.3. The Impact of Umoyo Network's Capacity Building Activities

'The programmes we are implementing are community-based. We have tried our best to get the communities to own these programmes, but if we want to make significant changes at community level we need more time.'

'I don't see any reason why USAID should bring in another contractor (to replace Umoyo Network). Its not just about money – its all the support they have given us'

(Views expressed by Umoyo Network partners)

As the Executive Summary of the ID Evaluation is attached in Part 2, this section highlights a few of the major findings of this evaluation. First it is useful to track how Umoyo Network's capacity building strategy has involved a strong combination of quantitative and qualitative investments, as illustrated below:

Type of input	Grants disbursement	Wide range of Training inputs; specific management & OD support
Output	Expansion of staff	Improvement in numbers and quality of staff at different levels: e.g. (Boards, management, supervision, service delivery) Improvement in financial systems
Result	Expansion of FP/STI/RH/HIV/AIDS/VCT services	Overall improvement in quality of service.

It is difficult in a summative evaluation of this type to document fully the expansion of services made possible by Umoyo Network's grants. However they include both an expansion in terms of geographical coverage as well as expansion in the range of services offered, especially in relation to HIV/AIDS services and VCT. A key point made by local partners in relation to this expansion of services has been Umoyo Network's willingness to fund core costs like rent, vehicles, and staff: even well-established local partners often find it difficult to mobilize resources for such core costs from other donors.

Secondly one successful component of the Network's approach has been its *pragmatic and flexible* approach in responding to the management needs of different organizations: examples are the secondment of a VSO volunteer to help introduce management systems at MANASO and the recent deployment of a local consultant to act as Executive Director of MANET to help resolve some long standing management problems. The capacity building work has also been quite



comprehensive, with training not just for staff but also for Board members, including, in the case of Ekwendeni Hospital, training for the whole Synod of the church. This is in contrast to many similar projects, which focus more efforts on training a narrower range of staff.

However sound this strategy, the current gains must be seen as relatively fragile, as the ID Evaluation emphasizes. There are still major governance problems in many Boards; and there is both a shortage of people in Malawi with the expertise and commitment to serve on a Board and a lasting expectation that Board members should be paid 'sitting allowances'. Also the training and exposure received by senior staff involved in the Network have made them more attractive to other employers, and by March 2003, with only three months more to go with USAID funding, at least one manager had decided to move on. Similar problems of staff retention are noted in the Quality of Service Evaluation, and were specifically reported in relation to VCT Counsellors working for MACRO and amongst CBDA's at Malamulo. In addition all the local partners lose tragically large numbers of staff every year as a result of HIV/AIDS. These factors can be seen as external 'threats' to the capacity building work largely outside Umoyo Network's control: while staff salaries in the mission organizations are in many cases pegged to government rates, the recent flow of funds into HIV/AIDS-related projects has increased the demand for staff with appropriate skills.

A further problem discussed in the ID Evaluation is that some local partners felt their staff were spending almost too much time in workshops and training courses. The implication for Umoyo Network is that **in future it should spread out formal training over a longer period, but back it up with more frequent 'mentoring and coaching' visits to partners.**

4.4 Monitoring and Reporting on Impact

Umoyo Network has taken many positive steps to ensure that its impact can be documented. There were baseline institutional assessments, baseline LQAS studies, mid-term evaluations of all local partners, mid-term LQAS studies, end-of-project LQAS studies and this final evaluation. In addition there have been many consultancies on a wide range of topics. What more could it have done?

One major finding is that in the first phase much senior management time that has gone into reporting to USAID could have been used for more creative purposes – especially more support to local partners. All reports need to either add to the learning by staff and local partners, or to meet USAID's accountability requirements as a donor. Long reports rarely achieve either purpose. The MIS report notes the problems of data utilization within Umoyo Network's local partners, and probably more data has been generated across the whole network than can be effectively utilized, especially if the project is closed down in mid-2003. There is a need to design reporting systems based on the principle of



“optimal ignorance”; and to continue the excellent work done in the MIS review to map out exactly who needs what kind of information at each level. As argued in the ID Evaluation, the Network needs to monitor its impact against a smaller number of critical indicators, and it needs to focus more on the impact it is having on its local partners.

These “core indicators” should be worked out with the Umoyo Network’s local partners and agreed with USAID at the start of any future project. They are likely to involve a combination of capacity building indicators, indicators for improved service and coverage, and a few behavioural change indicators which should be used for evaluation rather than quarterly monitoring purposes. Quarterly reports should report briefly on progress as perceived by the Network’s staff and local partners, and changes in the quality and quantity of services.

4.5. Benefits of a Network

It is challenging for an evaluation to document the benefits of a Network. There are some clear costs – the time that Umoyo Network staff put in to maintaining the network, and the time that local partners spend in coming to meetings. And many of the benefits appear as ‘subjective’ and hard to measure with conventional indicators. However both the ID Evaluation and this overall evaluation traced considerable gains achieved by partners as a result of networking, many of them with minimal costs.

One important benefit of a network is psychological. Staff who were previously isolated in their own organizations now have an opportunity to discuss common problems, find solutions, and hence improve their morale. This is a significant factor for organizations involved in what is often difficult and depressing work, and a number of partners said they now feel *‘part of a family’*. Secondly Umoyo Network has helped give individual partners a greater self-confidence and credibility in Malawi, with MANASO able to run the World Aids Campaign for 2002/3, and others able to access more drugs from the MOHP. Further indicators worth considering for any future programme in relation to network development might include:

- the development of a common advocacy plan, worked out jointly by Umoyo Network staff and its local partners. (See recommendations below)
- the total amount of non-USAID resources (both in terms of funds and other supplies and equipment) which local partners are able to access.

As regards the overall sustainability of the Network it is too early to expect the Network to continue to flourish as it is at present without outside funding. The evaluation of any further phase of funding of Umoyo Network will need to review



the probability of the Network being able to survive with significantly less external funding.

4.6. Umoyo Network's impact on the Quality of Service

The extent to which the benefits of capacity building and network development have translated into improved services on the ground have been explored in the Evaluation of the Quality of Services (QOS) undertaken by Lennie Kamwendo (see Attachment 2). Overall this evaluation found that the local partners

'...have made tremendous progress towards achieving the objectives of raising awareness, increasing access and providing quality care in areas of family planning, sexually transmitted infections and voluntary counselling for HIV/AIDS. Their strengths are in the proposals, which give clear indication of what needs to be achieved; good progress made in meeting targets which have been exceeded in some cases; evidence of commitment to achieving the objectives; widespread rapport with clients; some measure of integration of FP/STI/VCT services; commendable impact on individuals, families and communities as evidence by rising numbers of clients. The honesty with which negative aspects of care were shared, is also commendable.'

This report shows a major improvement in quality of care despite some gaps in relation to documenting what QOC means for each member of staff, and further problems in relation to infection prevention. In discussions in relation to this evaluation it turned out that one reason why infection prevention is sometimes not up to standard is due to a lack of water in some facilities.

The overall conclusion we can draw from the QOC Evaluation is that Umoyo Network's capacity building and network development activities have resulted in a considerable improvement in the quality of care offered. Separate from this evaluation, the Network has also produced data showing that its partners have also been able to increase the numbers of people they reach through their programmes.¹⁰

5. Conclusions of the Final Evaluation

It is important to acknowledge both the strategic importance of what has been achieved so far and the potential for the future. Umoyo Network's local partners have potential access to about 2.7 million people, or about one quarter of Malawi's population. If they can continue to provide high quality services in RH, FP, and HIV/AIDS in the long term then they should indeed be able to help bring about *healthier Malawian families*.

¹⁰ from Umoyo Network report 'Expansion of Sub-grantee Services'



The SOW for this evaluation posed two specific questions. The first question was *'What are the strategies that Umoyo Network utilized with the Sub-Grantees that have worked to improve and expand services and strengthened the organizations overall? Looking at these strategies – if they worked, why did they work? If not, why?'*

From the analysis above it will be seen that the key reason for the relatively high impact of Umoyo Network has been its use of a combination of strategies. The impact of grants management, capacity building, and network development activities have all been far greater than if any one of these activities had been implemented in isolation. The findings of this evaluation show an improvement in both the quantity and quality of services offered by Network partners, an expansion of their capacity, and the emergence of a strong network.

However the relatively short time scales have put pressure on the project to show immediate results in three broad areas where they are notoriously hard to achieve in a short timescale – the capacity development of local NGOs, the formation of a sustainable network, and key behavioural changes which will slow down the spread of HIV/AIDS. The ID Evaluation notes that capacity building and network development are long term programs requiring in USAID's own judgment a consistent and continuous investment over 5-10 years. While Umoyo started in July 1999, the current Programme Manager only arrived in November 2000, and there has been considerable uncertainty in the last 6 months due to the expected ending of the contract in early 2003 (now extended until June 2003). Given the brief (two-year period) between her arrival and the start of uncertainties relating to the closure of the current contract the present PM and her staff have done an extraordinary job, the impact of which on the local partners is well documented in the ID Evaluation. The challenge now is to increase the local ownership of Umoyo Network itself, and in the next phase there will be a significant management job to be undertaken to make the Umoyo Network staff a more cohesive team.

In relation to strategies, the option of making Umoyo Network a local NGO in its own right was reviewed and rejected at an early stage. This seems the correct decision in that there is already a surplus of donor-created local NGOs in Malawi, but many fewer successful networks.

The second question asked in the SOW was *'What kind of unintentional events have helped or hindered the achievements of the goal?'* The first point to make is that Umoyo Network's local partners have been implementing their programmes against a background of drought, food insecurity, and increasing rural poverty, all of which make behavioural change more difficult. The second contextual issue noted in this evaluation (especially in section 4.3 above) is Malawi's overall shortage of skilled health workers of all levels, especially in rural areas, which makes it difficult for Umoyo Network's local partners to retain key staff.



6. Recommendations for Umoyo Network

6.1. Capacity building

- 6.1.1 Reduce reporting burdens but increase internal monitoring of capacity building
- 6.1.2 Bring the same rigour to the M & E of capacity building has been introduced by the use of the LQAS method for M & E at the community level. This requires a more consistent approach to organizational assessments, followed by a process of defining and monitoring appropriate indicators for capacity building in close consultation with local partners. The regular review of these indicators then needs to become a more central part of discussions with local partners
- 6.1.3 In view of the pressures on local partners' current staff training courses should be carefully prioritized and spread out over a longer period, allowing more time for partners to 'internalise' the training. Formal training should be backed up with more frequent 'mentoring and coaching' visits to partners.
- 6.1.4 Umoyo Network should develop an electronic database of information on its local partners which can be accessed by all its staff. This should provide all key data on the NGOs, and the different capacity building activities including notes on all visits made.

6.2 Advocacy

- 6.2.1 One logical response to the various important external constraints has been the increasing amount of work that Umoyo Network is now undertaking at national level with the NAC and MOHP in relation to these issues. This activity is likely to be of increasing importance in the future, but there is a risk that all the effort committed will not in fact result either in improvements in the capacity of partners or in improved services on the ground. To avoid this we propose that the Network should develop and implement an advocacy strategy **in close consultation with its local partners**. As the Network develops, more of this advocacy work should be undertaken by the local partners, rather than by Umoyo Network staff.
- 6.2.2 This advocacy strategy needs to spell out the policy and practice changes that Umoyo Network is aiming for as a result of its interaction with different government agencies (e.g. MoHP, NAC, and other donor agencies), and should propose an indicative time schedule.

6.3 Monitoring and Evaluation



6.3.1 For any future programme make a clearer distinction between the M & E requirements of local partners and those of Umoyo Network. In order to meet the information needs of Umoyo Network, local partners should be encouraged to collect consistent, and comparable data at different points in time on a small number of indicators, rather than data on such a wide range of indicators.

6.3.2. In any future programme it would be desirable to divide up the M & E functions between:

- Monitoring of Umoyo Network's own work, making more use of capacity building indicators; and commissioning, implementing, and following up Mid-term Evaluations.
- Supporting the M & E efforts of partners, including both LQAS and helping them design appropriate M & E systems.

6.4 Grants management

6.4.1. Evaluate a sample of **small grants** distributed 6 months after disbursement, to see the impact of the funding. Use the results of this internal evaluation to fine-tune the policy in relation to small grants.

6.4.2 **Encourage longer periods of funding for well-established local partners** - probably for two years at a time, culminating in an LQAS & mid-term evaluation. The mid-term evaluations should review the amount of funds which local partners have been able to access from non-USAID sources.

6.5 Quality of services

- All facilities need to have ready copies of all protocols and standards related to FP, STI and VCT management and use these to measure quality of care.
- Infection prevention practices need to be strengthened in all areas of health care, with adequate water supply for all clinics.
- Facilities lacking the necessary transportation to implement outreach clinics should receive assistance with transport to enable access to the poorest clients
- Potential FP clients should receive a full medical assessment before CBDAs provide them with family planning methods



- Facilities should strive for full integration of services so that maximum compliance can be achieved. This can also reduce stigma, which deters many clients from seeking care, especially VCT.

7. Recommendations for USAID-Malawi:

7.1 Work to more realistic timescales

Capacity building by contract is unlikely to work. Continuity of funding is vital for any kind of long-term impact, including the retention of key staff both within Umoyo Network itself and within the partners. USAID in Malawi should consider moving towards a longer-term 'partnership' approach with agencies like Umoyo Network in which funding in principle is agreed for a 4-5 year period, with a 2-year mid-term review and an annual review if required. The problem may be less the time-scales themselves than the uncertainties that result from delays in decisions about future contracts.

7.2 Try to increase flexibility

Effective work in HIV/AIDS prevention requires a highly flexible and multi-sectoral approach. The more restrictions put on the type of activities that can be funded, the less effective capacity building will be. Some of the key needs identified during these evaluations of Umoyo Network include increased budgets for drugs, food for PLWHAs, their carers and families, and more transport to support community level work, especially in rural areas.

7.3 Reduce reporting requirements

As discussed in the report too much scarce management time, both of Umoyo staff and of its local partners, has gone into reporting to USAID, and the resulting reports have become rather long. At the start of any future contract USAID should agree with the contractor its minimum reporting requirements, and clearly specify the maximum length for reports. Normally a donor's overall accountability requirements are best met by a *combination* of formal reporting, informal monitoring by donor staff, and evaluations.

7.4 Agree core impact indicators for both behavioural change and capacity building.

Both USAID and Umoyo Network would find monitoring easier if at the outset they were able to agree a small number of key indicators to be monitored throughout the contract. These indicators should include both capacity building indicators and indicators of behaviour change.



ATTACHMENT A

Evaluation of Umoyo Network's Capacity Building - Rick James

EXECUTIVE SUMMARY

Umoyo Network has been supporting 11 Malawian NGOs with funding and capacity-building in order to improve the scope and quality of their work in reproductive health and HIV/AIDS. Umoyo Network has invested heavily in attempting to build the capacity of its sub-grantees, indeed this is one of the main differences of approach between Umoyo Network and other USAID-funded projects in the past. This is an innovative approach, but one that requires considerable analysis to find out whether such investment was worthwhile.

An evaluation of Umoyo Network's capacity-building work with sub-grantees was undertaken in October and November 2002 by INTRAC in order to find out:

1. the perceived impact on the Sub-Grantees of the Umoyo Network investment in Institutional Development over the last three years (questions of accountability)
2. what learning can be gained from this experience in order for Umoyo Network / USAID improve its institutional development support to Malawian NGOs in the future.

It is important to point out that this evaluation took place at a time of USAID funding insecurity and this may have affected the responses.

In order to answer **questions of impact**, it was necessary to answer three related questions:

- To what extent has capacity of sub-grantees increased over the period of Umoyo Network support?
- How has this affected beneficiaries and other stakeholders?
- To what extent can these changes be plausibly associated with Umoyo capacity-building inputs?

The findings from the different data gathering methodologies point to a very significant increase in sub-grantee capacity in the last three years. Sub-grantees estimate their overall capacity has increased by almost 50%. Although the starting base was very low and the sub-grantees may have overestimated the extent of their change, there is a clear improvement in capacity, particularly in organisational areas. The main areas of change are:



- Organisational and Programme Strategy
- Governance
- Leadership
- Management skills
- Team development
- Structural changes
- Planning, Monitoring and Evaluation (PME) systems
- Financial Systems
- Human Resource (HR) Policies
- Staff technical skills
- Funding diversification
- Profile
- Networking and Collaboration

This evaluation largely confined itself to analysing the impact of capacity-building on sub-grantees as other evaluation exercises are going to look at the all-important question of whether these organisational changes actually resulted in benefits at community level. The anecdotal evidence gained from this work, would point out very real benefits at community level both in terms of programme continuity (avoiding the interruption of community programmes through internal problems) as well as a shift towards more participatory and empowering approaches in service provision to communities. There were also significant benefits from Umoyo Network working closely with government departments (NAC and RHU), which brought a practical NGO perspective into policy development work, as well as linking NGOs with government much more closely.

The extent to which these changes in capacity can be directly attributed to Umoyo Network is impossible to ascertain as the variable of Umoyo Network capacity-building cannot be separated from the many other factors that also influenced NGO capacity over that same period. It is possible, however, to say that these changes in sub-grantee capacity can be 'plausibly associated' with Umoyo capacity-building inputs. Not only did sub-grantees often attribute the change to Umoyo inputs, but also Umoyo capacity-building inputs featured as key events when sub-grantees presented a history of their organisation.

As well as providing some accountability for resources expended, the evaluation also sought to systematically reflect on the capacity-building undertaken and highlight key learnings for Umoyo Network.

The main methods used by Umoyo to build capacity in sub-grantees were:

- Staff Advice
- Training (both technical and management)
- OD Consultancy
- Monitoring and evaluation processes
- Networking meetings



The **key variables** that determined whether or not the inputs actually built capacity were:

1. Sub-Grantees Taking Responsibility (owning the need for change)
2. Sub-Grantees Making a Willed Response (in particular leadership openness to change)
3. Sub-Grantees Having the Resources to Respond (financial and time)
4. Umoyo-Sub-Grantee Relationship
5. Overall Umoyo Network Capacity-Building Strategy
6. Quality of Specific Capacity-Building Support (by Umoyo staff and outside consultants/trainers)
7. The Context (social, economic and political)

Umoyo Network is clearly only able to influence some of these, while others depend on the sub-grantees and others the wider context.

Conclusions

Overall Umoyo Network is a very successful capacity-building programme in a very difficult context of Malawi. Umoyo Network has invested heavily in capacity-building, (particularly in the areas of management and organisation) and, even in the short-term, there have been considerable changes in sub-grantee capacity that can be plausibly associated with Umoyo inputs. Programme performance of sub-grantees in communities appears to have improved noticeably too. As USAID own policy guidelines state, 'PVO institutional ventures are not 'cheap' investments..., but if they engender even partially successful local institutions, they are cost effective in the long-run, given the continued flow of benefits as costs gradually decrease'¹¹.

Recommendations

The recommendations below are shared by sub-grantees, staff and senior management. There is remarkable coherence and overlap. The major message is that Umoyo should keep going in the same direction as it is an extremely good quality programme in very difficult circumstances. The recommendations of this evaluation are that Umoyo should:

Maintain:

- Umoyo Network's Overall Approach
- Management and Organisational Change as a key capacity-building area
- Holistic Approach
- Mix of Methods and Resource Support

¹¹ Accelerating Institutional Development, USAID PVO ID Evaluation Series, p 3



Improve by developing a more coherent and focused capacity-building strategy:

- Clarify Conceptually
- Individualise through a Participatory Capacity-Building Planning Process
- Prioritise and Sequence
- Follow-Through – More visits
- Fine-Tune Specific Capacity-Building Methods
- Shift the Relationship from a Sub-grantee to a partner

While the external programme recommendations can be seen as fine-tuning, many of the suggested improvements have been around for some time. An important question is why they have not been implemented before. The answer to this question probably lies in the OD issues of Umoyo itself. It is these internal issues that represent the greatest threat to Umoyo's sustained performance in the future.

Umoyo should address the internal implications and tensions:

- Re-structure to fit better with strategy
- Develop systems to monitor and evaluate the capacity-building
- Improve staff motivation and turnover through greater ownership and responsibility
- Review management culture and style

USAID also should recognise that their demands for quick results in a very short-time frame is an important factor in exacerbating these issues.



Attachment B.

Evaluation of Quality of Services offered by Umoyo Network Partners (Lennie Kamwendo – March 2003)

EXECUTIVE SUMMARY

1. Introduction

Four Umoyo Network Sub-Grantees were evaluated to determine the quality of care that these facilities provide. Field visits were made to Ekwendeni hospital, 5 Adventist Health Service facilities, Malamulo hospital and the MACRO centres in the three regions of Malawi.

2. Methodology

Data were collected using separate focus group discussions with service managers and providers; structured observation of health care provision and random exit interviews of family planning clients, patients with sexually transmitted infections and clients who had come for voluntary counselling and testing. Data were collected over a period of twelve days and the major areas of focus were availability of project proposals and knowledge of such proposals by service providers as this would form the basis for service provision. Information regarding strategies used for achieving the targets, quality of care, staff performance appraisal and training was also sourced.

3. Findings

- All facilities had proposals that clearly stated the program objectives and targets to be achieved. However, not all service providers had working knowledge of the objectives
- Strategies in place include some level of service integration, use of IEC with involvement of community leaders to raise awareness, increase access and provide care in the areas of family planning, sexually transmitted infection management and voluntary counselling and testing. Some facilities have well established youth clubs. Drama, the electronic and print media have also been used with commendable impact on individuals, families and communities.
- Quality of care was evaluated at program and operational levels. Sub-grantees have made tremendous progress towards achieving program targets and these have been exceeded in some cases. Structured observation and exit interviews indicated satisfactory provision of care as evidenced by short waiting time by clients, appropriate attitudes of service providers as well as the ability to attract large numbers of clients.



Voluntary counselling was exceptionally good and appreciated by clients. However, it was also clear that clients do not really know the difference between good and bad quality care because even those who had never been physically examined in the family planning units indicated that they were satisfied with the quality of care.

However, infection prevention practices were below standard as were the procedures for family planning. Lack of adequate space as well as laboratory facilities in some centres compromise quality. Shortage of staff and means of transportation also prevent meaningful implementation of outreach clinics.

- Staff performance appraisals are only done at the end of the year. There are no structured supervisory activities and checklists are not available except at MACRO Mzuzu centre. Operational level determination of quality of care is therefore compromised.
- Many service providers have undergone relevant training to enhance performance and improve quality of care.

4. Recommendations

- It is necessary that all service providers have a working knowledge of the program objectives so that they can have consistent guidance.
- All facilities need to have ready copies of all protocols and standards related to FP, STI and VCT management and use these to measure quality of care. The Reproductive Health Guidelines should be read and followed for client management. The protocols should be displayed on the walls for easy reference.
- Infection prevention practices need to be strengthened in all areas of health care
- Facilities lacking the necessary transportation to implement outreach clinics should be considered for such assistance to enable access to the poorest clients.
- Opportunity needs to be taken to assess all FP clients before CBDAs can provide family planning methods
- Facilities should strive for full integration of services so that maximum compliance can be achieved. This can also reduce stigma, which deters many clients from seeking care, especially VCT.



-
- Supportive supervision needs to be implemented at the operational level in order to improve the quality of care given as well as staff morale.
 - Training programs need to be planned and implanted more often in order to give opportunities to more service providers to be trained.



Appendix 1: List of documents consulted and people met

Documentation:

- Umoyo Network Partners: Mid Term Evaluation Reports - 2001
- Sub-grantee NGOs Management Information Systems, Documentation Report Sept 2002.
- LQAS Reports September 2002
- Network Development Report – Darcy Ashman (NGO Networks Washington,) Dec 2001

People met:

- Umoyo Network Staff
- Rick James, INTRAC, Blantyre
- Lennie Kamwendo, Consultant
- DAPP, TSA, and Malamulo Hospital staff
- Francina Nyirenda, MANASO
- Kumbukani Black, NAPHAM
- Florence Chipungu, AHS
- William Vargas, NGO Networks for Health, Washington
- Elise Jensen – USAID-Malawi
- Roy Hauya – NAC, Lilongwe
- Justin Opoku – Field Office Director (SC-US)



Appendix 2 – Scope of Work

Final Evaluation of Umoyo Network

I. GENERAL INFORMATION

Project Name:	Umoyo Network
Project Number:	HRN-A-00-98-00011-00
Field Officer Director:	Justin Opoku
Program Manager:	Carrie Osborne
Donor:	USAID
Consultant:	Hugh Goyder
Contractor/Grantee:	Save the Children, USA
Life of Project Funding:	1999-2003
Nature of work:	Lead the Final Evaluation of Umoyo Network.
Time frame:	Up to 10 working days (Wednesday 27 th November to Saturday 8 th December 2002) and 14 further working days from 3-14 March 2003

2. INTRODUCTION

Since 1999 Umoyo Network has been working with 11 Malawian NGOs to provide grants and technical assistance to improve the scope and quality of their work in reproductive health and HIV/AIDS. All of the NGOs have had the opportunity for institutional development and capacity building in governance, management and technical skills.

3. PURPOSE

The Final Evaluation of the USAID funding to Umoyo Network seeks to:

1. Document the accomplishments of Umoyo Network against its original objectives;

and to establish:

2. What are the strategies that Umoyo Network utilized with the Sub-Grantees that have worked to improve and expand services and strengthened the organizations overall? Looking at these strategies – if they worked, why did they work? If not, why?



3. What kind of unintentional events have helped or hindered the achievements of the goal?

Umoyo Network now requires a consultant to draw together the findings of various studies being undertaken towards the Final Evaluation of Umoyo Network. These studies include:

- An Assessment of the Institutional Development Program being undertaken by Rickk James of INTRAC;
- An Assessment of the changes since the mid-term evaluation in the quality of clinical services provided by four of the Sub-Grantees (MACRO, AHS, Malamulo, Ekwendeni);
- A Quantitative Survey, using LQAS, of the changes in knowledge, attitudes and behaviors at community level to measure the outcomes and impact of the work of the Sub-Grantees compared to the baseline survey (draft report complete);
- A Report on the Results achieved (from the Management Information Systems of the Sub-Grantees, reported in Quarterly and Annual Reports);

4. METHODOLOGY

The Consultant will:

- Review the indicators set to measure the project;
- Review assessment and evaluation reports and other documentation;
- Meet with the other external evaluators to discuss their findings, or plan their input;
- If required interview the Sub-Grantee Project Managers/ Directors and other senior staff;
- If required interview Umoyo Network and PVO Partner staff;
- Review the Reports from the other evaluations
- Produce a first draft Final Evaluation Report by 12th March 2003, of no more than 20 pages plus appendices and to produce a Final Report within 5 days of receipt of feedback on the Draft.