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EVALUATION

FINAL EVALUATION: AFRICAN STRATEGIES FOR HEALTH PROJECT

September 30, 2015

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EXTERNAL EVALUATION OF THE AFRICAN STRATEGIES FOR HEALTH PROJECT

September 2015

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ACRONYMS

ACD	Advocacy, communication and dissemination
AFR/SD/HT	USAID Africa Bureau Office of Sustainable Development Health Team
AfDB	African Development Bank
AfrEA	African Evaluation Association
AGOA	African Growth and Opportunity Act
APHRC	African Population and Health Research Center
ASH	African Strategies for Health Project
ART	Antiretroviral therapy
AU	African Union
AusAID	Australian AID Agency
CARMMA	Campaign for Accelerated Reduction of Maternal Morality in Africa
CBHI	Community-based health insurance
CDC	Centers for Disease Control
CHW	Community health workers
COR	Contracting Officer's Representative
DO	Development objective
DRC	Democratic Republic of the Congo
EAC	East African Community
ECOWAS	Economic Community of West African States
ECSA-HC	East, Central and Southern African Health Community
EHealth	Electronic health (the use of information and communications technology to support health, including health surveillance, health education and health services)
ELearning	Distance learning (education and training in electronic format)
FY	Fiscal year
FP	Family planning
GH	USAID Bureau for Global Health
HHA	Harmonization for Health in Africa
HIDN	USAID Office of Health, Infectious Disease and Nutrition
HIS	Health information system
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HSS	Health systems strengthening
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa
iCCM	Integrated community case management
ICT	Information Communications Technology
ID	Infectious diseases
IDSR	Integrated Disease Surveillance and Response
IPTp	Intermittent preventive treatment of malaria in pregnant women
IP	Implementing partner
IR	Intermediate result
IRS	Indoor residual spraying
ISED	Institut de Santé et Développement (located at Dakar University, Senegal)
KSPH	Kinshasa School of Public Health
LOE	Level of effort
MCH	Maternal and child health
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MDSR	Maternal disease surveillance and response

mHealth	Mobile health technologies
MMR	Maternal mortality ratio
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
MSH	Management Sciences for Health
NCD	Non-communicable diseases
NGO	Non-governmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PMP	Performance monitoring plan
RBM	Roll Back Malaria Partnership
RCQHC	Regional Center for Quality Health Care
RH	Reproductive health
RMNCH	Reproductive, maternal, neonatal and child health
RMS	Regional minimum standards
SADC	Southern African Development Community
SARA	Support for Analysis and Research for Africa Project
SOW	Scope of work
TB	Tuberculosis
TOR	Terms of reference
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAHO	West Africa Region's Health Office
WHO	World Health Organization
WHO/AFRO	WHO Regional Office for Africa

EXECUTIVE SUMMARY

EVALUATION PURPOSE

The end-of-project evaluation of the five-year African Strategies for Health (ASH) project was commissioned by the USAID Africa Bureau's health team through the Global Health Program Cycle Improvement (GH Pro) project between June and August 2015. Its purpose was to document the accomplishments, results and lessons learned from ASH during the final phase of implementation at the end of its fourth year, and prospects for reaching projected targets by 2016. The findings in this report will be used to inform decisions in the final year of the ASH project.

PROJECT BACKGROUND

ASH is a five-year, \$19.96 million USAID Africa Bureau Sustainable Development Office (AFR/SD) project for health systems and regional institution strengthening, technical and management support, designed to improve the health status of populations across Africa. ASH provides information on trends and developments in the region to enhance USAID and partner decision-making and investments in the health sector. The project is a cross-cutting mechanism that runs September 2011-October 2016 and is implemented through a contract with Management Sciences for Health (MSH) and several African subcontractors. The project is the fourth in a succession of Africa Bureau projects designed to improve national health policies and support the bureau, regional missions and African partner health institutions.

EVALUATION DESIGN, METHODS AND LIMITATIONS

The evaluation was a structured, moderately complex qualitative assessment and used a mixed-method approach to assess whether the project is on track to meet its stated purpose by its conclusion. The evaluation team did an extensive desk review of relevant documents and secondary data and used semi-structured interviews and data recorded according to interview guides tailored for specific key informant groups. Interviews were administered over the phone and by some face-to-face meetings. The evaluation team triangulated results and assessed the opinions of those responsible for the implementation of the activities at different levels, as well as those who used or benefited from project materials, technical assistance, tools or research. The team reviewed 106 documents, interviewed 64 key informants who had some direct knowledge or connection to the ASH project, and spoke to 27 other health specialists for general African health sector or USAID background information. The evaluation team also documented and assessed the project's attainment of its three stated intermediate results (IRs):

IR 1: *Expanding the body of knowledge of current trends, constraints and solutions to improve the health of Africans*

IR 2: *Consensus on priorities and strategies for improving the health of Africans*

IR 3: *Strengthened African institutions and networks*

Evaluation Limitations and Challenges: Evaluation limitations included a weak performance monitoring plan (PMP) approved in the project's third year; the elimination of organizational capacity surveys—making it difficult to attach a causal link between the work ASH supported at a given institution and improved operations at those institutions; and limited face-to-face interaction with African participating organizations that were reached by phone.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

- Forty-eight percent of respondents said that ASH performance and results were good to excellent and 75 percent found something of positive value in this project.
- The ASH project has met, or is on track to meet by the end of the project, all of the output targets identified by USAID. ASH has exceeded the target set for south-to-south dialogue.
- ASH generated or followed up on 58 ideas with the USAID/ASH core technical team, out of which were produced a total of 62 reports, publications and materials with a focus on some health trends, constraints and solutions for improved African Health;
- The mHealth compendia and related mHealth work is the most frequently cited product by respondents interviewed, with digital health cited by 22 percent of respondents to be ASH's most important contribution toward increasing new knowledge through dissemination of lessons learned from country experiences.
- In terms of reaching the project's three IRs, 72 percent of the 50 activities analyzed for this report were designed to achieve IR 1 (expanding the body of knowledge or current trends constraints and solutions to improve health), 22 percent were used for IR 2 (advocacy and communications), and only 16 percent went toward strengthening African institutions. The project contributed new ideas and material through evaluations, special studies, publications and conferences (IR 1), supported consensus-building work on specific strategies and approaches through regional meetings and conferences and follow-up with regional partners and WHO/AFRO (IR 2), and advanced the work of a small number of regional African institutions and networks (IR 3) through focused technical assistance and management support.
- Given the data on hand, it is not possible to draw a causal link between these results and changes in health status. Some of these results however, have contributed to strengthening some health systems, regional health networks such as Roll-Back Malaria (RBM), and regional norms and standards, and have focused attention on key health challenges such as pediatric TB.
- Despite a slow start and extensive staffing challenges, the project carried out 133 activities over the four years. During the final year that will begin in September 2015, ASH plans to carry out 23 activities, for a life-of-contract total of 156 activities across the region. The Year 5 work plan was under review at the time of this evaluation.

Question 1. Results, Innovation and Lessons Learned

Six ASH activities out of the 50 analyzed achieved some regional health results by Year 4. Project inputs were small, ranging from \$190,000 to \$300,000. Some activities had multiple years of funding, such as the Integrated Disease Surveillance and Response (IDSR) and pediatric TB, but most did not. ASH provided short-term technical assistance that complemented either other donor or other USAID external funding. Most of these activities were requested by the institutions and were part of these institutions' plans. Some benefited from an existing MSH country office presence to provide logistics support, identify short-term consultants and schedule key meetings. The MSH platform permitted more cost-effective ASH project start-up in-country.

ASH Regional Results:

- Support to the African Union (AU) for the its Campaign on Accelerated Reduction of Maternal, Newborn and Child Health (CARMMA) database and scorecard that assembled indicators across all 54 AU member states for use by regional policymakers
- Technical and management support for pediatric tuberculosis (TB) advocacy, technical and management decisions to advance region-wide pediatric TB programming led by WHO/AFRO, USAID Global Health (GH) and Africa Bureaus

- Support to WHO/AFRO for development of IDSR and maternal death surveillance and response (MDSR) planning in partnership with the Centers for Disease Control (CDC) and USAID/W, with an emphasis on the country response to disease surveillance information
- Strengthening and advancing preparation of Southern African Development Community (SADC) norms and standards for primary health care services in southern Africa for high-risk transport workers and other groups to prevent HIV and other sexually transmitted diseases
- Regional use of mHealth compendium, mHealth technical assistance to missions, and expanded awareness by the public and private sectors through the African Development Bank (AfDB) pre-forum
- Use of the RBM and WHO/AFRO ASH mid-term evaluations to make key organizational decisions

Country-level Results:

Several USAID missions noted that ASH technical management work is shaping USAID and host-country planning and activities, including the work with the Kinshasa School of Public Health (KSPH), the analysis of the cost effectiveness of health care financing options in Uganda and the private sector assessment in Rwanda.

Innovation:

The project's innovation lies in its ability to flexibly work across sectors and on multiple health issues with both regional institutions and USAID bilateral missions to highlight cross-cutting topics of importance to the region. The work on mobile health (mHealth) technologies is an example of ASH work designed to stimulate discussions and decision-making. The project's July 2015 technical brief on Ebola and other disease outbreaks and their implications for economic growth and trade is an example of a synthesis of existing multi-sectoral data prepared by the project for use by USAID. The project worked best with institutions when it was able to carry out work within the context of the organization's plan or mission on a task that was already defined. In the case of the AU, the creation of an innovative database helped it synthesize information about countries and make cross-country comparisons that strengthened its advocacy and policy work. With KSPH, ASH strengthened specific financial systems and reports that a respondent noted might be used by other parts of the university. This was a specific USAID/Democratic Republic of Congo (DRC) organizational priority and advanced the mission's bilateral funding objectives. ASH also worked well with African organizations when given vetted ideas by USAID/W to execute in collaboration with an African institution. ASH work on childhood TB was carried out within the framework of an established WHO/AFRO, Stop TB and USAID partnership; it synthesized information on this subject into a landscape analysis and then prepared insightful and useful country reports that policymakers and host-country technical teams used as the basis for country-specific action plans.

ASH Project Strengths:

- Ability to flexibly explore many under-researched topics of relevance to the Africa and Global Health (GH) bureaus, other U.S. Government agencies including CDC, and some key local institutions.
- Rapid-response capability for missions and USAID/W to access short-term technical assistance to evaluate or assess key time-sensitive questions. Interviews indicated that the seven mission field support buy-in tasks were among the most highly regarded of the ASH tasks.
- Serving as a multi-sectoral contract that has helped USAID to focus on cross-cutting problems that it may otherwise have not addressed and to have a dialogue with non-traditional health partners such as the AU and elements of the private sector.

- Studies and assessments that usually just touch the surface of a given topic and help to signal its importance, and reinforcement of findings through general dissemination through publications on other web sites, through a meeting or conference. Some peer-reviewed online ASH articles on HIV/AIDS and maternal health have been widely viewed.

ASH Limitations:

- On just a very few topics, including SADC HIV work, the AU's CARMMA work, pediatric TB with WHO/AFR and other partners, and mHealth, the project has clearly committed the multiyear financing and level of effort of ASH staff to carry out an initial advocacy and policy development agenda on the topic and then subsequent or related institutional capacity development with African institutions or USAID missions.
- The project has a broad agenda for a small project with a small contract team whose key personnel span several technical areas.
- ASH an effective communications, dissemination and advocacy plan for each activity linked to a specific policy change. The high number of products and their diverse target audiences also complicates the dissemination process. More documentation and follow-up is needed on the use of the full range of research and outcomes from conferences and meetings. The ASH team has made dissemination a key activity for Year 5.
- The project has been a good instrument to research and support ideas and events rather than being technical leaders in a specific area.
- The project has weak branding and is not readily identified as a source of technical expertise by key partners.

Lessons Learned:

- Institution-building requires sustained funding and does not lend itself to one or two activities. The ASH project, similar to the predecessor Africa 2010 project, has attempted to execute too many and too diverse a range of assignments.
- There were no seed funds provided to follow up on or to scale up a good idea, to launch an operations research project, or to pilot a service delivery approach. Many respondents indicated that a future project should narrow its focus and concentrate on fewer topics.
- From the outset, by design, the project was not directed to work with a core set of beneficiary institutions in the Africa region and looked for opportunities to fit in and make a difference. This approach took time and required extensive constituency building and multiple levels of approvals across USAID and partners.

Question 2. Contract Management, Administration and Funding

- ASH has fulfilled the management requirements and functions outlined in the contract and has created meaningful pieces of work that add value to the Agency's global health portfolio.
- The project team has worked well behind the scenes and supported USAID branding and enhanced USAID visibility at important African regional meetings and conferences. Partners identify ASH work as USAID Africa Bureau contributions to programs.
- MSH has added value through its 14 African country offices. Especially in the third and fourth years of ASH, more senior MSH technical and headquarters staff have consulted for ASH and provided well-regarded advisory services. This was an element missing in the project's first two years that was corrected by Year 3.
- The project has excellent financial and management tracking and reporting systems in place and works collaboratively across many programming areas with many Africa Bureau activity managers

and with funding streams that have different reporting and approvals. Of note is the transfer of some of these good financial management practices and skills to the KSPH.

- Staff turnover on both the ASH and USAID teams delayed programming of activities, especially during the first two years of the project. The shortfall in funds during the first year of operation and weak MSH strategic leadership during the first two years of the project also contributed to the slow start-up.
- The limited use of the full range of expertise available from Khulisa and African Population and Health Research Center (APHRC) subcontracts was a missed opportunity for the project to work on monitoring and evaluation (M&E) and further work on urbanization.

Leveraged Funding and Future Health Investments:

Of the six examples of leveraged funding or opportunities resulting directly from ASH work and partnerships framed by USAID missions or other donors, the top three are:

- ASH worked closely with DFID (through their contractor Evidence for Action) and AusAID to build a database, software and analysis tools for the CARMMA initiative. While AUSAID donated funding (\$92,250), ASH was the well-regarded technical lead for M&E and provided all the expertise on data and validation processes for an interactive web-based platform on health information for policymakers in 54 AU member states.
- ASH work with SADC on regional norms and standards was a shared level-of-effort partnership in which the Africa Bureau Activity Manager for HIV/AIDS paired an ASH staff member with the regional mission-funded Building Local Capacity for HIV Service Delivery project and the Global Fund-supported cross-border health posts.
- ASH work on mHealth disseminated to health officers at a regional meeting in Malawi influenced USAID mission bilateral funding. The project has not yet documented additional African resource mobilization resulting from ASH studies or support.

Conclusions

ASH is a unique, cross-sectoral, flexible analytic mechanism with a mandate to conduct innovative research beyond service delivery. It has helped the Africa Bureau and some sections of GH and Urban Planning focus on cross-cutting problems that may otherwise have not been addressed by USAID, and supported dialogue with nontraditional health partners such as the AU and elements of the private sector. Within USAID, there is no other pan-Africa contract that can address the full gamut of health problems with a variety of funding streams.

The evaluation team confirmed the continuing need for the Africa Bureau's regional approach to problem identification and problem solving in the health sector. The ASH project has met or is on track to meet its deliverables, and its main stakeholders are satisfied with the work. The project has increased USAID visibility in the region and supported regional initiatives. Its activities are closely coordinated with those of the GH Bureau. Excellent collaboration on RMNCH, HIV and maternal mortality, health care financing studies and mHealth led by AFR/SD/HT activity managers with ASH support has taken place.

ASH is a vehicle to translate the Africa Bureau's well thought-through and vetted ideas into tangible work products. Thirty-three percent of respondents interviewed believe that ASH's main contributions are its overall ability to provide technical and management support services to AFR/SD/HT and partners and to serve as a flexible procurement mechanism for short-term technical assistance; 28 percent said that ASH's versatility has been its main contribution.

The field support assignments have enriched the ASH project. A future mechanism should be geared to both Washington and mission needs. There is scope and need for a future project, but it must narrow

its focus and identify some policy outcomes upfront. The PMP needs to be timely, clear and linked closely to health outcomes.

Recommendations for Year Five

1. Accelerate widespread, multi-channel product dissemination and completion, and gather user satisfaction and end-use data.
2. Support key strategic planning work currently underway at WHO/AFRO.
3. Prepare a white paper that outlines next steps on mHealth, possible partners and the investment in electronic infrastructure and systems architecture—including memory storage and system bandwidth—that is required to move forward.
4. Complete the misoprostol, intermittent preventive treatment of malaria in pregnancy, and integrated community case management and SMS studies, and channel those findings into well-defined, time-limited actions. Share the findings with stakeholders, and use this as an opportunity to engage them in a discussion on future information gaps.
5. Document any domestic resource mobilization in African countries associated or linked to ASH work.
6. Use ASH subcontractor APHRC to identify and price next steps to launch model urban health services and best practices as a follow-up to the July 2015 ECOWAS Conference.
7. Consistent with the revised PMP, document the use of ASH materials and institutional or policy changes and agreements reached by the end of the project.

I. INTRODUCTION

EVALUATION PURPOSE

The end-of-project evaluation of the USAID Africa Bureau's five-year project (2011-2016) African Strategies for Health (ASH) is being conducted to document the accomplishments, results and lessons learned from the ASH project during the final phase of implementation, assess prospects for reaching projected targets by 2016 and inform the scope and size of the next generation of health programming funded by the Africa Bureau Office of Sustainable Development (AFR-SD). The evaluation is expected to accomplish the following objectives:

- Assess and document activity accomplishments and whether desired results have occurred;
- Capture lessons learned from project implementation;
- Identify common themes in how ASH is perceived and valued by key stakeholders;
- Determine the effectiveness and efficiency of project operations; and
- Identify potential opportunities for AFR/SD to fill unique gaps in technical assistance.

EVALUATION QUESTIONS

1. What results have been realized at both country and regional levels during the first four years of ASH? To answer this question, consider:
 - a. The extent to which ASH has achieved the technical and programmatic objectives described in the contract agreement;
 - b. Innovative and creative approaches ASH took to address regional health issues;
 - c. Lessons learned from ASH's efforts to strengthen regional institutions and, in the process, to improve country programs as a result of work with those institutions; and
 - d. The perceived impact of ASH on stakeholders (primary and secondary) working in the technical areas addressed by the project.
2. To what extent has ASH met the management requirements and functions outlined in the contract, including planning, allocation of funds, coordination/use of sub-agreements, and staffing requirements? To answer this question, consider:
 - a. The structure of ASH and AFR/SD/Health Team (HT) oversight and management that aided or hindered ASH in accomplishing work plan objectives; and
 - b. The engagement or lack of engagement of sub-partners [Khulisa, African Population and Health Research Center (APHRC), and Institut de Santé et Développement at Dakar University, Senegal (ISED)] that aided or hindered ASH in accomplishing work plan objectives.

II. PROJECT BACKGROUND

DEVELOPMENT CONTEXT AND PUBLIC HEALTH LANDSCAPE

The Presidential Policy Directive on Development emphasizes the importance of development as the third critical dimension of foreign policy, along with defense and diplomacy. In all regions, but especially in Africa, the preservation and enhancement of health is recognized as an essential precondition for development. Bearing the heaviest burden of the HIV/AIDS epidemic, plagued by malaria and experiencing frequent food shortages, Africa also has a critical shortfall in the number, composition and deployment of the health workforce,¹ as well as rapid population growth, low modern contraceptive use and unplanned urbanization. Africa is in great need of strategies and approaches that are appropriate for its context and that offer the greatest possibility for expanding and sustaining health benefits.

HEALTH TRENDS

Despite persistent problems, there are indications that progress toward better health in Africa can be accelerated. Over the past two decades, and accelerating since 2000, sub-Saharan Africa has made encouraging improvements in child health though the rate of change still lags. Positive gains have been demonstrated in malaria control, for people living with HIV/AIDS, in the slowing of the HIV epidemic, and in increasing contraceptive prevalence from 12 percent in 1990 to 27 percent during the period 2006-2012. Life expectancy for African men has risen from age 48 to 56 and for African women from age 52 to 59 between 1990 and 2012.²

Survival of children under 5 has improved notably; with an estimated 30 percent drop in the under-5 mortality rate from 180/1,000 live births in 1990 to 129/1,000 in 2009. Despite this improvement, one out of every eight African children dies before reaching age 5. The infant mortality rate (under 1 year of age) has dropped from an estimated 109/1,000 in 1990 to 81/1,000 in 2009. Twenty-five percent of this group dies during the first 28 days of life³. It is estimated that malaria control improvements have contributed 16-20 percent to the drop in under-5 mortality.⁴ Eleven of the President's Malaria Initiative (PMI) focus countries reduced childhood mortality rates 16-50 percent.⁵ However Africa bears the highest burden of malaria, and more than 85 percent of all malaria deaths occur among African children.⁶

Malnutrition has not kept pace with the decline in mortality. Stunting among children under 5 is 43 percent, down from 55.6 percent in 1990, the highest rate of malnutrition in the world.⁷ This rate has not changed over the last 15 years,⁸ and an estimated 15 percent of all infants in sub-Saharan Africa are born at low birth weight, an indication of the poor nutrition of so many mothers in the region.

The region still has the highest maternal mortality ratios (MMR) in the world, which have remained largely unchanged since 1990, though there are documented improvements in specific countries. The regional MMR estimate is 640 maternal deaths per 100,000 births, only a slight decrease from the 2005

¹ The number of physicians per 10,000 population was 2.6 as compared with 14.1 globally and the number of nurses and midwives was 12 compared with 29.2 globally in 2013; WHO/AFRO 2014 Health Statistics Report p 16.

² WHO/AFRO. 2014 Health Statistics African Regional Report. pp. 12 and 4.

³ PlosMedicine June 2010, vol 7, Issue 6, p.1.

⁴ 2008 figures from WHO Malaria fact Sheet #94, April 2010; RBM Progress and Impact Series #2, April 2010.

⁵ USAID Global Health Programs FY2016 President's Budget Request.

⁶ 2008 figures, WHO Malaria fact Sheet #94, 4/2010; World Malaria Report-2010.

⁷ USAID FY2016 Ending Preventable Child and Maternal Deaths Global Health Budget Request.

⁸ PRB 2008 Reducing Child Malnutrition surveys.

estimate of 710.⁹ Forty of the region's 46 countries have high or very high maternal mortality, and 13 percent of all mortality occurs in adolescents.

Africa also faces a severe TB burden, having 13 of the 15 countries with the highest incidence. WHO/AFRO estimates that there were 1,223,441 cases of TB in Africa in 2012. TB in children accounts for 10 percent of Africa's TB cases, compared to 2-3 percent in Bangladesh (GH/TB Team). Pediatric TB has been a neglected problem in Africa until recently, while cross-border TB due to civil unrest and migration is a serious challenge yet to be successfully addressed.

Although the number of AIDS-related deaths in sub-Saharan Africa fell by 39 percent between 2005 and 2013, Africa has the highest HIV prevalence, with 69 percent or 1.8 million of all new global HIV infections.¹⁰ HIV deaths in children fell from 5 percent of the region's cause-specific mortality in 2000 to 3 percent in 2012.¹¹ The region is home to 95 percent of all children orphaned by AIDS and has 2.3 million children living with HIV/AIDS.¹² Though the epidemic is slowing somewhat, HIV/AIDS continues to compound Africa's disease burden.

Africa is also facing the rise of non-communicable diseases (NCDs) with increased urbanization and changes in lifestyle, diet and exercise. WHO/AFRO estimates that by 2025, 65 percent of Africa's disease burden will be related to NCDs, principally cardiovascular disease, Type 2 diabetes and cancers. According to WHO/AFRO 2008 data, 35.5 percent of women over 25 had uncontrolled hypertension, 22 percent of all men over age 15 smoked, and adult (over age 15) alcohol consumption was six liters of pure alcohol per person per year; these rates are comparable to those in countries with severe NCD levels.¹³ The cost to tackle the multiple burdens of chronic and communicable diseases needs to be estimated now, so that cost-effective interventions are piloted and norms and standards developed.

Another visible trend is the growing effects of climate change, with increased encroachment on pristine environments and newly emerging diseases such as Ebola in West Africa with its great toll on human populations and fragile health systems. Local changes in temperature and rainfall have already altered distribution of some water-borne illnesses and disease vectors and have reduced food production for some vulnerable populations. Climate change increases risk of infectious disease transmission by altering the ecology of insect vectors and animal hosts, accelerating the life cycles of the pathogens (including viruses and bacteria) and introducing new diseases through shifting migratory paths and habitat shift.

The significant health improvements within some African communities indicate that better health is possible, even in this difficult environment. Countries such as Malawi, Madagascar, Eritrea, Botswana, Cape Verde and Seychelles are now on target for achieving the MDG4 goals by 2015.¹⁴ The successes achieved point to improved coordination by donors and international organizations, with active promotion of policies to adopt evidence-based approaches and interventions accompanied by substantial increases in funding. The wide dissemination of evidence-based learning, as supported by the prior Africa 2010 and Support for Analysis and Research for Africa (SARA) projects, has played a major role in informing and encouraging countries to improve outreach and service delivery at community and institutional levels. The integration of maternal, newborn and child health with infectious disease interventions offers great promise to improve related indicators, if adopted by countries and translated into policies and programs alongside strong government commitment.

⁹ Trends in Maternal Mortality: 1990-2008.

¹⁰ UNAIDS Report, November 2010.

¹¹ WHO/AFRO 2014 Health Statistics pp. 7 and 9.

¹² UNAIDS Report, November 2010.

¹³ WHO/AFRO 2014 Health Statistics Report p.15.

¹⁴ UNICEF State of the World's Children 2009.

INNOVATIONS, CHALLENGES AND A SHIFT IN DEVELOPMENT APPROACH

In recent years, community-based health insurance schemes have increased access and quality of health services; immunization campaigns and strengthened routine immunization services have reduced vaccine-preventable diseases in target areas; and expanded use of bed nets and indoor residual spraying significantly reduced the incidence of malaria in endemic countries. There are hopeful signs that prevention and treatment are beginning to slow the spread of HIV/AIDS in some countries. The President's Emergency Plan for HIV/AIDS Relief (PEPFAR), under the leadership of the Office of the Global AIDS Coordinator, and the Global Fund for AIDS, Tuberculosis and Malaria have significantly expanded resources to Africa to fight these diseases. Greater attention following the Ebola outbreak in West Africa has been focused on health security, the rise of emerging illnesses and the need for increased capacity within Africa to carry out risk assessment, and the importance of disease surveillance and timely response to disease outbreaks.

Nonetheless, major constraints and challenges remain. Low GDPs have impeded adequate government investments in health services. A severe health manpower crisis has resulted in shortages of competent providers of basic health services. Recent National Health Accounts in many countries show that most African health expenditures are out-of-pocket and consume a significant portion of family budgets. Studies also show that these expenditures go first to traditional healers and drug vendors rather than to formal health providers, resulting in inadequate but costly care. Gender disparities also mark the health sector; adolescent girls are being infected by HIV/AIDS at a rate three times as high as boys.

Given the scope of these problems, existing evidence-based interventions must be scaled up to achieve maximum impact, while innovative, cost-effective approaches need to be created. There is a continuing need to learn which innovations work well, which do not, and why. It is imperative to explore innovative approaches to health service delivery that reach beyond the formal government sector and find additional local African partners ready to scale-up innovative responses to alleviate the disease burden.

Over the next five years, USAID's approach to its health program will be characterized by a new development paradigm articulated in the principles of the Global Health Initiative¹⁵, the Ending Preventable Child and Maternal Deaths program that aligns resources with the highest-impact proven interventions to reduce mortality, and Feed the Future.¹⁶ USAID will continue to advocate for evidence-based policies, support the development of systems to deliver health services, and provide technical assistance to regional organizations, USAID missions and other development partners. However, its work will be done in accordance with a set of principles aimed at changing the relationship between USAID and its country counterparts from one resembling a donor-led relationship to a true partnership.

PROJECT OVERVIEW

ASH is a five-year, \$19.96 million project for health systems and regional institution strengthening, technical and management support, designed to improve health status across Africa. ASH provides information on trends and developments in the region to enhance USAID and partner decision-making and investments in the health sector. This cross-cutting mechanism runs September 2011-October 2016 and is implemented through a contract with Management Sciences for Health (MSH) and several African subcontractors. The project is the fourth in a succession of Africa Bureau projects designed to improve national health policies and support the bureau, regional missions and African partner health institutions.

ASH is charged with working with African institutions and other development partners to introduce, promote, monitor and evaluate policies and programs calculated to have sustainable health impact in

¹⁵ U.S. Global Health Programs Web site: Global Health Initiatives Seven Core Principles Last Updated December 11, 2014. <http://www.ghi.gov/principles/index.html>.

¹⁶ USAID Feed the Future web site: Feed the Future Progress Report July 28, 2015. <http://www.usaid.gov/what-we-do/supporting-global-nutrition>.

Africa, with an eye toward building the capacity and sense of ownership of all indigenous partners. The project was also expected to keep the Africa Bureau in the forefront of new ideas and to address critical assistance gaps. A measure of its success is the degree to which innovative approaches are introduced and later internalized by those counterparts and/or other partners. The ASH project was designed at a time when Africa Bureau core health funds had been fairly consistent. Between 2011 and 2015, however, the Africa's Bureau's health budget declined and ASH received less funding than originally envisioned. The project's main funding came from maternal and child health, with funds from malaria, TB, family planning and HIV/AIDS also programmed. (See page 26 for the proportion of funding from various USAID accounts.)

The ASH 'theory of change' assumes that its interventions and analyses will produce the basis for designing and implementing higher-impact interventions that, once delivered by the public and private sectors under conditions of improved preventive and care-seeking behavior among an empowered population, will result in improved health status of African families. The project's focus ranges across program components critical for the achievement of Millennium Development Goals (MDGs): maternal, neonatal and child health (MNCH), HIV/AIDS, malaria, TB, health systems strengthening (HSS) and family planning/reproductive health (FP/RH).

ASH Development Hypothesis¹⁷

Supporting African institutions and networks and assisting USAID and its cooperating agencies and partners to create a strategic vision for guiding health investments develops African leadership, strengthens national health systems, and improves the health of African populations.

ASH Results Framework and Log frame

Please refer to Annex VII for the project's results framework and log frame. The project's three intermediate results (IRs) are:

- IR. 1:** *Expanding the body of knowledge of current trends, constraints and solutions to improve the health of Africans*
- IR. 2:** *Consensus on priorities and strategies for improving the health of Africans*
- IR. 3:** *Strengthened African institutions and networks*

¹⁷ The development hypothesis "Describes the theory of change, logic, and causal relationships between the building blocks needed to achieve a long-term result. The development hypothesis is based on development theory, practice, literature, and experience, is country-specific, and explains why and how the proposed investments from USAID and others collectively lead to achieving the Development Objectives (DOs) and ultimately the CDCS goal." USAID Learning Lab, retrieved from <http://usaidearninglab.org/learning-guide/development-hypothesis>

III. EVALUATION METHODS & LIMITATIONS

This section summarizes the evaluation approach, methods and limitations. The methodology is described in detail in Annex II, data collection tools are found in Annex V and summary tables from the key informant interviews are in Annex VIII.

This final external evaluation assessed performance for each of the three intermediate results and outputs and included the ability of the organizations that benefited from the project to use the materials, tools and assistance produced by the project once the project ends. It also solicited input from key informants and users of the ASH mechanism across USAID and its partners about possible future needs that could be served from an Africa Bureau regional project. The evaluation followed USAID's 2011 Evaluation Policy aimed at improving accountability, learning and evidence-based decision-making. USAID's Health Sector Development Objective (DO), IRs and sub-IRs, and indicators are the framework upon which the evaluation is defined. This is a structured, moderately complex qualitative assessment using a mixed-method approach to assess whether the project is on track to meet its stated purpose by the project's conclusion.

Following USAID's guidelines, this evaluation provided a programmatic, technical and managerial assessment of ASH activities implemented to date, identified accomplishments, performance issues and implementation constraints. The evaluation team reviewed both regional planning documents and prime contractor headquarters plans that identified results and lessons learned. The evaluation report makes specific recommendations on activities to be continued, modified or enhanced in any future design.

EVALUATION APPROACH

This evaluation is based on a participatory approach and used primarily qualitative methods and quantification of key informant interviews on some questions and extensive use of secondary sources. The evaluation collected, analyzed and interpreted both quantitative and secondary source data in order to answer the evaluation questions. The quantitative data analyzed was data from anonymized surveys carried out during the life of the project and some raw event evaluation data and training evaluations from conferences and training. The team triangulated results and assessed the opinions of those responsible for the implementation of the activities at different levels, as well as those who benefited and used project materials, technical assistance, tools or research.

The qualitative methods applied in this evaluation consisted of the use of semi-structured interviews and data recorded according to interview guides tailored for specific key informant groups. The team interviewed 64 key informants who had some direct knowledge or connection to the ASH project, and spoke to 27 other health specialists for general African health sector or USAID background information. The interviews were administered over the phone and during some face-to-face meetings. Combining results from structured interviews at different levels permitted the evaluation team to assess the opinions of those responsible for the implementation of the activities at different levels, as well as those who benefited from the project. The subjects of these interviews are classified in three main groups: (1) officials from AFR/SD/HT, other USAID headquarters offices and field missions; (2) officials from African partner organizations, a multi-lateral donor (WHO/AFRO) and representatives of African ministries of in the region; and (3) staff from beneficiary organizations and institutions. The desk review and subsequent analysis of secondary sources and project reports covered 106 documents.

EVALUATION LIMITATIONS AND CHALLENGES

- I. The USAID Performance Monitoring Plan (PMP) for the project did not include health outcomes and impact indicators, but incorporated process outputs, some evidence-based institutional

outcomes and some limited customer satisfaction indicators. The PMP was drafted in December 2011 but was significantly revised and finalized in the third year of the project.

2. The project results do not lend themselves to a quantitative review of results beyond the output level. One way to approach this problem is to have access to high-quality baseline measurements that can provide statistical grounds for correct comparisons of the level of some key variables prior to the beginning of interventions and at the evaluation point. However, these data were not available for the ASH project.
3. The project did not routinely track the number of end users or host-country customer satisfaction with its products and all materials, although the evaluation team did have access to some raw participant data from the 2014 Africa Development Bank Ministerial Forum on Science and Technology and Innovation meeting and user feedback following a meeting that included dissemination of the mHealth compendium.
4. The project did not conduct organizational capacity surveys as specified in the PMP, as the organizational development staff position was cut by mutual agreement with USAID in 2012. The decision to delete an organizational development position and forego capacity assessments makes it difficult to attach a causal link between the work ASH supported at a given institution and improved operations at that institution.
5. The project design was extremely broad, incorporating eight major areas of service delivery, health policy and many African institutions. Due to time and financial limitations, the two-person external evaluation team was limited to one site visit to WHO/AFRO in Brazzaville and was not able to hold face-to-face meetings with African participating organizations, who were reached virtually by phone. Ten additional individual interviews were held with WHO/AFRO technical staff representing different technical clusters within that organization. Only three of the ten clusters had prior knowledge about the ASH project.

IV. FINDINGS

QUESTION 1: WHAT RESULTS HAVE BEEN REALIZED AT COUNTRY AND REGIONAL LEVELS DURING THE FIRST FOUR YEARS OF ASH?

The project has carried out 133 activities at the following pace: 22 in Year 1; 27 in Year 2; 45 in Year 3; and 39 in Year 4. In the fifth and final year that begins in September 2015, ASH plans to carry out 23 activities, for a life-of-contract total of 156 activities across the region. The Year 5 work plan was in development at the time of this evaluation and is expected to incorporate these evaluation findings into the final year of ASH work.

An analysis of the ASH COR Letter Tracking Sheet indicated that a number of activities were carried out over multiple years, including IDSR in Years 1-4; mHealth in Years 1-4; FP reviews in Years 2-4; TB in Years 2-4; Southern African Development Community (SADC) HIV work in Years 3 and 4; HIV and maternal health studies in Years 2-4; work with the Africa Union (AU) in Years 1-4; and work with KSPH in Years 3 and 4. The project worked toward developing a balance between new and continuing activities and multiyear support for some institutions. In Year 2, 10 out of 16 major activities were new; in Year 3, 11 out of 19 activities were new, and by Year 4 the number of entirely new major activities had dropped to 5 out of 18, with many activities carried over from prior years. Based on the tracking sheet, it also appears that USAID and the project team did a good job of balancing the number of one-time activities versus ongoing work. In Years 2 and 3, there were seven one-time activities, and in Year 4 that number had dropped to five.

The project has achieved numerous results for a small contract and a small team at both the regional and country levels across many health areas. Of note, over the four years of the project, ASH generated or followed up on 58 new ideas with the USAID/ASH core technical team, out of which came a total of 62 reports, publications and materials with a focus on health trends, constraints and solutions for improved African health.¹⁸ ASH has met, or is on track to meet by the end of the project, all of the output targets identified by USAID.¹⁹ The project has exceeded the target for south-to-south dialogue.

The third and fourth years of the project have witnessed good progress and accelerated completion of key outputs across all three IRs. Many studies launched in the fourth year are expected to be completed in Year 5 in time to publish and disseminate the results. However, IR 1, related to idea generation, has had more outputs than the other two IRs related to advocacy and communications and African institution building. By mutual agreement with USAID shortly following the award of the contract and a budget shortfall,²⁰ MSH deleted the full-time organizational development position and several others. The project was unable to carry out capacity assessments, so all findings concerning institutional strengthening are based on qualitative information from key informants.

Question 1a: Extent to which ASH has achieved the technical and programmatic objectives described in the contract

What follows are the highlights of some key programs by funding stream and the project's six health areas (MNCH, HSS, ID, FP/cross-sectoral (CS), malaria, HIV/AIDS). This section will review key regional results, country results, suggested impact and program funding for the entire program, which includes other crosscutting activities up to July 2015. (For the number of technical activities by technical area see Annex VII.)

¹⁸ ASH. June 2015 Results on Performance Indicators. p.13.

¹⁹ ASH output tracker.

²⁰ USAID Mudd/Bolton letter, dated January 17, 2012.

Maternal and Child Health

Highlights: Core funding from ASH has been used over the four years to identify regional and country solutions to improve MNCH primarily for five key interventions all working in the context of USAID's extensive bilateral and GH Bureau MNCH program. ASH MNCH work covered new knowledge generation around various high-impact, priority MNCH interventions that were not addressed by other USAID-funded programs. This work served to highlight areas of insufficient attention and compile knowledge for program consideration, such as the link between HIV/AIDS and maternal mortality. Incorporation of maternal death surveillance reporting into national integrated disease surveillance and response (IDSR) platforms is another ASH contribution.

Project Funding to Date: **USAID:** \$5.7 million **AusAID:** \$92,250

Regional Level: The project supported the African Leadership for Child Survival / A Promise Renewed Conference, a high-visibility, policy-level event attended by 200 African leaders; supported the AU Campaign on the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), including contributions to the innovative African Health Statistics web site; and led a national policy review of community-based distribution of misoprostol for prevention of postpartum hemorrhage in four countries (Madagascar, Mozambique, Nigeria and South Sudan). ASH carried out three systemic reviews on HIV-related maternal mortality; the full set of four studies will be completed by the end of 2015. The integration of maternal death surveillance and response (MDSR) into national IDSR systems has been an important step forward to gather key maternal death reports and ensure rapid response.

“The ASH support of the IT platform helped to communicate with AU member countries and ministries of health and to advocate for more attention to maternal mortality reduction programs.”

(The African Union)

Key Partners: Africa Union, WHO, UNICEF, national ministries of health

- **Results:** ASH support of the AU's CARMMA database and analytic tools served to improve access to key health information and data across all 54 AU member states by simplifying and consolidating the data and making them more user-friendly. Country Scorecards developed by ASH in coordination with the Evidence for Action (funded by DFID) and adopted by the AU provide data and track progress. At the request of USAID, ASH facilitated the Call to Action policy conference that achieved consensus on increased African political leadership to end preventable child and maternal deaths through more intensive geographic focus, scaling up access for high-impact interventions in underserved rural and local income groups, mutual accountability and financing to shared goals and common metrics. The conference resulted in revised country work plans for high-impact interventions. The integration of MDSR into routine IDSR systems has brought the issue of maternal deaths and the importance of a rapid response to the forefront. Some countries, for example Rwanda, must report all maternal deaths through its political structures as well as the health structures.

Country Level:

- **Anticipated Year 5 Results:** At the time of this evaluation report, ASH is finalizing case studies on the implementation of MDSR in Burkina Faso, Rwanda and Malawi. Results from these case studies are expected to influence refinement and scale-up for MDSR as part of a larger process of quality improvement during labor and delivery. Simultaneously, ASH conducted country-specific studies on the use of misoprostol in South Sudan, Madagascar and Nigeria to identify enabling factors for national policies on misoprostol use for the management of post-partum hemorrhage. It is expected that these country studies will also inform regional level policies and best practices.

ASH Contributions: The publication of two peer-reviewed journal articles on HIV and maternal mortality that have been distributed by a web-based journal, PLOS, was an important contribution to both the HIV and maternal and child health (MCH) literature. The study concluded that antiretroviral treatment (ART), initiated early in pregnancy and begun at higher CD4 levels, is associated with better health outcomes for pregnant women. The study concluded that 24 percent of maternal mortality in pregnant women is a result of HIV. The study findings were based on an initial review of 3,028 studies for eligibility, of which 48 were included in the ASH report and subsequent journal articles. These are significant findings and have served to direct additional USAID GH attention and possible funding to this issue from both the HIV and maternal health partners.

Health Systems Strengthening (HSS)

Highlights: The ASH priority areas for HSS funding have been: exploring emerging innovations in the area of mHealth across the region and specifically in Angola and Madagascar, health care financing options analysis, and building partnerships between regional institutions and ways to engage the private sector. An October 2014 African Development Bank (AfDB) meeting on Science, Technology and Innovation that brought together ministers of health and information technology featured an ASH-organized one-day pre-forum meeting to discuss digital infrastructure and collaboration between the public and private sectors. Corporate executives and the Department of State participated. A review of health-related corporate social responsibility across Africa builds on the project's landscape analysis of regional economic communities in the African health sector. ASH conducted an assessment of the challenges and opportunities for private sector engagement in Rwanda and a cost-effectiveness analysis comparing community-based health insurance and voucher schemes. Both assignments were praised by the USAID missions. By Year 3, ASH supported 17 HSS projects. By Year 4, the number had grown to 20. Some are one-time analyses and others are larger assessments.

Project Funding to Date: \$3,021,000

Key Partners: USAID missions, African universities (KSPH, Makerere, Nzumba), local implementing partners, ministries of health

Regional Level: During Year 1, ASH mapped the USAID-funded activities providing management training for health care workers and collaborated with WHO/AFRO to align efforts in the development of a management training curriculum; ASH launched support for the Harmonization for Health in Africa (HHA) mechanism of WHO/AFRO to support country-led HSS; ASH produced a landscape economic and health analysis, including profiles of 15 regional institutions documenting their relationship limitations and strategic advantages, and presented the study at the 2013 African Growth and Opportunity Act (AGOA) forum in Ethiopia; ASH analyzed the corporate social responsibility activities undertaken by four countries in Africa and produced five mHealth compendia volumes documenting 150 projects using digital health technologies and facilitated key mHealth meetings in Africa. Eight countries and 20 private sector companies sent participants to the Joint USAID/Africa Development Bank's one-day meeting on Investing in Technology and Innovations in Human Health, in which ASH led sessions on mHealth, helped frame the meeting agenda, wrote case studies, made and facilitated key presentations and captured the findings and lessons learned. The conference was the largest gathering of its kind with the private sector and ministers, and it resulted in collaboration across sectors, including identifying ways to access Universal Service Fund resources to scale-up eHealth solutions with Global Broadband.²¹

- **Results:** The Uganda study was done in collaboration with Nzumba University in Tanzania and Makerere in Uganda. The study will be presented at the international FP conference in Indonesia. ASH is not a service provider and is not setting up health care financing schemes, so it is able to objectively assess the evidence and identify gaps in health care financing, a principal investigator

²¹ October 14, 2014 ASH Meeting Report of Investment in Technology and Innovations for Human Development in Africa p. 9.

reported. Significant health funding is going to look at the integration of services in Africa, as there has been limited evidence of the costs of setting up and running integrated services and the effective approaches.

Country Level: ASH carried out four field support studies for missions: (1) a review of private sector engagement in Rwanda; (2) a cost-effectiveness analysis of two financing schemes in Western Uganda; (3) a randomized control trial of the effect of texting (SMS) reminders to antenatal care appointments and coverage of intermittent preventive treatment of malaria in pregnancy (IPTp) for an SMS system developed by UNICEF; and (4) an assessment of mHealth for Angola. In Malawi, ASH core funds are being used to study the country comparison of community health workers (CHW), how they influence program performance and how incentives influence volunteerism and patterns of remuneration. ASH sampled four CHW programs looking at USAID- and non-USAID-funded programs. The Uganda study looked at the cost-effectiveness of two specific health care financing mechanisms—reproductive health vouchers and community-based health insurance (CBHI)—being tested to expand and improve the use and provision of quality maternal care and improve maternal health outcomes. The study compared and contrasted the relative strengths and advantages of these policy options for Ugandan policymakers. The study used Makerere University as one of the principal investigators.

As a result of the ASH work, The Government of Angola drafted a strategic mHealth plan, set up a task force and is preparing to pilot mHealth solutions.

(MOH/Angola May 2015 mHealth Presentation)

- **Results:** USAID/Uganda and Makerere University reported a high degree of satisfaction with the study and its planned use by the Government of Uganda to make a key health care financing decision. USAID/Angola reports that the Ministry of Health (MOH) of Angola is using the mHealth assessment to draft a mHealth policy, action plan and direct future opportunities in this area. The study points out the requirements of interoperability and other infrastructure requirements for success. In Malawi, the CHW study is linked to an externally funded foundation's one million CHW campaign. The study will help donors to better understand the full costs of an integrated CHW program. The study is on the cutting edge of answering key questions of how countries and partners can contribute to supporting expansion and supervision of CHWs.

ASH Contributions: The ASH mHealth work is the most frequently cited product by respondents interviewed for this evaluation. Respondents indicated that it has contributed to synthesizing the body of evidence on cutting-edge innovation in a user-friendly format. Both USAID staff and some private sector providers (D-Tree International and African Evaluation Association) are using the document. Twenty-two percent of respondents for this evaluation found the mHealth Compendia series to be the most important contribution of the ASH project to increasing new knowledge. The mHealth Compendium has identified and documented policy constraints and opportunities for successful implementation of digital health in Africa and supported cross-sectoral learning to strengthen enabling environments for mobile health. Examples of the applications of digital health tools in the compendium are useful as countries seek to pilot or scale up the use of mHealth. Two important dissemination meetings have taken place to inform ministers of health and technology continent-wide, and a smaller meeting with USAID health officers to better inform their investment decisions on digital health technologies. The health care finance and private sector engagement studies are supporting timely policy decisions in Uganda and Rwanda.

Family Planning/Cross-cutting

Highlights: ASH has supported the Africa Bureau to explore the impact of FP on MNCH outcomes and economic growth, as well as the preparation of key sessions at conferences and workshops across the continent. It has also supported cross-sectoral issues and approaches to inform and strengthen health programming, including an advocacy piece and the dissemination of a paper highlighting urban health issues along the Abidjan-Lagos corridor linked to changes in demographics, including migration and settlement patterns. A cross-region health sector organizational landscape analysis was completed to highlight the work and better linkages and integration among the AU, EAC and ECSA and to strengthen these partnerships with West and South African regional intergovernmental organizations. A meeting will be held with the East, Central and Southern African Health Community (ECSA-HC), EAC, SADC, WAHO, AU and WHO/AFRO and the HHA secretariat to discuss ways of strengthening their analysis of regional sector players. WHO/AFRO reported that an MOU will be put in place between ECSA and WAHO to operationalize collaboration. The mHealth work, including the compendia, is in large part financed with FP funds, as many FP programs across Africa have been leading the way in the use of digital technologies.

ASH work on SADC norms and standards was noted by SADC leadership as having “served to encourage member states to provide integrated series beyond HIV and AIDS including TB, STIs, malaria and non-communicable diseases.”

Project Funding to Date: \$1,293,964

Key Partners: USAID country and regional missions, KSPH, APHRC, WHO/AFRO, EAC, USAID/GH

Regional Level: ASH has helped the Africa Bureau produce its FP annual reports that get wide use by technical assistance teams going to the field. Other technical reports have been used to make the case for the economic benefits and impact of FP in sub-Saharan Africa, where fertility rates continue to be high and modern method contraception remains low. The urban health advocacy work is the ASH project’s most visible advocacy tool to date to highlight demographic changes. The landscape analysis of African regional economic organizations is also expected to be used by WHO/AFRO and HHA in 2015 to highlight the strategic role of regional bodies in the health sector.

- **Results:** A respondent noted that the ASH Family Planning Country Briefers and annual reports are used to brief new ambassadors, for example, and for cross-country comparisons and lessons learned. According to a respondent, it is imperative that the Africa Bureau continue to support regional organizations that advance a FP agenda, particularly in West Africa. The Africa Bureau’s core FP funds are used to investigate integrated problems related to FP. This is a different approach from the GH/FP service and analysis projects that tend to have a more vertical focus. Since ASH was designed, there has been a global movement to invest in a program entitled Africa 2020, which is a major vehicle for foundations (including Gates) and bilateral and multilateral donors to raise money for global population programs.
 - The urban health tool that was recently disseminated by the Economic Community of West African States (ECOWAS) and at an Asian Global conference was used to raise awareness about mounting urbanization in Africa. No data are available to measure participant awareness following these two events. A USAID contact noted, “This analysis has direct implications for Africa’s health systems; for example, Ghana’s health system was not designed to reach the urban poor.” This analysis will be used across USAID’s Africa missions to make the case for urban health programs. APHRC, an ASH subcontractor, is one of the top African institutes with urban health research expertise, and it played a role in identifying organizations and data for this study.

Country Level: A field support grant from the DRC has channeled resources to an important capacity-building scholarship program for Masters in Public Health students. ASH has served as an excellent

mechanism for the mission to support the KSPH and has provided much-needed financial management training and budgeting templates to the school.

- **Results:** KSPH reports that the University has been very positive about the practical, hands-on ASH financial management training and is using the ASH tools for its financial management reports.

ASH Contributions: The ASH urban study and materials, built on the work of ASH subcontractor APRHC, are a useful cross-cutting tool to influence decision-making at the USAID mission level, where decisions are made through designs about the direction of health programming. It is hoped that in the future, APRHC will be able to pursue this line of work as a regional expert. A GH respondent noted that it is important for USAID to continue to have a broad idea-generation process that cuts across global centers. ASH is one of the few Agency projects that by design has cross-sectoral analytic capability. KSPH has noted that as a result of the ASH training, at the end of the three years, it will be able to become a direct recipient of U.S. Government foreign assistance.

HIV/AIDS

Highlights: ASH has carried out a major set of three studies initiated by ASH in Year 2 and finalized in 2013 to improve policies and services for pregnant and postpartum women living with HIV. ASH also supported the SADC in the development of sub-regional minimum package of norms and standards and branding for HIV and other primary care services along the Southern African trucking corridor.

Project Funding to Date: \$895,000

Key Partners: SADC, WHO/AFRO, SADC member state ministries of health

KSPH noted that by the end of the ASH project it will have all the financial management systems in place to become a direct recipient of additional host country and partner foreign assistance. “The ASH financial management tools are a good model for the University.”

Regional Level: The three systemic studies explored interventions to reduce morbidity and mortality in pregnant and post-partum HIV-infected women, and the health system and key barriers to ART initiation and retention. ASH carried out a situational analysis of HIV and other related health services provided along the transport corridor in Southern and Eastern Africa. ASH supported SADC in the development of regional minimum HIV and other health service norms and standards, and it will support the effective implementation of these standards at the country level by developing a monitoring tool that will allow SADC to measure and advocate for these norms and that may include a tracking scorecard

and possible evaluations of implementation at select cross-border sites.

- **Results:** The journal articles demonstrated the relationships between maternal mortality and HIV. The studies found that HIV-related maternal deaths remain high, accounting for 24 percent of all pregnancy-related deaths in sub-Saharan Africa. The three reviews were published in two separate articles by PLOS one in 2014.

Country Level: There was no field support from missions for HIV/AIDS work.

ASH Contributions: ASH supported drafting the standards. SADC notes that, “The standards provide guidance on uniform branding, clinic design, internal structure and equipment. The standards define the roles and responsibilities of SADC member states and the private sector, civil society and development partners to attain these standards. In January 2015, SADC presented the standards to the joint meeting of SADC ministers of health.”²²

²² SADC to Benavente follow-up note on regional minimum standards (RMS), dated July 20, 2015.

Infectious Diseases and Crosscutting ID-Funded Work

Highlights: Following an ASH consultation with USAID/AFR/SD/HT and GH, key critical knowledge gaps were identified in TB programming, including pediatric TB. ASH conducted a landscape analysis of childhood TB in the Africa region, focusing on 12 priority countries that served as a basis for country profile development and as a primary resource for baseline, country-specific information on childhood TB data, policy and programming. ASH supported SADC with the development of an integrated package of health services along the transport corridors that includes TB and with reviewing nutrition and HIV status and care for HIV/TB patients. ASH also produced a landscape analysis of USAID's contributions to TB control in Africa for a chapter that is to be included in a WHO report that documents the global TB control programs over the last 30 years. Related to Integrated Disease Surveillance Reporting (IDSR), which is funded with Agency Infectious Disease account resources and is crosscutting, ASH work has focused on IDSR evaluation with a small emphasis on IDSR advocacy. ASH supported the technical presentations for the 2013 AFENET workshop on IDSR hosted by UNFPA. MDSR was a featured presentation at this meeting. ASH along with WHO/AFRO is developing case studies for Burkina Faso, Malawi and Rwanda on MDSR.

Key Partners: CDC, WHO/AFRO, USAID/GH, UNICEF, TB Alliance

Project Funding to Date: \$2,309,600 (TB); Other ID (\$115,000) for IDSR

Regional Level: ASH made positive contributions to raising awareness about pediatric TB as an important childhood illness through its support of the first Regional Childhood TB Meeting (Johannesburg, April 2015) and by collecting country-level data on current policy and practice. In particular, the meeting galvanized the Africa region into action in this area. The TB chapter for the WHO book was praised by WHO/AFRO. ASH is credited with organizing a pediatric TB framework and a landscape analysis that surveyed DRC, Nigeria, Zimbabwe, Mozambique, Ethiopia, Tanzania, South African Uganda, Zambia, Kenya Malawi and Botswana and reviewed guidelines for children, as well as drafting the USAID TB videos and posters at the Childhood TB meeting in May 2015.

- **Results:** WHO/AFRO is preparing a childhood TB action plan. The conference was attended by more than 100 representatives from 23 countries, representing MOHs, implementing partners, African universities, WHO/AFRO and WHO/Geneva. USAID/GH has noted that ASH was instrumental in elevating this issue, generating the intellectual materials and synthesizing the evidence.

Malaria

Highlights: For the PMI, in November 2013 ASH completed a performance review of the WHO sub-regional networks implemented through Roll-Back Malaria (RBM), designed to facilitate partner coordination across countries and regions for malaria prevention and control. The RBM sub-regional networks were financed by the Global Fund. ASH also performed an external evaluation of the Indoor Residual Spraying (IRS) Program in Tanzania and IPTp in facilities in Uganda and Malawi.

Key Partners: PMI, WHO/AFRO, USAID missions in Uganda, Tanzania, Nigeria and Malawi

Project Funding to Date: \$541,317 for regional activities and \$196,593 for USAID/Tanzania

Regional Level: The ASH project focusses on activities aligned with core PMI interventions, including aspects of malaria in pregnancy, diagnosis and treatment, and community case management. The RBM study provided recommendations to WHO about ways to improve the performance and technical assistance provided by RBM. The IPTp facility study, while not yet complete, generated results in Uganda and a quality assurance and management tool that can be adapted to other PMI countries to increase IPTp coverage. The facility assessment is also taking place in Nigeria. ASH has also launched a community-based study to document the associated costs, the lessons learned and best practices for

overcoming any the financial, non-financial and systems barriers impacting the underutilization of integrated community case management of malaria in Malawi.²³

- **Results:** WHO/AFRO reports that the RBM evaluation is being used by the RBM Board as a decision-making tool. The Uganda facility assessment generated a tool that is being used in the facility study in Nigeria and may be used elsewhere, and it pointed to the practical considerations involved in improving coverage of IPTp. The integrated community case management (iCCM) study will yield first-of-its-kind, cross-country data to encourage governments, donors and NGOs to put more effort into developing solutions to reduce underuse of iCCM services and boost demand creation by those most in need.

The ASH evaluation of the RBM sub-regional networks is being used by the RBM Board as a tool for organizational decisions.

(An RBM Board Member)

Country Level: The IRS mid-term evaluation in Tanzania identified key lessons learned from this national program that is in the vanguard of IRS programming in the region, to inform the second phase of the project and assess the various approaches used by the Tanzania Vector Control Scale-up Project to determine what is working, the progress on capacity building, environmental compliance, cost savings impact on entomology and epidemiology and attention to insecticide resistance.

- **Results:** The mid-term evaluation pointed to considerable progress toward meeting reductions in malaria transmission in the IRS areas, reduced malaria morbidity in these areas, increases in geographic coverage and strengthened local capacity of the National Malaria Control Program and the Zanzibar Malaria Control Project and a sustainability plan for Zanzibar.

ASH Contributions: ASH has proven to be a useful independent assessment mechanism for some PMI malaria activities, including operations research that requires cross-country comparisons. The IPTp study may generate a useful regional tool if adopted and used in countries by PMI, and the iCCM study may yield lessons learned to be used by policymakers and public and private and NGO providers on how to address barriers to demand creation for malaria case management. These studies will be completed by the end of 2015.

Monitoring and Evaluation

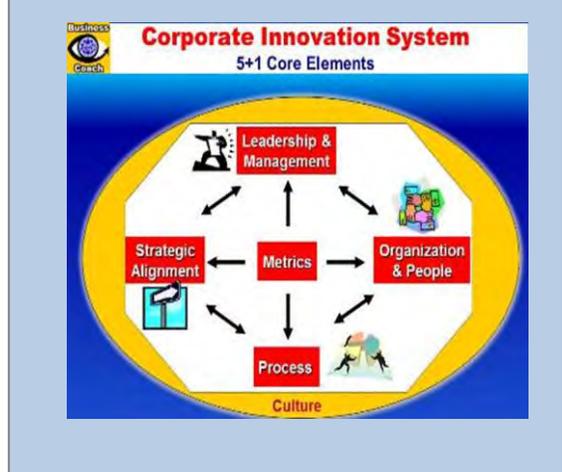
ASH has done three independent evaluations: a review of WHO's RBM sub-regional networks, the Tanzania IRS program, and the mid-term review of the USAID grant to WHO/AFRO.

Question 1b: Innovative and creative approaches ASH took to address regional health issues

The ASH project has been a useful mechanism to translate USAID and other stakeholder ideas into action. ASH creatively carved out useful activities and knit them together with larger ongoing activities and programs. The project has not lived up to the Africa Bureau's vision of generating innovation. One reason is the original design, which was very linear, did not focus on developing leadership and management—as this is function carried out by GH through the Leadership, Management and Governance Project (LMG)—required rapid research, and did not allocate funds for testing. For example, Apple, long considered one of the most innovative companies in America, has a corporate innovation model built on leadership and management (see Figure 1 below). While ASH did not follow the Apple paradigm, it has played an important behind-the-scenes role in the success of some region-wide initiatives such as the development of the African Health Stats web site (linked to AU's CARMMA initiative) and framing information to advance pediatric TB national action-plans. The number of discrete

²³ ASH Year Four Work-Plan

Figure 1. Apple's Innoversity: Apple Innovation Web site



ASH activities (133) and the budget levels for each activity, however, have meant that ASH has largely done rapid analysis and translated this knowledge into useful products. The project has not had funding to scale up new ideas or to pursue innovative new partnerships with the private sector or other donors, such as those that came up at the joint AfDB/USAID innovation and technology conference. Only 5 percent of respondents believed ASH was responsible for any technical innovation or had demonstrated technical leadership on a given subject.

The above notwithstanding, the ASH mechanism is a unique cross-sectoral, cross-cutting contract that has helped the Africa Bureau and some areas of Global Health and Urban Planning to focus on cross-cutting problems that may otherwise have not been addressed by USAID, and to have a dialogue with nontraditional health partners such as power

companies, broadband and mobile software solutions companies. ASH is small, flexible and primarily funded with core funds but able to take mission field support buy-ins, and it is able to subcontract with local firms and local consultants. As one key informant from the Global Bureau noted, "Having the ability to work more broadly and not narrowly focused is very useful." This ability to focus on basic costing of health care financing approaches, and funding behind-the-scenes work to organize some key pediatric TB events are two examples cited of ASH filling mission and region-wide needs.

Within USAID there is no other pan-Africa health contract that can address the full gamut of health problems with a variety of USAID funding streams. Several key informants for this evaluation cited this as the main reason that ASH was needed and was creative, and 30 percent of respondents interviewed for this report cited ASH's technical support and ability as a procurement mechanism to flexibly work on a key problem to be some of the main contributions of ASH for USAID and participating organizations. WHO/AFRO, which has a five-year large grant with the Africa Bureau, is the only other Africa Bureau cross-cutting mechanism, and that mechanism is primarily used to staff key regional initiatives such as IDSR and vaccine development.

The evaluation team confirmed the continuing need for the Africa Bureau's regional approach to identifying and solving problems in the health sector and the push to innovate closely follows concepts for innovative management and problem solving followed by companies such as Apple (depicted in Figure 2). The ASH mechanism is not duplicative of the work of the Global Health Bureau, but its activities are closely coordinated with those of the Global Health Bureau. Interviews with WHO/AFRO and Global health confirmed good collaboration on RMNCH, HIV and maternal mortality, health care financing studies and mHealth. ASH is a vehicle to translate the Africa Bureau's well thought-through and vetted ideas into tangible work products. Twenty-five percent

Figure 2. APPLE's Innoversity: Guiding Principles



of respondents believe that the main contributions of ASH are its overall ability to provide technical and management support services to AFR/SD/HT and partners.

Seven ASH activities, out of the 50 analyzed in detail by the evaluation team from the total of 133, have achieved potential regional health outcomes by Year 4. The project's inputs were small, ranging in size from \$190,000 to \$300,000. Some of the activities had multiple years of funding, such as the KSPH and IDSR, but most did not. ASH provided short-term technical assistance that complemented either other donor or other USAID external funding. Of note, all of these activities were requested by the institutions and were part of their own institutional plan. Some of these activities benefited from an existing MSH country office presence in the country to provide logistics support to the ASH project, identify short-term consultants and schedule key meetings to permit rapid ASH start-up in-country. (See Annex VII for a list of the 50 projects and those that have generated impact.) Two of the six activities identified by the evaluation team as having regional results, Uganda and South Africa, have MSH country offices.

Several USAID missions noted that ASH analytic work, including the work with the KSPH, the analysis of the cost effectiveness of health care financing options in Uganda, the private sector assessment in Rwanda and the mHealth assessment in Angola, are key reports²⁴ shaping USAID and host country planning and activities.

An ASH project strength has been its ability to flexibly explore many under-researched topics of relevance to the Africa Bureau, the State Department and some key local institutions. It has been a rapid-response mechanism for some missions and USAID/W for short-term technical assistance to evaluate or assess key time-sensitive questions. Interviews indicated that mission field support buy-in tasks were among the most highly regarded by partners and USAID missions. WHO/AFRO has worked with ASH to rapidly develop country-specific childhood TB profiles for a key technical and policy meeting that galvanized support for childhood TB programming. These ASH assessments usually just touch the surface of a given topic, help to signal its importance and reinforce the findings through general dissemination from the research, publication on the web site, or a meeting or conference.

On just a very few topics, including SADC HIV work, the AU's CARMMA work and pediatric TB with WHO/AFR and other partners, the project has clearly committed the financing and the level of effort of ASH staff to carry out an initial advocacy and policy development agenda on the topic and then subsequent or related institutional capacity development with African institutions. Members of the original USAID ASH design project launch teams have indicated that this three-pronged process from idea generation to institution building was the stated intention of the project.

The ASH project team has worked well behind the scenes and supported USAID branding. Partners identify ASH work as USAID Africa Bureau contributions to programs.

The project has also carried out some highly successful, well-attended conferences across a range of health sector issues. The "Call to Action" conference hosted by WHO/AFRO and led by the Ministry of Health of Ethiopia used the ASH team to develop the conference agenda, handle the complicated logistics and deliver the conference synthesis report. The African Evaluation Association (AfrEA) conference, with ASH support, highlighted the health sector for African evaluation organizations and is now about to issue a publication to its members on health sector programs and their results. These are

²⁴ Of these reports, AFR/SD/HT confirmed that the Angola mHealth report, Rwanda private sector engagement report and the IPTp facility assessment report were still in draft awaiting USAID mission approval (E-mail, Hall/Brown, dated August 5, 2015.).

both good examples of ways the ASH project has been used to disseminate information across regional African audiences.

Another way the ASH project has been used creatively to support or shape regional thinking is by doing independent evaluations. The RBM evaluation, according to a board member interviewed for this report has provided the board with key management recommendations to make necessary organizational changes of the RBM sub-regional networks.

The project has produced many beneficial and highly valued products that USAID, other partners and beneficiaries are using. These tools and ASH technical assistance have begun to produce tangible results beyond the information dissemination phase. These include the mHealth compendium series and subsequent conferences and technical assistance, the published studies on maternal mortality and HIV, the FP and childhood TB country reports, the West African urban corridor study and the HIV and maternal death publications. According to the mission staff interviewed for this report, the special assessments and evaluations that the ASH team have done in Uganda and Rwanda are studies being used by those two governments to make major health policy and investment decisions that are anticipated over the coming year. The ASH short-term technical assistance provided to KSPH and WHO/AFRO, CDC, IDSR and AFR/SD/HT on evaluations, country reports, conference logistics and technical background work, meeting follow-up and advisory services on key topics have also been highly valued by multiple key informants.

A key tenet of ASH is that its activities have complemented both USAID bilateral and centrally funded projects. ASH has partnered with some African institutions for consensus building and action (SADC, AU, several African universities and ministries of health in Uganda and Angola) and have done some institutional strengthening work with KSPH. The ministries of health in Malawi and Ethiopia were both unclear as to the ASH project's specific contributions to their work, and no other ministries of health were contacted or identified as key informants. Because the ASH work is small compared to other externally financed programs, an across-the-board comment by many partners interviewed for this evaluation is that ASH work is not branded as a project and, therefore, many do not understand that ASH is a special USAID Africa Bureau project. Limited marketing of the project by both the contract team and AFR/SD/HT to partners and few highly specialized recognized technical experts may have contributed to ASH's low profile.

In terms of limitations of the ASH project's approach, because it is small and highly targeted on a given idea or product and does not have funds to replicate or demonstrate proof of concept for every idea, the project has rarely taken a topic and fully disseminated this knowledge through a cohesive advocacy or communications agenda.

In general, the project's approach to research has been fairly descriptive, with an emphasis on landscape analyses. The project has not used mixed-method research approaches. Another limitation of this approach to regional health issues is that, as currently designed, there are no funds allocated to pilot an approach or tool. WHO/AFRO respondents to this evaluation noted the selection of research topics and the full range of ASH activities have not been closely coordinated with WHO/AFRO. One way AFR/SD/HT can leverage more external partner and WHO/AFRO participation in studies is to fund some ideas that are WHO/AFRO regional priorities.

Overall, dissemination of project products has been fairly limited thus far and lacks planning and specific targets. The evaluation team raised this with respondents and found a high percentage, including in USAID/W, who did not have ASH materials. This fact was confirmed at WHO/AFRO. As reported to the evaluation team by the USAID COR, and confirmed in a meeting with the ASH team in Arlington, Virginia in July 2015, ASH has only begun in June 2015 to track data on the number of hits on its web site. By the end of June to present, there have been 1,618 unique ASH web site page views, of which 20 percent were to the "resources" landing page and 10 percent were to the mHealth database. ASH

reports that the fifth volume of the mHealth compendium reached 500 contacts, and 50 of those requested follow-up links to access additional information. ASH uses e-mail lists and the CORE organization's contact list to 670 non-governmental organizations to disseminate project information. Tracking who is using the information and how they are using it should be an important priority to be carried out in Year 5. ASH is using some web-based colorful postcards in French and English to notify users of new materials such as the urban health study.

The project does not yet have an effective communications, dissemination or advocacy plan for each activity linked to a specific policy change. The project has used a variety of approaches to present new knowledge, including technical briefs, policy briefs, factsheets, country posters and peer-reviewed journal articles. The sheer number of products and their diverse target audiences has been one factor complicating the dissemination process. The ASH team noted that dissemination will be a key priority in Year 5 of the project.

The overall number of participating African institutions in multiyear programming through ASH was relatively small—seven institutions, including SADC, KSPH, Makerere, AU, AfrEA, MOH Malawi and the MOH in Ethiopia—as was the size of each activity, ranging from \$190,000 to \$400,000. The USAID target for the number of African institutions and networks participating in ASH-supported capacity building over the five years is 10.

The project has surpassed the USAID target of seven set for the number of south-to-south information exchanges opportunities, due to the number of regional conferences and meetings it has supported both in-person and virtually. Eight such exchanges have taken place by the end of Year Four. All of these south-to-south activities represent USAID's contribution to larger region-wide advocacy initiatives, such as the AGOA conference, the pediatric TB meeting hosted by WHO/AFRO that included 100 representatives from 23 countries, and the USAID- and UNICEF-led African Leadership for Child Survival meeting.

While the quality of the data gathered on key research questions is considered by respondents to be high, the rapid approach to data collection is fairly uniform and does not involve mixed research methods to enhance the validity of findings.

In the area of M&E, due to a shortage of funds during the project's first year and a rethinking about project priorities, the project eliminated funding for training by Khulisa for African institutions to carry out M&E. The evaluation team believes that this was a missed opportunity for African institution building.

Lessons learned from ASH's efforts to strengthen regional institutions and in the process, to improve country programs as a result of work with those institutions

There are many important lessons learned from the ASH experience. First and foremost is that institution-building requires sustained funding and is difficult to accomplish through one or two activities. ASH, similar to the predecessor Africa 2010 project, has attempted to do too many and too diverse a range of assignments. There were no seed funds provided to follow up on or scale up a good idea or to launch an operations research project or pilot a service delivery approach. Many respondents indicated that the project should narrow its focus and concentrate on fewer topics. From the outset, by design, the project lacked a core set of partners in the region and looked for opportunities to fit in and make a difference. This approach took time.

The project worked best with institutions when it was able to carry out work within the context of the organization's plan or mission on a task that was already defined. In the case of the Africa Union, this was the creation of an innovative database that helped it to synthesize information about countries with contextual analysis that strengthened its advocacy work. The work with KSPH on strengthening specific financial systems and reports was a specific organizational priority and advanced the USAID bilateral

funding objectives. Another way that ASH worked well with African organizations was to be given vetted ideas by USAID and then to execute to that vision. ASH work on childhood TB was to take place within the context of a WHO/AFRO, Stop TB, and USAID partnership to synthesize information on this subject into a landscape analysis and then to prepare insightful and useful country reports, which policymakers and host country technical teams used as the basis for country-specific action plans. This required USAID coordination by AFR/SD/HT across bureaus, ASH technical assistance and follow-through and close work with donors and other partners.

Another lesson learned is that information dissemination has to be intentional, planned and funded. An understanding should be spelled out upfront regarding who will use products and their intended impact on changes in policy and investment decisions. The advocacy strategy for the project submitted in August 2012 was not carried out as planned. While the strategy points to a Policy Pie²⁵ from the knowledge toolkit, going from “know to do,” in practice the project has not systematically followed this approach to advocacy, communication and dissemination (ACD). There has also been ACD staff turnover.

In terms of reaching the project’s three IRs, 72 percent of the 50 activities analyzed for this report were designed to achieve IR 1 (expanding the body of knowledge or current trends, constraints and solutions to improve health), 22 percent were used for IR 2 (advocacy and communications), and only 16 percent went toward IR 3 (strengthening African institutions).

Table 1. ASH Activities by Intermediate Result

IR	Frequency	Percent
IR 1	36	72%
IR 2	11	22%
IR 3	8	16%
IR 1 & IR 2	7	13%
IR 2 & IR 3	4	7%
Total	55	100%

Of the 11 activities supporting IR 2, seven are also strongly linked to IR 1, and activities were closely aligned with IR 3. A relatively small number of activities (11) focused on more than one IR, which was the original intention of the project. In terms of technical areas, 56 percent of ASH activities were dedicated to the area of MNCH, 18 percent to HSS, 8 percent ID and 10 percent in CC/CS.

²⁵ ASH Advocacy Communications and Dissemination (ACD) Strategy. August 2012. p.7.

Table 2. ASH Activities by Technical Area

Technical Area	Frequency	Percent
MNCH	28	56%
ID	8	16%
HSS	9	18%
CC/CS	5	10%
Total	50	100%

Eight of the 33 USAID respondents (24 percent) contacted for this evaluation suggested that it was unrealistic for a project based in Washington, with a team of general public health specialists, to assume that institution strengthening could be effectively carried out. For example, there are no malaria experts on the ASH team, and a high level of technical expertise in malaria can be readily obtained by African institutions through other USAID implementing partners and WHO. Ideas to obtain better institution building out of this type of mechanism that came out of the interviews were pre-selecting some African institutions and then embedding technical assistance, or co-locating regional technical assistance in places of importance such as the African Union or WHO/AFRO or within a USAID Regional Office (REDSO/WA). Several people noted that “idea generation should take place in the field,” and the locus of new ideas comes from countries and regional institutions. Another observation was that the strongest need of regional institutions is short-term technical assistance to help them frame these ideas and fund their research, dissemination and adoption. WHO/AFRO, for example, has formulated clear research agendas for all of the technical clusters interviewed for this evaluation. Reaching out earlier to WHO/AFRO to operationalize some of these ideas may have led to greater leveraging of the ASH findings and more coordinated and systematic dissemination of findings and use by host countries.

Another key lesson learned from the ASH experience is that in order for new ideas to be readily adopted by African organizations, advocacy approaches need to be much more sophisticated, well-articulated and differentiated. This requires a high level of competence in political advocacy, something that the ASH project does not presently have but that other organizations such as WHO/AFRO have in their organization. Lobbying, more face-to-face dialogue with heads of organizations, meetings, conferences, new articles, media, letters, mailers, electronic blasts of information and some outreach to community organizations are required to move a high number of ideas from a nascent phase into action plans and actual services or operations. ASH as currently designed did not allocate funds for any given topic that would permit it to engage in higher intensity advocacy. A key lesson learned from the ASH experience is that having political partners such as the AU and the regional African bodies such as ECOWAS on board and involved in the topic is as important as having the right public health specialists involved in studying and analysis of problems.

ASH Impact on Stakeholders:

Overall, 48 percent of respondents said that ASH performance and results were good to excellent, and 75 percent found something of positive value in this project. A question related to customer satisfaction and use of ASH products was raised with all 64 respondents interviewed. (See the interview guides in Annex V.) Twenty-five percent said ASH had done a good job and its work was highly valued, 30 percent said its work was good to above average, and 9 percent said that it was of no value. Of the 64 people interviewed, only 17 percent had in-depth knowledge of the entire gamut of ASH work, while 60 percent had a good working knowledge of ASH work in a specific technical area. Those who knew ASH’s work in IDSR, pediatric TB, and health care financing were very pleased with the work and believed it made a difference. Not surprisingly, USAID missions that had contracted for a well thought-through scope of work were pleased with the work. The WHO/AFRO HHA work on the landscape

analysis was valued; however, this was just one contribution to a large interagency program, so the ASH contribution did not galvanize new support or investment. ASH work in IDSR was a noted exception. ASH assistance in IDSR follows on a long series of USAID Africa Bureau-supported partnership work through predecessor projects. In this context, ASH work was viewed as invaluable and ASH was a trusted, consistent partner.

The mHealth compendium and updates were the top-rated ASH products. Many missions are using it to identify new approaches and applications for mobile banking, disease surveillance, and patient retention and case management. The product and the subject were disseminated to USAID Africa Bureau health officers at a regional conference. Since that time, some missions such as Angola have commissioned their own in-country analysis by ASH. The one private sector organization interviewed that was involved with mHealth noted that it used the mHealth compendium but did not view ASH as the leading experts in the field.

In terms of the best features of ASH, key stakeholders noted that the best feature was the mechanism's ability to take field support buy-ins for missions. Another 27 percent noted that the flexibility and versatility of the mechanism was an important feature.

ASH studies on community case management of malaria in pregnant women and prevention may prove to be widely used by USAID health officers and other technical stakeholders like WHO/AFRO. Specific information dissemination plans need to be put in place. A general finding across the project is that in order to get out the project's most innovative work products, more work is needed on targeted dissemination to stakeholders with specific messages about why the work is important and how it can be used or is in use. Program managers at key stakeholder organizations have a plethora of knowledge and information to deal with each day, particularly in light of the fast-paced and changing landscape in Africa. Well thought-through dissemination work needs to be as carefully planned as the research and should be built into each activity.

Involving key stakeholders and partners in work planning is one way to ensure better collaboration and use of project products. In the areas of childhood TB and IDSR, ideas and tasks were vetted and then assigned to ASH. The stakeholders were pleased with the products. The evaluation team found that the subcontractors were not systematically involved in work planning, nor was WHO/AFRO. It was therefore not surprising that they were unaware of the full gamut of ASH work or its utility. Thirty percent of respondents were unable to comment on ASH technical leadership. In general, capping the number of discreet activities might help to streamline the flow of information to stakeholders.

QUESTION 2: TO WHAT EXTENT HAS THE ASH PROJECT MET THE MANAGEMENT REQUIREMENTS AND FUNCTIONS OUTLINED IN THE CONTRACT, INCLUDING PLANS, ALLOCATION OF FUNDS, COORDINATION AND USE OF SUB-AGREEMENTS AND STAFFING REQUIREMENTS?

This section of the report reviews the ASH project's management requirements, including how the project plans its agenda and aligns funds, financial performance, the project's technical leadership including agenda-setting by the prime contractor, internal project management including the use of sub-agreements, and staffing. Additional information is offered on USAID technical oversight, the project's design, and performance tracking tools for deliverables, activities and outputs.

Contract Management Requirements and Functions:

ASH Planning: ASH has fulfilled the management requirements and functions outlined in the contract. Formal planning for ASH activities is articulated in the annual work plans. While ASH developed and submitted its first year work plan on schedule, due to staff turnover in the AFR/SD/HT team and

concerns about the quality and strategic focus of this plan it took nearly a year for the Africa Bureau to approve the first year work plan. During the first year of the project, some (3-4) activities were launched but not completed at the request of the Africa Bureau, such as the oral rehydration and zinc study, when new evidence from the field was presented that certain studies were not necessary. USAID was also faced with new Agency-wide priorities such as the Global Health Initiative, which was launched in 2012 after the award of the ASH project. From the outset, the contract and original design did not identify important unanswered regional questions for the contractor to address. The process of determining these questions and areas took time.

During Year 1 and in subsequent years, the ASH team was used extensively by AFR/SD/HT to respond to time-sensitive events and actions in addition to maintaining and accelerating knowledge gathering and plans for new ideas. The second year's work plan also took time to develop and required several drafts and discussions before obtaining a document with the strategic focus that USAID sought. This plan was approved by USAID in March 2013.

The ASH contract calls for USAID to provide technical oversight to guide the contract, while the contractor is tasked with providing the technical expertise to identify new ideas and plan the technical agenda. A technical working group set up by AFR/SD/HT along thematic lines at the project's launch (malaria, HIV, MNCH, HSS and cross-cutting questions) generates and vets programmatic ideas. The original project design called for the contract team to serve as more of a think tank that would be the incubator of ideas and new directions to lead the AFR/SD/HT investments. These core teams include USAID core staff and the ASH technical team member. The core teams' role is to jointly plan and discuss ideas and funding. At the end of the year, the efficiency of the technical working groups is assessed by the core team members; this includes the use of anonymous survey tools to solicit real-time data and opinions on team and project performance.

In practice, many of the new ideas and directions for the project are emanating directly from the AFR/SD/HT activity managers with AFR/SD/HT taking the lead in vetting the ideas within USAID and ASH fleshing out the ideas and developing them into activity letters of agreement. The challenge in planning the activities is that ASH is by design a cross-cutting mechanism. This is as one USAID manager noted, "a strength and a project weakness" because the project has to very flexibly work across many subject areas and multiple funding streams. The project has 133 activity agreements in place. The letters are approved by the COR and contain information on the proposed intervention, duration of the activity, the funds allocated for the activity, and the accounts from which the funds are drawn (e.g., malaria, HIV). In Year Four, USAID moved to streamline the approval process and consolidate all planned inputs under an activity unto a single activity letter. This system has worked well and provides USAID and the ASH team with a record of the agreements made. Given the wide spectrum of activities across five health areas, the letters also permit the ASH team to categorize and document which IR the activity fulfills.

ASH Project Design: The ASH project was designed in 2011 as follow-on to the predecessor Africa 2010 project. Its aim was to assist USAID/AFR's health sector work with African institutions and other development partners within the U.S. Government to provide a strategic vision for guiding health investments to further the health of Africans. This largely core-funded mechanism was intended to complement activities undertaken by the implementing entities supported by the USAID pillar bureaus and USAID bilateral projects in Africa. The contract provides for extensive short-term technical assistance by the prime contractor, subcontractors and outside consultants to study and evaluate new or emerging health problems, to translate this knowledge into action through advocacy and communication plans, and to convene and organize conferences and key technical and policy meetings to support specific institutional capacity building and advance the project's technical agenda. As one project manager noted, "ASH has a big scope for a small project." Another noted that ASH is the AFR/SD/HT's

“bilateral.” One of the most attractive features of the current ASH project is its ability to address immediate situations. It can convene events and also identify new issues on the horizon.

To some extent, the number of activities in any particular thematic area relates to the amount of unduplicated assistance required by the Africa Bureau in the strategic area. A second key factor reported by the Global Health and AFR/SD team members interviewed for this evaluation is that some AFR/SD/HT activity managers generated more ideas and secured more ASH core funding, mission and GH buy-ins. A third factor related to idea and activity development is the expertise and leadership provided by the ASH technical team member. The external evaluation team found that the top-ranked ASH technical team members were the ID team lead, the HSS strengthening team members—including the health care financing team, the mHealth and IT expert, the HIV team leader, and the senior finance advisor. The strategic teams with the strongest ASH technical team members correlate to the highest number and achievement of activities.

Internal Project Management: The project received continuous management oversight, albeit by three different CORs from its inception to Year 3. Nevertheless, depending on the COR, the emphasis shifted somewhat, with more emphasis on new knowledge development by the original COR and greater emphasis on project results and the dissemination of these ideas, field support buy-ins, and greater coordination with the Global Health Bureau from subsequent AID managers. The change in staff did result somewhat in a deviation from the original design, from a balance of work on new knowledge generation, advocacy and communication, and institution building, to a largely idea-generating mechanism with some moderate amount of short-term institution building and some very targeted advocacy work on a few projects (urban corridor, the AU, AGOA and mHealth, AGOA and emerging infections, FP and equity, pediatric TB, and SADC HIV/AIDS services regional norms and standards).

There are regular bi-weekly COR meetings, quarterly meetings, annual reviews and reports by the contractor. Contractually mandated strategic technical team meetings and annual core team technical reviews are held and well documented. Coordination with USAID’s Global Health teams also takes place on a regular basis depending on the subject matter. For example, the GH-led HSS team was reported to meet biweekly.

The project has made good use of electronic tools to enhance and solicit objective performance feedback and to strengthen team performance. Two anonymized surveys carried out through Survey Monkey in January and November 2014 provided real-time feedback to the entire USAID and ASH contract team on the quality of products, their timeliness, contractor staffing and the regularity and consistency of strategic activity team meetings between AFR/SD/HT and the ASH technical teams. The surveys also highlighted the most highly regarded and useful products and studies for USAID generated by the project, including the mHealth compendia, SADC HIV norms, the maternal mortality in HIV publications, pediatric TB plans, work with the African Union’s consolidated and streamlined maternal mortality and child survival database, the post-partum hemorrhage and use of misoprostol study, and the urban health monographs. The surveys also pointed out areas for contractor improvement, such as the need for more innovative design formats for materials, the need for study results to be shorter, more concise and easily digestible and the need for more development of tools for country use. These surveys and feedback were particularly useful as the ASH project works with more than six activity managers and up to seven bilateral mission team managers at any given time across a wide spectrum of health subject matter and countries across Africa. The evaluation team found evidence that over the course of the four years of the project, the contract team was highly responsive to USAID needs through staff changes and continuous dialogue with the Africa Bureau about work products, and it strove to meet USAID performance expectations.

The project is currently structured in a manner that necessitates a number of approvals before ASH can proceed with work. The number of approvals depends on the technical cluster. For example, in the area

of maternal health and HIV, approvals would come from both the AFR/SD/HT MNCH and HIV activity managers and the GH maternal health and HIV technical focal points. The disadvantage is that this approach takes time. The advantage is that it helps to ensure Agency-wide buy-in for the work product or research. The ASH team reports that they were advised not to liaise directly with other USAID offices and other WHO/AFRO clusters. This may have impeded timely information dissemination between these organizations. In the case of field research that entails human subjects, internal review board (IRB) host country ministry of health approvals have also delayed studies, for example the SMS study in Uganda and the IPTp study in Malawi.

Ninety-nine signed COR letters are on file, which require clearance by activity managers, other technical team members and the COR. The evaluation team sampled four of the letters from the early and later periods of the project and reviewed the June 23, 2015 COR tracker. Currently, these COR activity letters document the period of performance of the activity and provide an overview of the project, the scope of work, the budget and the funding. The letters have been adapted over time and currently contain highly useful and more strategic information for reports and accountability. According to the ASH team, the average approval time for these letters, however, can run anywhere from one month to several months, depending on how developed the idea is at the time of submission, the clearance process for that technical area, and the activity manager. The misoprostol study has taken almost one year to move from an idea to the field due to the need to obtain extensive host country approvals, while the Ebola Technical Brief went from idea to product in two months. In the case of some of the policy work in the field using core funds, this has contributed to delays in meeting targets.

A key weakness of the internal project management system—which is a result of a weak USAID PMP at the time of the design that emphasized uniquely process outputs—is that neither USAID nor the ASH team set usage or distribution targets for any of the ASH products. In Year 3, USAID worked closely with the ASH team to strengthen the ACD strategy, which included an ACD plan for each activity. The November 2014 Monitoring and Evaluation Plan, produced by the ASH contract team three years into the project, lays out the correct assumptions and theory of change that a better understanding of key trends of health issues will translate to evidence-based planning and implementation of solutions, and the evidence and guidelines from ASH products are used by decisionmakers, program managers and/or health care workers. This last step, gathering data on the use of project-generated materials, publications and other work, has not yet been done but should be done in Year 5 before the project's conclusion. The project has not assembled data on the percentage of users who report that knowledge gained from an ASH publication or activity has been used, and there is no documentation on ways the project's consensus-building activities have contributed to changes in African policies, programs or approaches. Hence, the evaluation team has found it difficult to ascertain the exact impact of the ASH project's products and their changes in health outcomes. Where data exist, the evaluators have noted key ASH contributions throughout this report.

The decision to delete an organizational development position and forego capacity assessments makes it difficult to attach a causal link between the work ASH supported at a given institution and improved operations at that institution. Nevertheless, the evaluation team has used qualitative information to document institution-strengthening results.

Financial Performance: At the time of this external evaluation, 46 months into the project, the project has received \$13,722,620 million from USAID from all sources of the \$19,984,075 originally budgeted. Of this amount, MSH has expended \$10,751,551 or 68 percent of the resources obligated. The monthly burn rate during the period September 2012-March 2015 was \$271,861 and has been consistent since the project's launch.²⁶

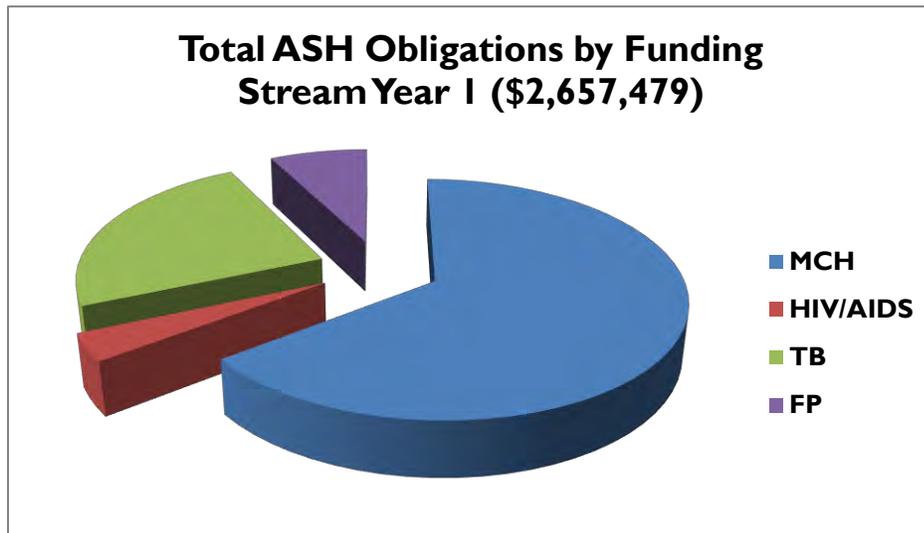
²⁶ E-mail, T. Hall to B. Brown, dated July 21, 2015.

From the outset, the Africa Bureau’s funding for this contract was below the planned contract award levels. The first year of funding was over \$1.3 million, or 33 percent, below the planned level. A letter to MSH from the USAID Contracting Officer concerning the budget shortfall advised MSH to make downward adjustments in the budget²⁷ and to make the necessary changes, including suggestions for some staffing changes. Increased funding was received in Years 2 and 3, but Years 3 and 4 have continued to lag behind the planned levels in the contract at a time when the number of activities peaked. (See Annex X for ASH Funding Obligations by year.)

The funding shortfall in the first year required MSH to make big changes and adjust every element of the operation, as costs had to be cut in all areas. MSH reduced the number of activities, reduced most of the key staff time to 80 percent time (less than full time), reduced the size and scope of the subcontractors, and limited travel, especially overseas. In order to retain the key personnel, MSH allocated the 20 percent time of some key staff to other MSH assignments. In consultation with the Africa Bureau, the ASH team during Year 1 opted to retain the full complement of technical staff that USAID requested in the request for proposal and outlined in the contract. While the subcontracts were put in place with the three African subcontractors in Year 1 as planned, the budget shortfall, combined with a change in the Africa Bureau’s short-term technical assistance requirements, led to a reduction in the budgets for all of the subcontractors, including their travel within the region. Khulisa’s budget, for example, went down by 37 percent, and its original scope of work to strengthen the M&E capacity of African institutions was modified. Despite the variation in funding from the contract award, the project has managed to generate a pipeline of obligated funds available for the fifth year of approximately \$2.057 million. An additional Year 5 obligation of \$1.107 million is now planned.

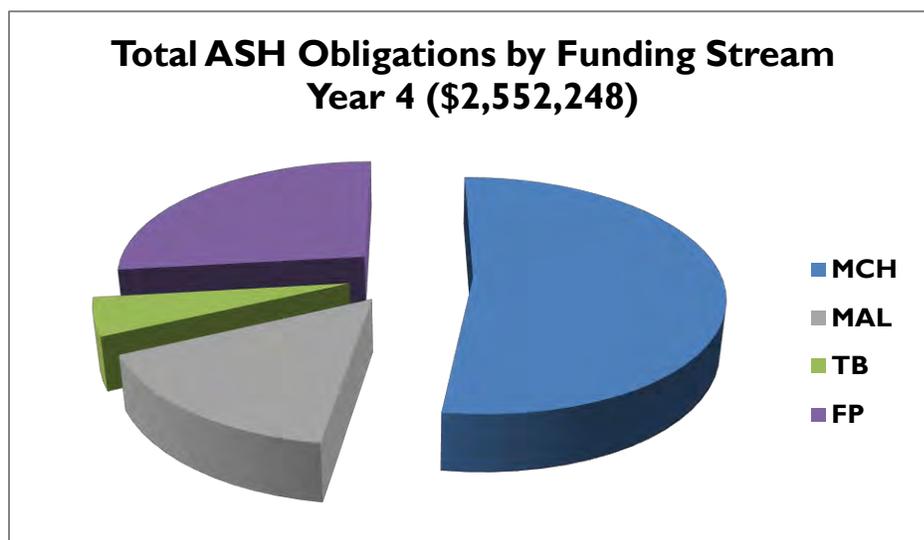
Core funds from four Agency programs earmarked in the Agency’s child survival account contributed to the project at the time of the initial award, with MCH funding accounting for 64 percent of funding in Year 1 and 52 percent in Year 4. Malaria funding began during the end of the project’s second year. The breakdown of funding by account in Years 1 and 4 follows.

Figure 3. Total ASH Obligations by Funding Stream: Year 1



²⁷ USAID Mudd/Bolton letter, dated January 17, 2012.

Figure 4. Total ASH Obligations by Funding Stream: Year 4



By Year 2, the ASH Project's End of Second Year Report submitted in December 2013 noted that 72 percent of the funding went to IR 1, (knowledge); 12 percent to IR 2 (advocacy), and 16 percent to IR 3 (African institution strengthening). This disproportionate skewing of funding in favor of IR 1 continued throughout the four years of project funding and is indicative of the weight that the USAID management team placed on these activities and the contractor's comparative advantage in carrying out these types of activities.

Leveraged Funding: There are seven examples of leveraged funding, or opportunities resulting directly from ASH project work and partnerships framed by USAID missions or other donors. One area of the project that has not been quantified is how much funding the ASH project has been able to leverage from African domestic health funding streams.

- ASH worked closely with DFID and its contractor to build a database, software and analysis tools for the CARMMA initiative. While AusAID donated \$92,250 to the Africa Union, ASH was the well-regarded technical lead for M&E and provided all the expertise on data and validation processes for an interactive web-based platform on health information for policymakers in 54 AU member states. ASH also developed MNCH policy briefs for AU use and helped the AU finalize the 2012 and 2014 reports on MNCH status to the African Ministries of Health, which lead the way for better regional priority setting for MNCH by the African Heads of State.
- ASH work with SADC on the regional norms and standards was a shared level of effort partnership in which the Africa Bureau Activity Manager for HIV/AIDS paired an ASH staff member with the USAID regional mission-funded Building Local Capacity for HIV Service Delivery project and the Global Fund-supported cross-border health posts. ASH was available to fill a need for technical input that lead to the preparation of the SADC norms and standards.
- ASH work on mHealth disseminated in Malawi to health officers influenced the USAID/Madagascar bilateral project to carry out a mHealth country assessment similar to what had been done by USAID/Angola with ASH support. USAID is funding mHealth work in their bilateral program.
- The joint AfDB/USAID Meeting on Technology and Innovation in which ASH played a key role was the largest and first public/private sector gathering in identified ways to access the Universal Service

Funds to scale up eHealth solutions and explored potential collaboration with Power Africa on power issues.

- The Global Bureau's Urban Planning Unit in the Economic Growth Center provided \$30,000 for the urban health advocacy materials and dissemination. The presentation has been used for a key meeting with ECOWAS members, and it is hoped that this will lead to further funding by regional organizations and ECOWAS member states for urban health services.
- The findings of the ASH Integrated Disease Surveillance Landscape study were shared with the Gates Foundation by the ASH chief of party at the donor's request for possible follow-up Gates Foundation funding. At the time of this report the Gates Foundation had not yet determined whether it would fund additional IDSR work.
- In terms of influencing mission investments in areas that ASH studied, the Angola mission intends to do more work with bilateral funds in mHealth following the ASH mHealth assessment, and the Madagascar mission used its bilateral project to assess mHealth after learning of the work in Angola. The well-received Rwanda Private Sector Assessment that was carried out by ASH at the request of the Government of Rwanda may yield some new directions for USAID bilaterally funded private sector work, and ASH work with KSPH has led to direct funding for the school by the USAID bilateral mission.

Field Support: ASH was designed as an Africa Bureau mechanism with Africa mission field support capacity for fieldwork that would yield region-wide results. The USAID mission field support capacity of the project was not actively promoted during the project's first year by the original COR and Acting Africa Bureau Health Office management team. By 2013, when the COR and the management changed the project actively sought out field support. This was a major shift from the predecessor project, Africa 2010, which did not take field support funds. As of July 2015, seven buy-ins totaling \$2.147 million were received. Interviews with mission staff, field support funded recipients (KSPH, the Ministry of Health in Ethiopia and Makerere University in Uganda) and the Rwanda bilateral mission (private sector study) indicate that the field support funding responded to a need for rapid, high-quality short-term technical assistance. The field support assignments offered USAID the independent assessment of new ideas and the rapid application of some new technologies. Eleven interviews with organizations or WHO/AFRO clusters that benefited from ASH technical assistance in the field underlined that the ASH assistance was highly valued and that lessons learned from one country relevant to others in the sub-region (CBHI and voucher study in Uganda) were being disseminated to neighboring countries. The field support work has also made ASH more relevant to the field's needs and to some key hot-button issues of concern to African host countries, such as the work in Uganda on financing, and the private sector and mHealth work in Rwanda and Angola. In hindsight, the project could have accommodated more field support requests. This may not have proven to be a good tactic, as the project does not anticipate meeting the contract ceiling of \$19.9 million, and several field support requests were turned down.

ASH Staffing: Significant staff turnover at MSH throughout the first two years of the project took place due first to attrition of the technical director to a U.S. Government agency, then a decision by USAID in late 2012/early 2013 that the ASH senior leadership team lacked the strategic focus that USAID sought in this contract. The launch of the ASH project also took place during a period of heavy staff turnover with the AFR/SD/HT team and the issuance of a new Africa Bureau strategy in December 2013. The new AFR/SD/HT worked closely with ASH and MSH leadership team to more closely align the project with the Bureau's strategy that included three development objectives: strengthen ideas, advocacy with key stakeholders and institution building. A new results framework for the project was adopted in 2013.

MSH responded by redeploying two existing ASH team members to the chief of party and technical director positions and supporting the ASH team with additional senior headquarters staff. The evaluation team confirmed that the current ASH leadership team is responsive to USAID needs and direction and that the skills of the leadership team are highly complementary. The evaluation team also

noted that many MSH country office and headquarters staff have been used since 2013 for ASH technical assignments or have served in an advisory capacity on the design of some key studies, for example in health care financing in Uganda. There are also several examples of ways that the MSH country office staff supported ASH information dissemination at the bilateral level, such as in Nigeria, where they have helped to recruit local research consultants, and at regional organizations like ECOWAS and the regional “Call to Action Meeting” in Ethiopia.

However, the staff changes at ASH reported to the evaluation team led to significant delays in defining the scope of work for activities in the maternal and child health area and some delays on the TB and IDSR advocacy strategy, and a delay in implementing the IPTp facility survey in Malawi programs and completion of the elected officials’ paper. Many ASH staff covered more than one technical area. There is evidence that there were also delays on some planned ASH activities as a result of new emerging and competing priorities by the AFR/SD/HT management team during the second year of the project that directed the ASH project toward providing management support to the African Union to host the African Leaders Conference in Ethiopia and the West Africa Region’s Health Office (WAHO) during its regional conference on health information systems (HIS).

By mutual agreement of both AFR/SD/HT and MSH for cost considerations, the full-time organizational development position was deleted. This reduced the team’s overall level of effort for institution strengthening (IR 3). A new mix of skills to meet the challenges in the RMNCH area, advocacy and information dissemination, led to changes in the maternal and child health and advocacy positions. The health systems strengthening team was also replaced following staff attrition.

During this period of staff transition, the AFR/SD/HT activity managers and the full-time COR who took over in March 2013, along with the remaining ASH staff, helped to keep activities on track and to accelerate the completion of tasks. Overall, the replacement in 2013 of the chief of party and appointment by MSH of a both a new chief of party and technical director who were promoted from within the team, as well as closer, more supportive supervision by MSH headquarters and the arrival of a full-time COR, led to greater team “cohesion.” Over time, USAID has expressed through surveys and interviews by this evaluation team that the ASH staff has “improved,” “the project is on track,” “the team has found their voice” and that the staff are “enthusiastic,” more “engaging” and “work more collaboratively” with the pillar bureaus. The staff changes have ultimately led to greater productivity by the end of Year 3 and Year 4, as indicated by the AFR/SD/HT activity managers and GH counterparts. In response to USAID requests, ASH transitioned from very senior staff in all key personnel functions to mid-level and junior technical professionals mentored by senior seasoned MSH headquarters staff and more seasoned team members.

It is important to note that since the award of the project, all key personnel positions have turned over. The current finance advisor, who joined ASH three months into the project, has been in the same position throughout the last three-and-a-half years, and the current chief of party has been with the project in different capacities for nearly four years, while the technical director has been with the ASH project, although in a different capacity, since the end of 2012. The net result of all of these changes is that in the four years of the project there have been two distinctly different organizational charts.

Both USAID and ASH senior leadership believe the existing ASH staff has the drive, flexibility and responsiveness to the donor, and ability to listen, collaborate and coordinate with AFR/SD/H activity managers and other Global Health CORs and technical team members. Nearly 50 percent of the AID managers interviewed from the Africa Bureau or former AFR/SD/HT staff said the team is still lacking visionary technical leadership and is not driving and elevating new ideas. This appears to have been a source of disappointment by the AFR/SD/HT team, as many team members anticipated that new ideas

would be bubbling up from the ASH technical team.²⁸ The above notwithstanding, only 11 percent of the 64 people interviewed for this report knew of the ASH staffing changes, particularly those in 2012-2013, and 56 percent had no opinion on the 2012-2013 time period. Three percent of respondents reported that funding appeared to be a problem in the 2012-2013 time period, while 27 percent said that multiple factors delayed the project between 2012 and 2013.

USAID Project Oversight and Leadership: AFR/SD/HT had a major change in its staff in 2011 and 2012, which coincided with the launch of ASH. Following the retirement of the office director, who played a pivotal role in the ideas for the design of the three predecessor projects and the early concept development for ASH, the ASH team faced some rethinking of its role and purpose and its fit within the context of the Africa Bureau's IRs linked to knowledge, advocacy and African capacity development. The departure in early 2013 of the COR that launched ASH in 2012 and the lead USAID design team member who drafted the ASH request for proposal, combined with the shortage of first-year funds, delayed project start-up and consistent execution of activities in Year 1 and the beginning of Year 2.

MSH has offered USAID increased value through its 14 African country offices. In Years 3 and 4 more senior MSH staff have served as ASH consultants and provided well-regarded advisory services.

An interim COR was assigned for the entire second year of the project. In 2013, the Africa Bureau assigned a permanent COR who remained with the project until May 2015. Beginning with the arrival of the new COR and a change in the chief of party and technical director, the project began to live up to its original design. Thirty percent of the respondents interviewed for this evaluation were able to cite multiple factors that lead to the ASH team's slow start-up, while 37 percent indicated they were related to the ASH team and MSH shortcomings, and 28 percent said that factors including an open-ended weak design, shifting guidance from USAID to ASH, and USAID budget shortfalls were the main causes. There is general agreement that the project took over two years to reach its full performance level. Some AFR/SD/HT respondents (17 percent) noted that the project has continued to operate at a less than optimal technical capacity due to the insufficient level of effort allotted by the technical team, with USAID management approval, to some technical tasks. Other issues raised by AFR/SD/HT include the timely completion of tasks and long lead-times for work products.

ASH Organizational Structure: The evaluation found that there are multiple management advantages for USAID of the existing DC-based ASH project configuration, which leverages both MSH country and home office technical and administrative staff. Basing the contract team close to the Africa Bureau in DC has permitted the ASH team to be close to its main client. Overseas, the project has been able to use the MSH country office platform to respond to rapid requests for hosting and convening USAID/Africa Bureau events, producing and disseminating ASH project materials and supporting ASH consultancies, assessments and studies which require rapid acquisition of country data. The project has used local staff from the MSH country teams to keep ASH support costs and operating costs low. For example, MSH has preselected competitively awarded vendors and support service contracts in 14 African countries. The ASH management staff estimates that, depending on the nature of the activity, the use of the MSH implementation arrangements in country saves the project 5-10 percent per activity. Given that the budgets for activities range from \$300,000 to \$400,000 per activity, this savings results in added benefits for each activity.²⁹ Implementation is also faster in these 14 countries since MSH already has staff on the ground and ASH can purchase country office staff time as necessary. Support services sourced from MSH country offices include arranging for survey and events or local research logistics, and identifying, hiring and managing local consultants. This was confirmed in interviews with several regional MSH

²⁸ ASH. Year 2 End-of-Year Report for 2012-2013.

²⁹ E-mail, Milton Da Silva to Brown, dated June 24, 2015.

regional country directors in South Africa and Nigeria and USAID project managers (Rwanda, Uganda and Angola). Nigeria’s MSH office is the second largest MSH office in the world with 160 employees. The MSH country offices are based in the countries with some of the largest USAID global health portfolios and include Angola, Ivory Coast, the Democratic Republic of the Congo, Ethiopia, Ghana, Madagascar, Malawi, Mozambique, Nigeria, Rwanda, South Africa, South Sudan, Tanzania and Uganda. An example of the rapid response capability and use of the local country office platform was the inter-ministerial “Call to Action Conference” held in Ethiopia in 2013. The conference hosted 200 high-level visitors including the USAID Administrator. MSH’s in-country presence in Ethiopia permitted ASH to rapidly support this important regional conference. Several USAID and partners noted, however, that for timely and meaningful institutional capacity development to take place, the ASH mechanism should have a field presence and be closer to its institutional clients.

The ASH Article, “A Systematic Review of Health System Barriers and Enablers for Antiretroviral Therapy (ART) for HIV-Infected Pregnant and Postpartum Women” was

- viewed 2,259 times
- downloaded 392 times
- cited 4 times
- shared 2 times
- saved 1 time

The ASH Publication “A Systematic Review of Individual and Contextual Factors Affecting ART Initiation, Adherence, and Retention for HIV-Infected Pregnant and Postpartum Women” was

- viewed 2,623 times
- downloaded 420 times
- cited 1 time
- shared 17 times
- saved 6 times

Tracking Allocations and End-Users: ASH made good use of multiple tracking tools for deliverables, activities, funds allocation and outputs by IR and by source of funds. (See Annex XI for a sample of these tools) A full-time M&E specialist was assigned to the project by Khulisa, an African public health M&E for-profit company based in Johannesburg, South Africa. The project has not tracked and was not asked by USAID to track the number of end users of its materials and work. However, some information was provided to the evaluators retrospectively, including the number of users of the fifth compendium mHealth materials (500 contacts) and the number of users of the ASH maternal health and HIV published studies. As reported by ASH,³⁰ through the PLOS One web site, ASH articles on HIV and maternal health have been widely viewed. Some ASH articles were also selected for inclusion in a few prominent technical circulars.³¹

Use of Subcontractors: The ASH project planned to use three African subcontractors to carry out short-term technical assistance in the field and to provide key personnel to the project. The project has not, however, made full use of its subcontractors for the full range of technical expertise they originally anticipated offering, in part due to funding and

in part due to the nature of the requests for technical assistance that the project received and addressed. This change in arrangements was approved by USAID.³² The subcontractor’s role and contribution toward institutional capacity building deviated from the original planned areas of work in the area of monitoring, evaluation and research as anticipated in the project’s original design and request for proposal (RFP). The limited use of the subcontractors was a missed opportunity for the ASH project to demonstrate the depth of expertise available in Africa to respond to health sector questions.

³⁰ E-mail, Konopka/Brown, dated August 20, 2015.

³¹ The Individual and Contextual Factors article was chosen to be a part of the 12th issue of *HIV This Month* (December 2014), a newsletter of UNAIDS Science Now, a UNAIDS-hosted platform for discussions on HIV science and for sharing what’s current in scientific journals. It was made available via e-mail distribution and is posted on <http://sciencenow.unaids.org>. The second article on Health System Factors was featured in the IATT Informer (electronic newsletter of the Interagency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children, hosted by UNICEF) on October 15, 2014, and the Maternal Health Task Force’s Maternal Health Buzz on October 22, 2014.

³² E-mail, Hall/Sikipa, dated July 18, 2013.

- Khulisa:** An 18-year-old monitoring and evaluation (M&E) firm based in Johannesburg, South Africa, Khulisa has served more than 140 different clients including the South African Government and many donors and foundations. Khulisa performs data quality analysis work with several PEPFAR-funded programs and has built the data quality capacity of PEPFAR partners to carry out their own internal assessments. Khulisa’s annual budget is between \$3.0 - \$4.0 million. MSH proposed to use Khulisa to strengthen the M&E work of ASH-supported African institutions. This expertise has only been partially used, and the major role of Khulisa has been to provide a full-time M&E advisor in DC to track ASH performance and some short-term ad hoc technical assistance. As a result of the shortfall in funds during the first year of the project, the Khulisa subcontract was reduced from \$1.6 million to \$1.0 million over five years.³³ To date, Khulisa’s short-term technical assistance has been to support AfrEA, an African evaluation membership organization on an evaluation conference that featured special sessions on the health sector and, most recently, taking the proceedings from this conference and other key evidence-based health studies solicited across Africa and support to AfrEA in publishing a special edition of its “African Evaluation Journal,” devoted to the health sector.³⁴ In general, Khulisa has played the role of a technical resource organization rather than a full subcontractor. After Year 1, the Khulisa headquarters has not had substantive input into the work plans, nor has it contributed to the generation of new ideas. Khulisa has not carried out or participated in any of the ASH external evaluations.
- African Population and Health Research Center (APHRC):** In its original response to the USAID request for proposals, MSH proposed a \$1.4 million subcontract with APHRC, a Kenya-based African research organization that has 130 people on its staff, including 50 African staff with PhDs focused on health systems challenges, organizational development problems, urban migration and population dynamics, and reproductive health and education sector projects. APHRC has a \$17 million annual operating budget, with clients drawn from private foundations including the Packard and Carnegie Foundations, as well as bilateral AID organizations including DFID and USAID/Kenya. They currently manage an average of 15 new studies per year and are now working in 12 African countries. Of note, over the four years their ASH subcontract changed from deploying a full-time African advocacy and communications advisor to ASH in Arlington, Virginia that was charged with defining an advocacy roadmap for the project and carried out several high visibility conferences in Africa, including the Call to Action in Ethiopia in August 2013. Following a suggestion by AFR/SD/H, the full-time APHRC advocacy position was deleted, the APHRC subcontract ceiling was reduced to \$1.1 million, and MSH hired a key personnel advocacy and communications specialist directly. APHRC moved from employing a full-time key personnel position on the ASH team to a serving as a technical resource group providing short-term technical assistance based on ASH needs. To date, less than \$500,000 has been expended under this APHRC subcontract. Since 2013, APHRC contributed to the West African urban advocacy study and material, but has played virtually no role in ASH strategic planning, visioning, new idea formulation or institution strengthening and moving ideas from studies into tangible action. In general, the APHRC subcontract did not live up to the original design intent for this instrument, although the ASH team has discussed with APHRC possible follow-on work in Year 5 on the urban health research if funding is secured. In the view of the evaluation team, this was a deviation from the original design. It was a missed opportunity for ASH, since APHRC is an African institution that is working on other research projects designed to provide focused evidence to support changes in policies in several African countries. It has completed studies and policy work in the education sector in one country on the age of marriage. In Kenya, the USAID mission is working with APHRC as a subcontractor on a FP project to generate evidence for decisionmakers on community-based FP services in two counties.

³³ MPS interview

³⁴ MA interview

- **Institute for Health and Development-University of Dakar (ISED):** ASH reported to the evaluation team³⁵ that although ASH planned to use ISED for short-term technical assistance and a subcontract was put in place, when ASH reached out to it to field a team for the RBM malaria assessment, the two consultants' prior experience excluded them from participation. No other short-term expertise was provided by ISED.

Use by ASH of an External Resource Network: MSH initially proposed the use of resources network comprised of Brandeis, Harvard School of Public Health and African non-profits working on health training such as CAFS. In the early years of the project, MSH did tap into this network, but it has not done so since 2014, as the needs, priorities and consulting requirements of USAID shifted toward more rapid-response products and operational field service delivery research that MSH was able to accommodate in-house.

The ASH Mechanism: The contractual mechanism for ASH originally awarded was a hybrid contract with a fixed price and cost reimbursable component. The project was amended in 2011 as a total cost plus fixed fee mechanism to give the project more line item flexibility. Overall, the team seems satisfied with the ASH mechanism, which currently gives greater control to USAID managers. Any future project would need to determine whether a contract or another mechanism is appropriate to carry out the scope of work.

Collaboration with Global Health and Other Donor Programs: The majority of global health managers and subject matter experts interviewed indicated that ASH collaborates well with other larger global centers and a USAID LAB digital technology project. The areas of pediatric TB, health systems strengthening, HIV and maternal mortality, mHealth, and urban health were cited as good examples of ASH collaboration and coordination. Careful selection and vetting of ideas by AFR/SD/HT activity managers has been instrumental in forging good coordination. In four of the 10 clusters of WHO/AFRO where ASH provides support, the managers were pleased with the level of collaboration and partnership. Other WHO/AFRO clusters expressed a strong interest in working with ASH.

Areas of Concern:

- A main concern raised by several AFR/SD/H activity managers that work with ASH is the continuing struggle the small ASH project team faces in meeting both urgent rapid response ad hoc requests from the Africa Bureau for technical and management support for events and reporting, while also keeping on track the delivery of timely, thoughtful studies, policy and advocacy work and capacity development services.
- A second but related problem is that in 2013 a conscious effort was made to involve all of the activity managers in ASH programming decisions. This has benefited the project as noted above in terms of better coordination across subject matter and with the Global Health Bureau. A disadvantage of this approach is that ASH must be responsive and attend to a multiplicity of subject matter technical meetings with many activity managers that can result in diverting the team from other important work. Managing this process requires good collaboration and communication between the COR and the chief of party. USAID Activity Letter approvals also require a long lead-time to develop in sufficient detail and were noted by a few contacts interviewed by the survey to be an obstacle to advancing time-sensitive work. A better balance needs to be struck on this issue during the remaining year of the project.
- Several USAID field officers or participating/beneficiary organizations did not know much about ASH beyond the specific work they had done with the project, and only 26 percent of those interviewed knew about ASH's work. Of note, few of the USAID field staff nor many of the GH collaborating activity managers, office directors or WHO/AFRO staff interviewed had seen or

³⁵ E-mail, R. Thetard to Brown, dated July 22, 2015.

were familiar with the other ASH work products beyond those in their field of expertise. The subcontractors had not contributed to the ASH web site nor had they reviewed its contents. WHO/AFRO indicated that having direct input in the ASH work plan would have enhanced coordination and may have led to wider dissemination of ASH research and tools.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Despite the slow start and other identified barriers such as funding, especially in the first year, the project is on course to meet its outputs and deliverables. The third and fourth year of ASH have witnessed good progress and accelerated completion of key outputs across all three IRs. More work has taken place on knowledge generation than on consensus building and institution strengthening. Some of the project's results have contributed to strengthening health systems and regional norms and standards. There are six activities out of the 50 analyzed in detail that achieved regional health outcomes by Year 4.

There are not sufficient data as yet on the results of ASH work on African policy development by regional African institutions such as the AU or ECOWAS, or specific health sector investment decisions by African partners or USAID missions linked to ASH support, beyond those reported in this document under Question 2, leveraged funding. The project has attracted a limited amount of leveraged financing by other donors. The project's decision to delete an organizational development position and forego capacity assessments makes it difficult to attach a causal link between the work ASH supported at a given institution and improved operations at that institution.

Several USAID missions noted that ASH analytic work, including the analysis of the cost effectiveness of health care financing options in Uganda, the private sector assessment in Rwanda and the mHealth assessment in Angola, are key reports that may shape USAID and host country planning and activities.

The ASH project is viewed by partners as an extension of USAID's Africa Bureau. The project's branding and behind the scenes work at USAID-financed and supported events has advanced the Africa Bureau's visibility and input at key region-wide health meetings and conferences.

The ASH project is a unique cross-sectoral, cross-cutting mechanism. Within USAID there is a continuous need, perhaps more than ever due to the complexity of the challenges Africa is facing, for innovative thinking, new ideas and cross-sectoral action.

In Year 5, further studies will be completed and disseminated, the misoprostol, HIV and maternal mortality study dissemination and advocacy will continue, and these could have great promise for better health outcomes.

RECOMMENDATIONS

The evaluation team has identified seven priority recommendations to increase the project's impact in its final year.

Recommendations for Year 5 of the ASH Project

1. Accelerate widespread, multi-channel product dissemination of completed products and gather user satisfaction and end-use data to learn more about who uses the materials and why. Assure that key stakeholders like WHO/AFRO obtain findings and participate in teleconference meetings.
2. Complete the misoprostol, IPTp and iCCM, and SMS studies and channel those findings into well-defined, time-limited actions and results. Share the findings with key stakeholders.
3. Support key strategic planning work currently underway at WHO/AFRO. Assure that ASH products and materials are widely disseminated to all of the WHO/AFRO clusters, including those that do not currently work with ASH. WHO has an electronic library and ASH should explore if this is an additional channel to disseminate the project's research and tools.
4. Prepare a white paper on mHealth that outlines next steps, possible partners and the investment in electronic infrastructure and systems architecture, including memory storage and system bandwidth that

is required to move forward region-wide. The report should project the status of country planning for mHealth by the end of 2015.

5. Document by the end of 2015 any increases in domestic resource mobilization associated or linked to ASH work, including any new private sector investments that may have followed the completion of private sector or mHealth country assessments or new investments by governments in pediatric TB.

6. As follow-up to the ECOWAS conference in July 2015 in Burkina Faso, which included ASH work on urban health, use APHRC to identify and cost out key next steps to launch urban health services. Link APHRC with ECOWAS so they and other African organizations can conceptualize a plan for integrating better urban health planning across the region.

7. Consistent with the revised PMP, document the use of ASH materials and institutional or policy changes and agreements reached by the end of the project.

ANNEX I. SCOPE OF WORK

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

July 7, 2015

- I. **TITLE:** African Strategies for Health: Final Evaluation (084)
- II. **Requester / Client**
 USAID/Washington
Office/Division: Africa Bureau/Office of Sustainable Development/Health Team (AFR/SD/HT)
- III. **Funding Account Source(s):** (Click on box(es) to indicate source of payment for this assignment)
- | | |
|--|---|
| <input type="checkbox"/> 3.1.1 HIV | <input checked="" type="checkbox"/> 3.1.6 MCH |
| <input checked="" type="checkbox"/> 3.1.2 TB | <input checked="" type="checkbox"/> 3.1.7 FP/RH |
| <input checked="" type="checkbox"/> 3.1.3 Malaria | <input type="checkbox"/> 3.1.8 WSSH |
| <input type="checkbox"/> 3.1.4 PIOET | <input type="checkbox"/> 3.1.9 Nutrition |
| <input type="checkbox"/> 3.1.5 Other public health threats | <input type="checkbox"/> 3.2.0 Other (specify): |
- IV. **Cost Estimate: Note:** *GH Pro will provide a final budget based on this SOW*
- V. **Performance Period**
Expected Start Date (on or about): June 2015
Anticipated End Date (on or about): October 2015
- VI. **Location(s) of Assignment:** (Indicate where work will be performed)
Work will be conducted remotely ; with a trip to the Republic of the Congo
- VII. **Type of Analytic Activity** (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision-making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

VIII. **BACKGROUND**

Background of project/program/intervention:

In all regions of the world, but especially in Africa, the preservation and enhancement of a population's health is recognized as an essential precondition for development. Bearing the heaviest burden of the HIV/AIDS epidemic, plagued by malaria, and facing stubbornly high levels of maternal mortality and critical health workforce and financing problems, Africa is in great need of strategies and approaches conceived in a manner that is appropriate for the African context and which offer the greatest possibility for expanding and sustaining health benefits.

Despite persistent problems, there are indications that progress toward better health in Africa can be accelerated. In recent years, community-based health insurance schemes have increased access and quality of health services; immunization campaigns along with strengthened routine immunization services have reduced vaccine-preventable disease rates in target areas; and expanded use of bed nets

and indoor residual spraying significantly reduced the incidence of malaria in endemic countries. There have also been hopeful signs that prevention and treatment measures are beginning to slow the spread of HIV/AIDS in most countries. Additionally, over the past two decades and with increased acceleration since 2000, sub-Saharan Africa has made encouraging improvements in child health (although still lagging behind Asia and Latin America in the rate of improvement).

Nonetheless, major constraints and challenges remain. African Strategies for Health (ASH) is the fourth in a succession of USAID AFR/SD/HT projects designed to (1) improve national and regional health policies in Africa through work to strengthen and utilize regional and sub-regional health institutions, and (2) support the health team in taking the lead on African health issues. The AFR/SD/HT has taken considerable pride in its ability to identify emerging and/or neglected health issues in Africa; (3) to elevate those issues on the development agendas of other bureaus within USAID, host country governments, non-governmental organizations, the private sector and other development partners; and (4) to engage those partners in the creation and implementation of dynamic interventions to address those health issues.

Since the 1995, AFR/SD/HT has called upon a team of technical experts assembled in a single project to build the foundation upon which the process of issue identification, research, analysis, advocacy, and engagement could proceed. Predecessors to ASH include Africa Health in 2010, 2005-2010 (Africa 2010) and Support for Analysis and Research in Africa (SARA) I and II, 1995-2000 and 2000-2005, respectively.

Description of activity/project/program

ASH is a five-year contract funded by the USAID's AFR/SD/HT for the period September 1, 2011 to August 31, 2016. The award price for the contract is \$19,984,075.00. It is being implemented by Management Sciences for Health (MSH) in partnership with three Africa-based partners: African Population and Health Research Center (APHRC), Khulisa Management Services and Institute pour la Santé et le Développement (ISED), of Dakar University, Senegal. ASH also works in close consultation and collaboration with a variety of African public sector, civil society and private sector health development institutions

The overall ASH Strategic Objective is the "Improved Health Status of Africans" and the project's purpose is to "support African institutions and networks and assist USAID, its partners within USG, and cooperating agencies and partners to create a strategic vision for guiding investments to further the health of Africans and facilitate the development of African leadership." It does this through the three following IRs: (1) Expanding the body of knowledge of current trends, constraints, and solutions to improving the health of Africans, (2) Creating consensus on priorities and strategies for improving the health of Africans, and (3) Strengthened African institutions and networks. See ASH Results Framework below.

The focus of the project ranges across program components critical for the achievement of MDGs: maternal, newborn and child health (MNCH), HIV/AIDS, malaria, tuberculosis, health system strengthening (HSS), and FP and reproductive health (FP/RH). Because of the cross-cutting nature of many development problems, ASH was requested to work across sectors such as education, democracy and governance, agriculture, and the environment to improve the health status of Africans. To optimize the use of financial and human resources, ASH was asked to work closely with USAID pillar and regional bureaus to complement existing projects and avoid costly duplication of efforts.

Some of ASH's activities have continued over multiple years of the project, and some have been short-term/one-time in duration. Activity scopes of work have been negotiated by strategic teams and activity POCs, who cover MNCH, ID (Malaria, TB and HIV/AIDS), HSS (HSS and FP), and cross-cutting issues. In the second year, a strategic opportunities fund was negotiated with ASH, which

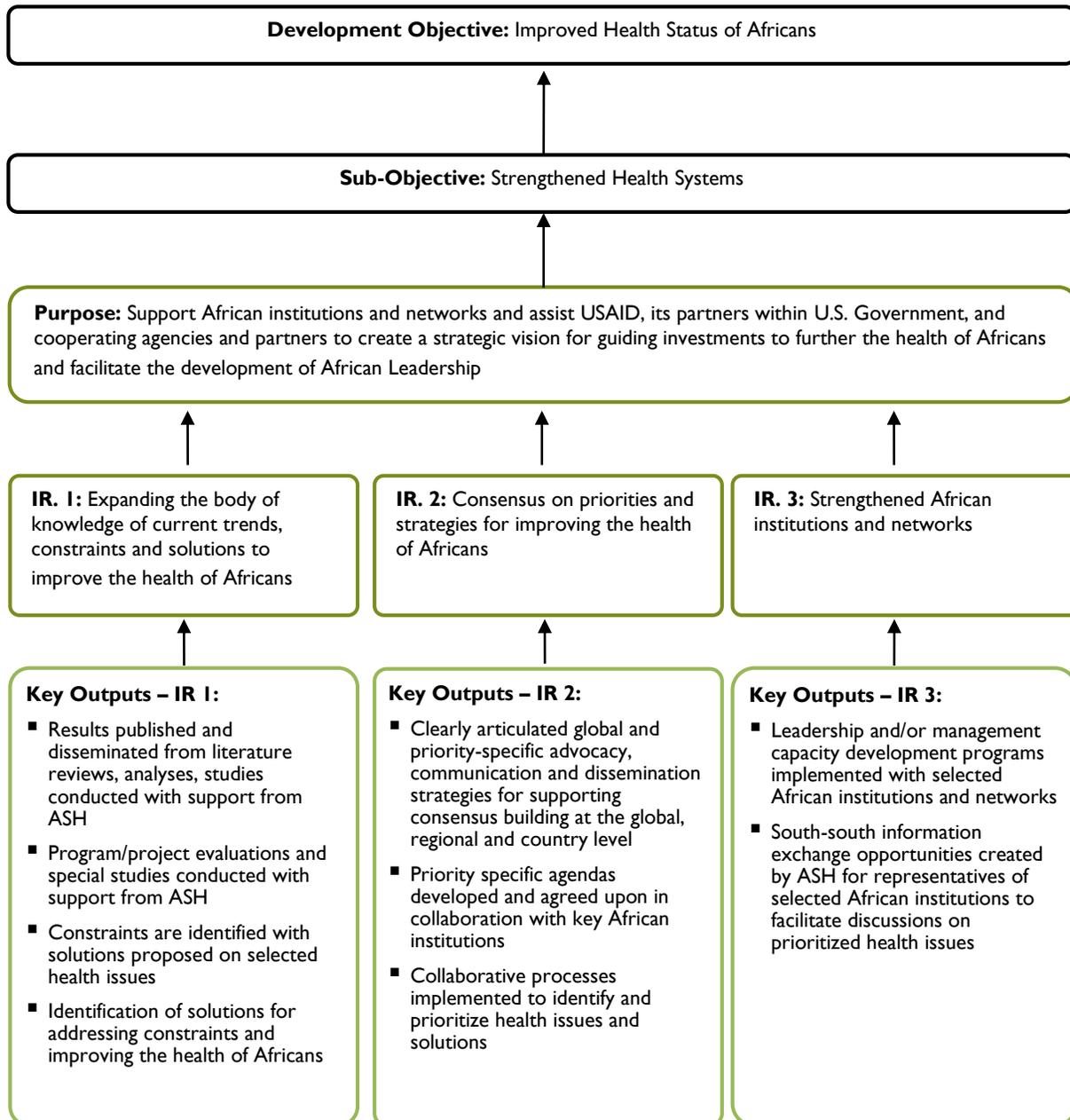
captures contingency funding that is available to cover the costs of unanticipated opportunities, which may evolve during the course of the year.

While most of the funding contributing to the TEC is directly from AFR/SD/HT, some missions have taken advantage of the project, buying in for specific technical expertise (e.g., Rwanda for a private sector engagement activity, Angola for mHealth activity, and Uganda for an mHealth study and voucher/community-based insurance scheme study) or the project's capacity. For example, when the Global Health Bureau's central evaluation contract was unavailable, ASH was able to accommodate two urgent and high profile evaluations (e.g., Tanzania's IRS evaluation, HIDN/PMI's evaluation of sub-regional networks). When the DRC mission was unable to find a mechanism to sub-contract directly with the Kinshasa School of Public Health, ASH was able to do so and provide financial management guidance.

USAID's Contracting Officer Representative (COR) has changed once thus far over in the life of the project. Andrea Sternberg officially took over as COR after a six-month gap in April of 2013. It is anticipated that a new COR will take over the project in April of 2015. Tom Hall has consistently been the alternate-COR from the project's conception. ASH has had a number of changes related to its key personnel. Please see Annex I for a summary of key personnel changes.

Describe the theory of change of the project/program/intervention.

Strategic or Results Framework for the project/program/intervention (paste framework below)
ASH Results Framework



What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Africa Region

IX. SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The end-of-project evaluation of the Africa bureau’s five-year project (2011-2016) African Strategies for Health (ASH) is being conducted to inform the scope and size of the next generation of AFR/SD funded health programming. The evaluation is expected to accomplish the following objectives:

- i. Assess and document activity accomplishments and whether desired results have occurred;
- ii. Capture lessons learned from project implementation;
- iii. Identify common themes in how ASH is perceived and valued by key stakeholders;
- iv. Determine the effectiveness and efficiency of project operations; and
- v. Identify potential opportunities for AFR/SD to fill unique gaps in technical assistance.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

AFR/SD/HT is the primary users of this evaluation. ASH implementing partners (IPs) may also benefit.

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

Results of the evaluation will specifically inform to what extent creating consensus and capacity building is included in the next project, the structure of the next award, including recommended key personnel, use of sub-partners, cost construction, as well as potential technical areas of expertise.

D. **Evaluation questions:** Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

The evaluation will focus on a programmatic, technical and managerial assessment of ASH activities implemented to date. The evaluation will identify accomplishments, performance issues and constraints in implementation of the project. The evaluation will also take into consideration regional planning documents and headquarters-based programming as it identifies results and lessons learned, making recommendations on activities to be continued, modified or enhanced in any future USAID/AFR/SD/HT programming decisions.

	Evaluation Question
1.	<p>What results have been realized at both country and regional levels during the first four years of ASH?</p> <ul style="list-style-type: none"> • To answer this question, consider: <ol style="list-style-type: none"> a. The extent to which has ASH achieved the technical and programmatic objectives described in the contract agreement b. Innovative and creative approaches ASH took to address regional health issues c. Lessons learned from ASH’s efforts to strengthen regional institutions and, in the process, to improve country programs as a result of work with those institutions d. The perceived impact of ASH on stakeholders (primary and secondary to be determined at a later date) working in the technical areas addressed by the project
2.	<p>To what extent has ASH met the management requirements and functions outlined in the contract, including planning, allocation of funds, coordination/use of sub-agreements, and staffing requirements?</p> <ul style="list-style-type: none"> • To answer this question, consider:

	<ul style="list-style-type: none"> a. The structure of ASH and USAID/AFR/SD/HT oversight and management that aided or hindered ASH in accomplishing work plan objectives b. The engagement or lack of engagement of sub-partners (Khulisa, APHRC and ISED) that aided or hindered ASH in accomplishing work plan objectives
3.	<p>What strategies should USAID/AFR/SD/HT pursue in future programming directions to address the challenges and gaps reached in this evaluation?</p> <ul style="list-style-type: none"> • To answer this question, consider: <ul style="list-style-type: none"> a. In the light of available funding, cost-efficient and effective approaches for achieving project results (evaluation from both a short and long-term perspective)

E. Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

Document Review (*list of documents recommended for review*)

USAID/AFR/SD/HT and ASH will provide the evaluation team with historical documents before the team planning meeting. The team will review all available materials prior to key information interviews and as necessary throughout the course of the assessment to be able to determine the extent and nature of their use. Of note, a key output of ASH’s monitoring and evaluation system has been the creation of COR letters that routinely track project inputs and then deliverables for each of the technical activities in which ASH engages.

The following project documents will be made available to evaluators:

- Initial request for procurement, contract and all contract modifications
- Project monitoring plan
- Annual work plans
- Annual project performance plan and reports, including reviews of strategic teams
- Agendas and PowerPoint presentations from Quarterly Reviews
- Complete list of COR activity letters (please note the design of COR letters changed in year two)
- Financial Information, including monthly vouchers
- Final evaluations from SARA and Africa’s Health 2010
- Regional Development Cooperation Strategies (RDCSs) from EA, WA, SA Regional, and AFR/SD

Secondary analysis of existing data (*list the data source and recommended analyses*)

The following data will be available for the evaluation team. Secondary data analyses will be conducted as needed to address the evaluation questions		
Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis
ASH PMP indicator data	ASH routinely collects and reports project performance monitoring data on specified indicators. The data collected for project reporting will be shared as requested by the evaluation team.	
DHS Program Data: <ul style="list-style-type: none"> • Demographic and Health Surveys (DHS) • AIDS Indicator Surveys (AIS) 	Data are available from most African countries through the DHS program. Using DHS Stat Compiler or direct access to survey data, these data can be analyzed, if needed to address the evaluation questions. Data are	

<ul style="list-style-type: none"> • Service Provision Assessment (SPA) Surveys • Malaria Indicator Surveys (MIS) 	available on MCH, FP, HIV/AIDS, malaria and service provision.	
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■ **Key Informant Interviews** *(list categories of key informants and purpose of inquiry)*

The evaluation will also conduct in-depth interviews with key stakeholders and partners of ASH. The evaluation team will develop a semi-structured interview guide that will be used to conduct the interviews. Interviews will be conducted through face-to-face contact or by telephone as necessary. Respondents will be identified by USAID/AFR/SD and ASH. A list of potential respondents will be developed prior to the start of the evaluation process, and will include representatives from:

- ASH staff (MSH, APHRC, Khulisa and ISED)
- Secondary ASH partners from African public sector, civil society, and private sector health development institutions
- AFR/SD/HT

■ **Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

A brief structured survey that will take approximately 15 minutes to complete, using Survey Monkey, will be sent to key informants inquiring about ASH implementation, management, results, strengths and shortcomings.

X. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data is to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The evaluation team will be responsible for coordinating the data analysis. The analysis will use social science approaches to answer the evaluation questions outlined above. The Evaluation Team should propose a robust analysis plan that would generate robust evidence needed to answer the evaluation questions. Each team member will participate in the analysis and contribute to the interpretation of the data, as their area of specialty allows.

The evaluation will utilize both qualitative and quantitative data related to ASH in order to answer the evaluation question stated within this SOW.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as location and sex, when appropriate. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate. In the report the Evaluators will describe the statistical tests used.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, homogeneity, and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project performance indicator data and DHS) will allow the team to triangulate findings to produce more robust evaluation results.

XI. ACTIVITIES

List the expected activities, such as team planning meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

Background Reading—Several documents are available for review for this evaluation. These include the ASH RFP, proposal, contract with modifications, annual work plans, M&E plans with performance monitoring plan (PMP), progress reports, routine reports of project performance indicator data, evaluation reports, and other project-generated reports and materials. This desk review will provide background information for the evaluation team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting—A three-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW;
- Clarify team members' roles and responsibilities;
- Establish a team atmosphere, share individual working styles and agree on procedures for resolving differences of opinion;
- Review and finalize evaluation questions;
- Review and finalize the assignment timeline and share with other units.
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report; and
- Assign drafting/writing responsibilities for the final report.

Briefing and Debriefing Meetings—Throughout the evaluation, the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include the all evaluation team experts, but will be determined in consultation with USAID/AFR/SD/HT. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID/ AFR/SD/HT, GH Pro and the team leader to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team leader, and review the initial schedule and review other management issues.
- **In-briefing with USAID/AFR/SD/HT**, as part of the TPM. This briefing may be broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM when the evaluation team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-briefing will be the format and content of the evaluation report. The time and place for this in-briefing will be determined between the team leader and USAID/AFR/SD/HT prior to the TPM.
- **In-brief with ASH**. The evaluation team will meet with ASH to discuss the evaluation and expectations of involvement and cooperation of ASH staff and partners. This meeting will also provide ASH an opportunity to present the evaluation team an overview of the project.
- The team leader (TL) will brief the USAID/AFR/SD/HT **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an e-mail.
- A **final debriefing** between the evaluation team and USAID/AFR/SD/HT will be held at the end of the evaluation to present preliminary findings to USAID/AFR/SD/HT. During this meeting, a summary of the data will be presented, along with high-level findings and

draft recommendations. For the debriefing, the evaluation team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debriefing in the evaluation report. (**Note:** *preliminary findings are not final, and as more data sources are developed and analyzed these finding may change.*)

- **ASH debriefing/workshop** will be held following the final debriefing with the USAID/ AFR/SD/HT. The evaluation team will discuss with USAID who should participate.

Fieldwork, Site Visits and Data Collection–The evaluation team may conduct site visits to Republic of the Congo to meet with WHO/Afro. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

XII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
<input checked="" type="checkbox"/> Launch briefing	June 15, 2015
<input checked="" type="checkbox"/> Work plan with timeline	June 25, 2015
<input checked="" type="checkbox"/> Final evaluation design, methods and data collection tools	June 25, 2015
<input checked="" type="checkbox"/> In-briefing with mission or organizing business unit	June 22-24, 2015
<input checked="" type="checkbox"/> In-briefing with ASH	June 26, 2015
<input checked="" type="checkbox"/> Draft evaluation report outline	June 30, 2015
<input checked="" type="checkbox"/> Routine briefings	weekly
<input checked="" type="checkbox"/> Out-briefing with mission or organizing business unit with PowerPoint presentation	August 17, 2015
<input checked="" type="checkbox"/> Findings review workshop with ASH with PowerPoint presentation	August 18, 2015
<input checked="" type="checkbox"/> Draft report	September 7, 2015
<input checked="" type="checkbox"/> Final report	September 21, 2015
<input checked="" type="checkbox"/> Raw data	September 21, 2015
<input checked="" type="checkbox"/> Post evaluation report to the DEC	October 12, 2015
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 business days

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

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.

- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members.

The team will be comprised of two consultants, one of which will be the team leader. Additionally, and up to two USAID staff (depending on availability and time) will join the evaluation team for the full period of performance of this evaluation. The team should have the following skills mix:

1. Public health expertise in health systems strengthening (e.g. health financing, private sector involvement, or m/eHealth) and two or more of the following areas:
 - a. Maternal, newborn and child health
 - b. Malaria
 - c. HIV/AIDS
 - d. TB
 - e. Family planning
 - f. Cross-sectoral programming (e.g. health and governance, health and education, health and environment).
2. Financial grants management
3. Organizational development and capacity building
4. Understanding and knowledge of USAID/AFR/SD and USAID regional missions and programs
5. Knowledge and experience in design, implementation, and monitoring and evaluation of international health programs in Africa.

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position.

Roles & Responsibilities: The team leader will be responsible for (1) managing the team's activities, (2) ensuring that all deliverables are met in a timely manner, (3) serving as a liaison between the USAID and the evaluation team, and (4) leading briefings and presentations.

Qualifications:

- Minimum of 10 years of experience in public health
- At least 5 years' experience in M&E, preferably on USAID projects/programs
- Excellent skills in planning, facilitation and consensus building
- Demonstrated experience leading an evaluation team
- Excellent interpersonal skills
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills
- Familiarity with USAID policies and practices
 - Evaluation policy
 - Results frameworks
 - Performance monitoring plans

Key Staff I Title: Evaluation Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will insure highest level of reliability and validity of data being collected. S/He is responsible for all data analysis, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He

will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing. Furthermore, this s/he will serve as a technical expert on the team to review ASH M&E efforts, including evaluations conducted under ASH.

Qualifications:

- At least 5 years of experience in USAID M&E procedures and implementation
- At least 8 years managing M&E, including evaluations
- Experience in capacity development for M&E
- Ability to evaluate the conduct and outputs of other evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience in design and implementation of evaluations
- Experience in data management
- Experience using analytic software
- Experience evaluating health programs/activities
- An advanced degree in public health, evaluation or research, or related field
- Experience working on or with USAID health projects in Africa in at least two of the following areas:
 - Maternal, newborn and child health
 - Malaria
 - HIV/AIDS
 - TB
 - Family planning
 - Cross-sectoral programming (e.g. health and governance, health and education, health and environment)
- Understands USAID contracting of centrally funded and bilateral projects preferred

Number of consultants with this expertise needed: 1

Key Staff 2 Title: Health System Strengthening Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in health systems development, public health management, institution building, capacity development and health policy. S/He will assist with data collection, data analysis and report writing.

Qualifications:

- At least 8 years' experience USAID health program management, oversight, planning and/or implementation
- Expertise in HSS and health policy
- Experience in capacity development related to HSS
- Experience in stakeholder engagement
- Experience in change management
- Experience in conducting USAID evaluations of health programs/activities
- An advanced degree in public health, or related field
- Experience working on or with USAID health projects in Africa in at least two of the following areas:
 - Maternal, newborn and child health
 - Malaria
 - HIV/AIDS
 - TB
 - Family planning

- Cross-sectoral programming (e.g., health and governance, health and education, health and environment)
 - Understands USAID contracting of centrally funded and bilateral projects preferred
- Number of consultants with this expertise needed: 1

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who: **1-2 USAID staff will be assigned by USAID/AFR/SD/HT as Evaluation Team members for the full period of performance**

No

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- a) For each column, replace the label “Position Title” with the actual position title of staff needed for this analytic activity.
- b) Immediately below each staff title, enter the anticipated number of people for each titled position.
- c) Enter row labels for each activity, task and deliverable needed to implement this analytic activity.
- d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- e) At the bottom of the table total the LOE days for each consultant title in the ‘Sub-Total’ cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable		Evaluation/Analytic Team			
		Key Staff /Team Lead	Evaluation Specialist	USAID on Evaluation Team	Local Evaluation & Logistic Assistant
Number of persons →		1	1	1-2	
1	Launch briefing	0.5	0.5	.5	
2	Desk review & data synthesis	4	2	3	
3	Team planning meeting	2	2	2	
4	In-briefing with mission	0.5	0.5	1	
5	In-briefing with ASH, including preparation	0.5	0.5	1	
6	Finalize data collection forms & procedures for all data collectors (circulate with USAID and GH Pro for QA)	1	1	1	
7	Evaluation report outline	0.5	0.5	1	
8	Preparation/logistics for data collection	.5	.5	.5	
9	Data collection in U.S.	10	10	10	
10	Travel and data collection in Addis and Brazzaville	10	10	10	
11	Data analysis & synthesis	4	4	4	
12	Debriefing with USAID with presentation, including preparation	1	1	1	

Activity / Deliverable		Evaluation/Analytic Team			
		Key Staff /Team Lead	Evaluation Specialist	USAID on Evaluation Team	Local Evaluation & Logistic Assistant
13	Incorporate USAID's feedback	.5	.5	.5	
14	Debriefing with ASH, including preparation	1	1	1	
15	Draft evaluation report	5	3	2	
16	GH Pro report QA review & formatting				
17	Submission of draft report(s) to mission				
18	USAID report review				
19	Revise report per USAID comments	3	1	.5	
20	Finalization, format and submission of final report				
21	508 compliance review & editing				
22	Upload evaluation report to the DEC				
	Sub-Total LOE (per person)	44	38	39	
	Total LOE	44	38	39-78	

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

Work will be done remotely, but will include travel to Brazzaville, Republic of the Congo.

XIV. LOGISTICS

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

USAID Facility Access

Specify who will require Facility Access:

Electronic County Clearance (ECC) (International travelers only)

GH Pro workspace

Specify who will require workspace at GH Pro: Conference room for TPM and in-briefs and debriefs with USAID and ASH

Travel-other than posting (specify): Travel to Brazzaville

Other (specify):

XV. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)

- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro web site. If the report is internal, then copy editing/formatting for internal distribution.

XVI. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

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

Before Field Work

- SOW.
 - Develop SOW.
 - Peer-review SOW.
 - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

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

After Field Work

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

XVII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

The **Evaluation Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- a. The report must not exceed 40 pages (excluding executive summary, table of contents, acronym list and annexes).
- b. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- d. For additional guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The preliminary findings from the evaluation will be presented in a draft report at a full briefing with USAID/GH/OHS and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 2 pages);
- Table of Contents (1 page);
- Acronyms
- Evaluation Purpose and Evaluation Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations
- Annexes
 - Annex I: Evaluation Statement of Work
 - Annex II: Evaluation Methods and Limitations
 - Annex III: Data Collection Instruments
 - Annex IV: Sources of Information
 - List of Persons Interviews
 - Bibliography of Documents Reviewed
 - Databases
 - [etc.]
 - Annex V: Disclosure of Any Conflicts of Interest
 - Annex VI: Statement of Differences [if applicable]

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

All data instruments, data sets, if appropriate, presentations, meeting notes and report for this evaluation will be presented to USAID electronically to the Evaluation Program Manager. All data will be in an unlocked, editable format.

XVIII. USAID CONTACTS

	Primary Contact (until April 6, 2015)	Primary Contact (after April 6, 2015)	Alternate Contact
Name:	Andrea Sternberg	Megan Rhodes	Tom Hall
Title:	Health Team Deputy	Health Team Deputy	
USAID Office/Mission	USAID/AFR/SD/Health Team	USAID/AFR/SD/Health Team	USAID/AFR/SD/Health Team
E-mail:	asternberg@usaid.gov	mrhodes@usaid.gov	thall@usaid.gov
Telephone:	202-712-4257		
Cell Phone (optional)			

XIX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

- Initial RFP, contract and all modifications
- Annual work plans
- Annual performance plan and reports
- Agendas and PowerPoint presentations from Quarterly Reviews
- Complete list of COR activity letters
- Financial information, including monthly vouchers
- Final evaluations from SARA and Africa’s Health 2020
- Regional Development Cooperation Strategies for WA, EA, SA and AFR/SD

XX. Evaluation Design Matrix

This design matrix may be helpful for connecting your evaluation methods to questions. Often more than one method can be employed in an analytic activity to obtain evidence to address more than one question. A method should be listed by question when it will include specific inquiries and/or result in evidence needed to address this specific question.

Evaluation Matrix

Evaluation Questions	Data Source/Collection Methods	Sampling/Selection Criteria	Data Analysis Method
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List of Key Personnel Changes

- The project's original technical director/HSS technical officer (TD) left the project in March 2013.³⁶
- The original Infectious Disease technical officer was made (TD) in April 2013.
- A new health systems strengthening (HSS) technical officer was hired in May 2013.
- The project's original chief of party/HIV technical officer was removed by USAID in August 2013.
- The TD was promoted to chief of party in September 2013.
- The Advocacy, Communications and Dissemination (ACD) Advisor resigned in September 2013.
- A program research assistant was promoted to HIV/AIDS technical officer in October 2013.
- The original M&E technical officer was promoted to TD in October 2013.
- A new ACD advisor was hired December 2013.
- ASH decided to let their HSS technical officer go in August of 2014.
- ASH decided to let their Maternal and Child Health (MCH) technical officer go in September of 2014.
- A new MCH technical offer was hired in September of 2014.
- A new M&E officer was hired in October of 2014.
- The TD resigned to take a permanent position with USAID/Washington in Jan 2015.
- The HIV/AIDS specialist was promoted to TD in Feb 2015.
- A new HSS technical officer was hired in Feb 2015.
- Current staff vacancies include M/E health advisor and ACD advisor.
- There has been turnover among the Project Associates assigned to work on TB.

ANNEX II. EVALUATION METHODS AND LIMITATIONS

This final external evaluation assessed performance for each of the three IRs and outputs and included the ability of the organizations that benefited from the project to use the materials, tools and assistance produced by the project once the project ends. The evaluation also solicited input from key informants and users of the ASH mechanism across USAID and its partners about possible future needs that could be served from an Africa Bureau regional project mechanism. The evaluation followed the USAID 2011 Evaluation Policy aimed at improving accountability, learning and evidence-based decision-making. USAID's Health Sector DO, IRs and sub-IRs and indicators are the framework upon which this evaluation is defined. The evaluation is a structured moderately complex qualitative assessment and used a mixed-method approach to assess whether the project is on track to meet its stated purpose by the project's conclusion to support African institutions and networks and assist USAID, its partners within the U.S. Government, and cooperating agencies and partners to create a strategic vision for guiding investments to further the health of Africans and facilitate the development of African leadership. The evaluation also documented and assessed the project's attainment of its three stated IRs.

Following USAID's guidelines, this evaluation provided a programmatic, technical and managerial assessment of ASH activities implemented to date, and it identified accomplishments, performance issues and implementation constraints. The evaluation team reviewed both regional planning documents and prime contractor headquarters-based plans that identified results and lessons learned. The evaluation report makes specific recommendations on activities to be continued, modified or enhanced in any future USAID/AFR/SD/HT design.

EVALUATION APPROACH

A major challenge of a performance evaluation is to compare the status of the beneficiaries before and after the intervention in a manner that accounts for the effect of the project relative to other factors external to the program. In the case of ASH, the beneficiaries of this project are organizations internal and external to USAID. ASH is a small project that has carried out specific tasks on a wide spectrum of health areas. Many events where ASH participated or handled the agenda or logistics arrangements were hosted by other donors or external partners such as WHO/AFRO. Given the specific characteristic and scope of the ASH project—technical studies and programmatic reviews, country and regional assessments, information and analytical support to USAID/AFR/SD/HT and USAID field missions, and assistance to African regional organizations—with a focus on producing and monitoring outcomes, this evaluation calls for a structured qualitative approach and an in-depth review of secondary sources generated by the project and other external partners. This evaluation is based on a participative approach and used primarily qualitative methods and quantification of key informant interviews on some questions and extensive use of secondary sources. The evaluation collected, analyzed and interpreted both quantitative and secondary source data in order to answer the evaluation questions. The quantitative data analyzed were from anonymized surveys carried out during the life of the project and some raw event evaluation data and training evaluations from conferences and training.

The qualitative method applied in this evaluation consisted of the use of semi-structured interviews and data recorded according to interview guides tailored for specific key informant groups. The interviews were administered both virtually over the phone and during some face-to-face meetings. Combining results from structured interviews at different levels permitted the evaluation team to assess the opinions of those responsible for the implementation of the activities at different levels as well as those who benefited and made use of the project. The subjects of these semi-structured interviews are classified in three main groups: (1) officials from AFR/SD/HT, other USAID headquarters offices and field

missions; (2) officials from African partner organizations, a multilateral donor (WHO/AFRO) and representatives of African ministries of in the region; and (3) staff from beneficiary organizations and institutions. The evaluation's desk review and subsequent analysis of secondary sources and project reports covered 106 documents.

SECONDARY SOURCES

The ASH project has generated an abundance of secondary data collected from the different activities. As confirmed by the USAID ASH COR, some of these products intended for public use are accessible on the ASH project web site.³⁷ As of July 2015, some of the documents and materials were also in draft, including the TB tracker and landscape analysis. Still others are in various stages of approval and review by USAID missions, including the Rwanda Private Sector Engagement study, the IPTp facility assessment report and the Angola mHealth assessment. USAID also maintains an archive of project background documents and project management and activity agreements, progress reviews, annual reports, and budget and fiscal information. The ASH documentation is also described in activity designs, activity reports, conferences presentations and reports, and activity briefs. In addition to these ASH-specific materials, the project evaluation team had access to ASH project and USAID records. The team had background briefing/informational sessions with 27 other ASH, MSH and USAID staff.

SAMPLE DESIGN AND FIELDWORK

Given its qualitative approach, the universe for this evaluation comprised the key technical professionals that participated in the design, development and implementation of the project from various levels across USAID and from beneficiary organizations in a select number of African countries where ASH has had assignments of varying complexity spanning a year or more. Sixty-four individuals were selected to be interviewed. This heterogeneous sampling approach included individuals representing beneficiary organizations from the three IR areas and across the various health accounts that financed the project. The sample was designed to produce information-rich data from a sample of key informants chosen to speak on the research questions related to ASH based on their experience in some capacity linked to the ASH project. The team then used a moderate snowballing technique to obtain the names of other key informants that participants mentioned in the course of their interviews as being knowledgeable about the subject matter.³⁸ The first step in the sample determination was to define the different levels of agencies, institutions and organizations participating directly or indirectly in the project. They included:

1. ASH project, AFR/SD/HT, other USAID headquarters offices and field missions, the prime contractor, MSH and two subcontractors; and
2. African partner institutions/organizations and representatives of MOHs in the region, including WHO/AFRO.

RESPONDENT CHARACTERISTICS

The second step was the selection of subjects to be interviewed. This entailed a purposeful selection of officials from the different participant institutions suggested by USAID, the contractors and subcontractors and key informants over the course of the interview process. For a complete list of key informants see Annex III. A total of 64 participants agreed to be formally interviewed for this evaluation. Verbal consent was obtained to assure that respondents' agreement to have their names include in the annex of the report. Their participation in the evaluation depended on their familiarity/knowledge of the project or their contact with the Africa Bureau Health Team, knowledge of an Africa Bureau health

³⁷ Hall/Brown e-mail dated August 5, 2015.

³⁸ Qualitative Methods in Public Health: A Field Guide for Applied Research by Ulin, Robinson and Tolley Josey Boss Publication pp 33-58.

office technical mechanism and the AFR/SD/HT mandate, and availability and willingness to be interviewed. The majority of interviews (65 percent) took place virtually by phone, while 20 percent were carried out in Washington, DC at the outset of the assignment and 15 percent took place in Brazzaville, Republic of Congo at the WHO/AFRO headquarters. Respondents were selected from a broad range of technical areas and sub-regions within Africa. Notably, 11 of the respondents came from the AFR/SD/HT office, while 11 came from the USAID Global Health Bureau, six from USAID missions, one from the private sector, three from ministries of health and 18 from partner organizations. The evaluators attempted to have a balance of views from Washington, DC and USAID missions, partner organizations and participating African organizations. Table I below summarizes the distribution and make-up of key informants. An additional 24 individuals across the areas noted in Table I also provided background and corroborating information on specific topics raised by the evaluation team. For a complete list of all people contacted for the evaluation see Annex III.

Table I. Key Informants by Institutions or Agencies

Source of Information (Detailed)	Frequency	Percent
1=USAID-AFR/SD/H	11	17%
2=USAID GH	11	17%
3=AID missions	6	9%
4=ASH/MSH	5	8%
5=MSH/headquarters	3	5%
6=MSH field off.	6	9%
7=WHO/AFR/AU	12	19%
8=Partners/Beneficiaries	6	9%
9=Subcontractor	4	6%
TOTAL	64	100%

DATA COLLECTION AND INSTRUMENTS

Data collection covered the period June 24–August 1, 2015. Five interview assessment guides and questionnaires were designed and applied to relevant staff according to the table below.

Table 2. Data Collections Instruments by Subject

Instruments	Subjects
1. Semi-structured interview: ASH project team	To be applied to managers and professionals from ASH project
2. Semi-structured interview: Questions for AFR/SD/HT Bureau, other USAID headquarters offices and field missions.	To be applied to USAID officials at the different levels
3. Semi-structured interview: Questions for African partner institutions/organizations and representatives of MOHs in the region	To be applied to responsible of central MOH and leaders of the different partner organizations.
4. Semi-structured interview: Beneficiary organizations and institutions	To be applied to officials from beneficiary organizations and institutions familiar with the work of ASH & USAID
5. Questions for donors and other partners	To be applied to donor officials and other implementing partners

DATA MANAGEMENT

Data from these interviews were coded and entered into a customized database created for the evaluation by the senior evaluator. Double data entry was used to check the quality and consistency of entries. In addition, external validation of the data collection and quality of data was carried out. All data were analyzed with the support of Excel spreadsheets. Findings were developed and discussed amongst the evaluation team members.

DATA ANALYSIS PLAN

The evaluation team developed a data analysis plan focused on gathering data from interviews with USAID/Washington and field staff, ASH contractor staff in Arlington, Virginia and the home office, MSH country team members, two subcontractors, and key stakeholders and participating organizations in Africa. Comparisons and summation of findings across respondents was done. Data analysis included triangulating findings from secondary documents, in-person and phone key informant interviews and background briefings with the contractor and some key stakeholders like WHO/AFRO. Summary tables from the key informant interviews appear in Annex VIII. The evaluation team held a day-long meeting in Brazzaville focused on answering the specific questions outlined in the scope of work. Team members contributed to the interpretation and triangulation of the data based on their areas of expertise and observations. Weekly meetings of team members were also carried out to interpret new findings and information.

EVALUATION LIMITATIONS AND CHALLENGES

1. The USAID PMP for the project did not include health outcomes and impact indicators, but incorporated process outputs, some evidence-based institutional outcomes and some limited customer satisfaction indicators. The PMP was drafted in December 2011 but was significantly revised and finalized in the third year of the project.
2. The project results do not lend themselves to a quantitative review of results beyond the output level. One way to approach this problem is to have access to high-quality baseline measurements that can provide statistical grounds for correct comparisons of the level of some key variables prior the beginning of interventions and at the evaluation point. However, these data were not available in for the ASH project.
3. The project did not routinely track the number of end-users or host country customer satisfaction with its products and all materials, although the evaluation team did have access to some raw participant data from the 2014 Africa Development Bank Ministerial Forum on Science and Technology and Innovation meeting, and user feedback following a meeting that included dissemination of the mHealth compendium.
4. The project did not conduct organizational capacity surveys as specified in the PMP, as the organizational development staff position was cut by mutual agreement with USAID in 2012. The decision to delete an organizational development position and forego capacity assessments makes it difficult to attach a causal link between the work ASH supported at a given institution and improved operations at that institution.
5. The project design was extremely broad, incorporating eight major areas of service delivery, health policy and many African institutions. Due to time and financial limitations the two-person external evaluation team was limited to one site visit to WHO/AFRO in Brazzaville and was not able to hold face-to-face meetings with African participating organizations, who were reached virtually by phone. Ten additional individual interviews were held with WHO/AFRO technical staff representing different technical clusters within that organization. Only three of the 10 clusters had prior knowledge about the ASH Project.

ANNEX III. PERSONS INTERVIEWED AND OTHER CONTACTS

ORGANIZATION	NAME	TITLE	E-MAIL
USAID MISSIONS			
*Uganda	Andrea Sternberg	Former COR for ASH	asternberg@usaid.gov
*Uganda	Wilberforce Owembabzi	HSS/CBHI	wowembabzi@usaid.gov
*Ethiopia	Mary Harvey	Former COR for ASH	maharvey@usaid.gov
*Tanzania	George Greer	Former AFR/SD/H Team Member	ggreer@usaid.gov
*Rwanda	Jesse Joseph	Current ASH activity manager in USAID/Rwanda	jjoseph@usaid.gov
*Accra	Danielle Nyirandutiye	USAID/ACCRA/WA	dnyirandutiye@usaid.gov
*DRC	Dr. Godefroid Mayala	Manager for KSPH	gmayala@usaid.gov
*Madagascar	Jean-Claude Randrianarisoa	Senior Economist, M&E Officer	jcrandrianarisoa@usaid.gov
*Angola	Giselle Guimaraes	Health Project Manager	gguimaraes@usaid.gov
USAID WASHINGTON			
*	Lisa Baldwin	Team Leader, AFR/SD/H	lbaldwin@usaid.gov
*	Karen Nelson	Deputy Director	knelson@usaid.gov
*	Hope Sukin	Former Team Leader, AFR/SD/H	hopesukin@gmail.com
*	Jenny Albertini	Current ASH activity manager in AFR/SD/H	jalbertini@usaid.gov
*	Keri Lijinski	Current ASH activity manager in AFR/SD/H	clijinski@usaid.gov
*	Sara Zizzo	Current ASH activity manager in AFR/SD/H	szizzo@usaid.gov
*	Karen Fogg	Former ASH activity manager in AFR/SD/H	kfogg@usaid.gov
*	Lungi Okoko	Former ASH Technical Director	lokoko@usaid.gov
*	Megan Fotheringham	Worked with ASH on Evaluation of RBM Sub-regional Networks	mfotheringham@usaid.gov
*	Kovia Gratzon Erskine	Worked with ASH on evaluation of AFRO	kgratzon-erskine@usaid.gov
*	Elizabeth Fox	TB	efox@usaid.gov
*	Julie Wallace	PMI	jwallace@usaid.gov
*	Anthony Kolb	Urban Health	akolb@usaid.gov
*	Clydetta Powell	Health	cpowell@usaid.gov
*	Karen Cavanaugh	Director, Office of Health Systems	kcavanaugh@usaid.gov

*	Tom Hall	Alt COR, ASH	thall@usaid.gov
*	Margaret D'Adamo	Worked with ASH on Mobile Technology	mdadamo@usaid.gov
*	Adam Slote	Same as above	aslote@usaid.gov
*	Roy Miller	Former ASH activity manager in AFR/SD/H	romiller@usaid.gov
*	Ishrat Husain	Current ASH activity manager in AFR/SD/H	ihusain@usaid.gov
*	Kaitlyn Patierno	Current ASH activity manager in AFR/SD/H	kpatierno@usaid.gov
*	John Borrazzo	Chief, Maternal and Child Health Division	jborrazzo@usaid.gov
*	Michael Zielinger	Director, Office of Policy, Programs and Planning	mzeilinger@usaid.gov
*	Andrew Thompsett	Program Analyst, PMI	athompsett@usaid.gov
WHO/AFRO			
*	Phanuel Habimana	Acting Director for Program Management CAHN	habimanap@who.int
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*	Catherine Taylor	Vice-President	ctaylor@msh.org
	Sherri Haas	mHealth Technical Officer	shaas@as4h.org
	Rebecca Levine	Principal Technical Advisor	rlevine@msh.org
	Alison Corbacio	Senior Project Associate	acorbacio@as4h.org
*	Ken Heise	Principal Technical Advisor	kheise@msh.org
*	Sara Holtz	Technical Advisor	sholtz@msh.org
*	Mary Burket	Senior Manager, Communications	mburkitt@msh.org
*	Sarah Johnson	Director	sjohnson@msh.org
*	Sarah Konopka	Technical Director and HIV/AIDS Advisor	skonopka@as4h.org
*	Fabio Castano	Global Technical Lead for Family Planning	fcastano@msh.org
MOH			
	*Malawi	Humphrey Nsona	Head, IMCI Unit hnsona@gmail.com
	*Ethiopia	Ferew Lemma	Office of Minister lferew@gmail.com
CDC*	Helen Perry	IDSR Team lead	hap5@cdc.gov
KHULISA*	Mary Pat Selvaggio	Khulisa - ASH Subcontractor	mpselvaggio@khulisa.com
INDEPENDENT CONSULTANT*	MK Cope	CSR	mklaynecope@gmail.com

APHRC*	James Kiplimo	ASH Subcontractor	jkiplimo@aphrc.org
SADC*	Alphonse Mulumba	HIV/AIDS Advisor	amulumba@sadc.int
KSPH*	Kaba Kinkodi	Deputy Dean Kinshasa School of Public Health	didnekaba@yahoo.fr

*Interviewed

ANNEX IV. SOURCES OF INFORMATION

ASH PROJECT DOCUMENTS

1. Management Sciences for Health Technical Proposal: RFP No. M-0AA-GRO-EGAS-11-0001 and Technical Annexes submitted to USAID, July 7, 2011.
2. ASH Contract
3. MSH Contract Modification Documents (multiple)
4. MSH/ASH Monthly Financial Reports: October 2011- September 2012 (11 Reviewed)
5. ASH Work Planning Meeting Notes: August 6, 2012
6. ASH Strategic Team Review Year One
7. ASH Annual Report Year One: 2011-2012: October 2012
8. ASH Annual Report Year Two: 2012-2013: December 2013
9. ASH Annual Report Year Three: 2013-2014: October 2014
10. ASH Work Plan Year 1 (2011-2012)
11. ASH Work Plan Year 2 (2012-2013)
12. ASH Work Plan Year 3 (2013-2014)
13. ASH Year 2 Core Team Technical Review Presentation November 2013
14. ASH Year 3 Core Technical Team Retreat: November 2014
15. ASH Work Plan Year 4: October 2014 –September 2015
16. ASH Work Planning Meeting Notes: August 6, 2012
17. ASH Quarterly Review: September 10, 2013
18. ASH Quarterly Review: September 3, 2014
19. ASH Quarterly Review: November 5, 2014
20. ASH Quarterly Review: February 11, 2015
21. ASH Advocacy, Communication and Dissemination Strategy: August 2012
22. ASH Draft Performance Monitoring Plan December 28, 2011
23. ASH Monitoring and Evaluation Plan submitted to USAID November 25, 2014 (version 3)
24. ASH Budgets and Obligations
25. MSH Trip Report Summary of ASH at ECOWAS Forum August 15, 2015
26. ASH Trip Report: Sarah Konopka, Trip Supporting SADC to Develop RMS for the Road Transport Corridors, Johannesburg, South Africa, August 11-13, 2014
27. ASH Deliverables Tracker June 23, 2015
28. ASH Year 4 Activities Tracker: June 2, 2015

ASH TECHNICAL REPORTS AND PUBLICATIONS

1. ASH Urban Health Slideshow, “A Corridor of Contrasts,” ECOWAS Forum of Health Practices in Burkina Faso July 30, 2015.
2. AGOA Technical Brief: Ebola and Other Disease Outbreaks: Implications for Economic Growth and Trade July 2015.
3. ASH Urban Health Banners, Posters and Postcards in French and English developed for electronic dissemination: 2015.

4. Investing in Technology and Innovations for Human Development in Africa Meeting Report Joint USAID-African Development Bank Meeting Rabat, Morocco October 14, 2014.
5. A Systematic Review of Interventions to Reduce Mortality among HIV-Infected Pregnant and Postpartum Women (May 2013).
6. Hodgson, Plummer, Konopka, Colvin, Jonas, Albertini, Amzel and Fogg: *A Systematic Review of Individual and Contextual Factors Affecting ART Initiation, Adherence and Retention for HIV-Infected Pregnant and Postpartum Women*: PLOS ONE, November 2014, Volume 9, Issue 11.
7. Colvin, Konopka, Chalker, Jonas, Albertini, Amzel and Fogg: *A Systematic Review of Health System Barriers and Enablers for Antiretroviral Therapy (ART) for HIV-Infected Pregnant and Postpartum Women*: PLOS ONE, October 2014, Volume 9, Issue 10.
8. HIV and Maternal Mortality: What Works, What Helps and What Gets in the Way: Edna Jonas Presentation June 10, 2013.
9. ASH Technical Report: HIV-Related Maternal Mortality in the ART Era: A Synthesis of Three Systematic Reviews: May 2013.
10. ASH Technical Report: A Systematic Review of Demand-Side Factors Affecting ART Initiation and Adherence for Pregnant and Postpartum Women with HIV: May 2013.
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12. Thetard, Navindra, Persaud, Jonas: Missed opportunities for IPTp in Malawi: Client and Facility Characteristics: January 17, 2013.
13. Landscape Analysis and Business Case for mHealth Investment in Angola, February 2015.
14. mHealth Compendium Reports, Volume One: November 30, 2012.
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16. mHealth Compendium Reports, Volume Four: October 2014.
17. mHealth Compendium Reports, Volume Five: June 2015.
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19. Integrated Disease Surveillance and Response: AFENET 2013 Pre-Conference Workshop Meeting. Addis Ababa, Ethiopia, November 17, 2013.
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22. Nineteen Country-Specific Pediatric TB Posters Prepared for April 21-22, 2015 WHO/AFRO, UNICEF and USAID Childhood TB Meeting.

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1. Joint Review of the USAID Grants to WHO/AFRO: USAID-WHO Collaboration on Africa: A Qualitative Snapshot of the Relationship, July 2014.
2. Joint Mid-term Review of USAID Africa Bureau Grant to WHO/AFRO: A View Towards Improving Grant Management (June 30, 2014).
3. Survey Monkey for WHO/AFRO Qualitative Evaluation May 5-16, 2014
4. Survey Monkey of ASH MNCH Core Technical Team Year 3

5. Review of U.S. Government-supported Global Fund Technical Assistance for Malaria Funding Investments: November 2013.

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2. USAID Contract AID-OAA-C-11-00161 Awarded to MSH September 23, 2011
3. USAID COR Letter Tracking Sheet All Fiscal Years, updated May 20, 2015, listing 99 activities AFR/TR/HT
4. USAID ASH Team Retreat Agenda and Report, January 24-25, 2012
5. USAID ASH Work Plan Meeting 2013: Notes, March 2013
6. USAID/ASH Strategic Team Review Year 1: Internal Report, March 2013
7. USAID/AFR-ASH Quarterly Meeting Agenda and Handouts, June 17, 2013
8. USAID/AFR-ASH Quarterly Review Meeting, January 23, 2014
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10. USAID/AFR-ASH Quarterly Meeting, September 3, 2014
11. USAID/AFR-ASH Quarterly Review Meeting, November 5, 2014
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13. Mudd/MSH Letter
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6. Africa on the Move, Health as a Driver of Sustained and Accelerated Trade and Investments, AGOA 2013. Addis Ababa, Ethiopia, August 9-13, 2013.
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5. ASH COR Letter Tracking Sheet

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2. Global Health Technical Assistance Project. Final Evaluation of Africa's Health in 2010 – EOP Report (2005-2011). February 2010.

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1. WHO/AFRO. Harmonization for Health in Africa (HHA), Operational Guide 2014 -2015.
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3. USAID/UNICEF/UNFPA. Acting on the Call—Ending Preventable Child and Maternal Deaths. June 2014.
4. WHO/AFRO. The Health of the People—What Works. The African Regional Health Report 2014.
5. WHO/AFRO. The Transformation Agenda of the World Health Organization Secretariat in the African Region (2015-2020).
6. WHO/AFRO. Integrated Disease Surveillance Quarterly Bulletin. May 2015.
7. Ulin, Robinson, Tolley. Qualitative Methods in Public Health: A Field Guide for Applied Research. Family Health International (FHI)-Josse-BASS Publishers: 2005.
8. WHO/AFRO. eSurveillance in the context of Integrated Disease Surveillance and Response in the WHO African Region. 2015.
9. Ministry of Health/Angola Presentation to the mHealth Meeting: May 2015.
10. Khulisa Management Services Corporate Report for 2012-2015.
11. UNICEF: April 2015 Slideshow Presentation on Childhood TB Within the Context of a Child Survival Agenda: Johannesburg, South Africa.

ANNEX V. DATA COLLECTION INSTRUMENTS

INTERVIEW GUIDE FOR LOCAL ORGANIZATIONS/INSTITUTIONS

Person Interviewed:

Organization:

Title:

Date:

Relationship to the ASH Project:

We would like to ask you a few questions related to the African Strategies for Health (ASH) Project's work with your organization.
1. What are the key roles/activities of your organization?
2. Are you familiar with the objectives and activities of the ASH Project? If not, explain the three results areas of the project (knowledge, strategic planning, evaluation, advocacy and communications, and institutional strengthening and capacity building) and then ask; what are the key challenges your organization is facing?
3. Have you received any assistance from the ASH Project? If not, ask what types of short-term assistance could an external partner provide that would be useful. (skip questions 4 - 11 if the organization has not used ASH or is not familiar with the project's work)
4. Can you specify some contributions of the ASH Project to your technical/programmatic activities? If so, please provide us with specific examples.
5. If yes, how did you or your organization use this assistance? Has this support translated into specific results?
6. Has the ASH Project assisted in reinforcing the capacity of your organization? <ul style="list-style-type: none"> • Has ASH provided any assistance in the area of planning and management? • Has any of this support included: human resources planning? • In the area coaching, mentoring, supportive supervision and training? • And monitoring and evaluation, technical oversight or quality assurance?
7. Has ASH's role in the area of institutional development improved your organizational capacity to implement your programmatic activities?
8. Has your work with ASH facilitate the access of your organization to new programmatic opportunities?
9. Describe the changes, if any, that you have noticed in your organization from receiving ASH's assistance.
10. Has the ASH Project helped your organization to interpret the health needs in Africa and use this as opportunities to advance health conditions?
11. In your view, what are the key results/accomplishments of the ASH Project to date?
12. Given your organization's needs, is there local technical assistance available such as local consulting firms, research organizations or universities where you could obtain this assistance?

INTERVIEW GUIDE FOR WHO/AFRO

Person Interviewed:

Organization:

Title:

Date:

Relationship to the ASH Project:

We would like to ask you a few questions related to ASH's work with WHO/AFRO.
1. What joint programmatic and research and evaluation activities has WHO/AFRO undertaken with ASH in the past three years?
2. What are the objectives of the ASH project and how do they support or align with WHO/AFRO strategic plans or needs?
3. How would you describe the partnership you have established with the ASH Project?
4. Has WHO/AFRO received any assistance from the ASH Project in the area of strategic planning and management, evaluation, advocacy or new knowledge development?
5. How has the ASH Project helped your organization to interpret the health needs in Africa? Has the project served to shape your investment decisions in the region? Have you used the project to leverage new sources of funding for health work in Africa?
6. Describe the process that took place leading up to ASH assistance on specific subjects. (Where did the proposal of support originate?)
7. Could you describe the specific roles of WHO/AFRO and ASH in this partnership?
8. Did this partnership include any private sector involvement?
9. Could you describe the specific programmatic results from these joint ventures?
10. Has the ASH Project contributed in any way to strengthening the coordination role of WHO/AFRO at the regional level?
11. Has the ASH Project contributed to advancing the Integrated Disease Surveillance work in the region? If so, how?
12. Has the ASH Project contributed to resource mobilization or other health care financing or health systems strengthening work in the region or alongside WHO/AFRO?
13. Has WHO/AFRO used the ASH materials on urbanization and its implications for health, mHealth or the landscape analyses? (Show the ASH products)
14. Has the ASH project supported capacity building of WHO/AFR staff to strengthen other African institutions, conduct operations research, carry out evaluations or strategic planning?
15. Has the ASH Project developed tools which you have used in your work?
16. What in your view are the significant successes (and shortcomings) of your partnership with ASH?
17. What is your overall evaluation of your joint activities with the ASH Project?
18. What, if anything, is missing from the ASH mechanism that you wish it had offered?
19. What in your view are the specific needs of WHO/AFRO that USAID could foster in the future through a regional mechanism such as ASH?
20. What specific advocacy tools would advance your work at WHO/AFRO?
21. What are the specific institution-strengthening tools that would advance your health systems strengthening work at WHO/AFRO?

22. The health landscape is changing very rapidly across Africa, what, if any, in your view are the key under-researched questions and topics that need to be assessed in the future? What is the best way to investigate these issues?

INTERVIEW GUIDE FOR USAID/W PARTICIPATING HEALTH STAFF

Person Interviewed:

USAID/W Organization:

Title:

Date:

Relationship to the ASH Project:

GENERAL USAID QUESTIONS

1. Describe how ASH collaborated with other USAID (DC and missions) projects or other donor projects.
2. Describe how ASH has contributed to global leadership on health issues in AFR..
3. From your perspective, does the project respond well to the region's priority health problems and needs?
4. Describe the role ASH played in evaluation/research and disease surveillance.
5. Do the goals and intermediate results designed in 2011 align with USAID current programmatic realities and changing landscape? (The intermediate results are: **knowledge, advocacy, strategy, leadership and institutional strengthening.**)
6. What are the objectives of this project, and what role does it play?
7. What do you perceive to be the benefits of having the project based in DC?
8. Can you cite a few of the top results of this project by IR (knowledge, consensus building and advocacy, and institution strengthening)—highlight by IRs and/or health areas (MNCH, TB, malaria, health systems strengthening)? Is there evidence that the project has had an impact?
9. What is the optimal ASH staffing mix given funding?
10. What is the comparative advantage of an African regional project relative to other global or country projects?
11. What health gaps in Africa has ASH addressed?
12. Has the ASH model of using a DC home office and MSH country offices facilitated implementation?
13. Name the 3 top achievements of ASH and the key outputs and products:
 - By health areas
 - By management, support and technical assistance
 - By IR (knowledge, advocacy, strategy, leadership and institutional strengthening)
14. What was missing from ASH that you wish it had tackled? What prevented this activity or activities from being carried out?
15. What has been the most attractive feature/products of ASH? At the following levels:
 - Missions
 - Africa/TR
 - Other USAID/W offices
 - USAID/Africa regional missions

- Participants
 - Stakeholders
 - Users of ASH products
16. If you were designing a regional AFR program, what elements would you add to or omit from those in the current ASH project?
 17. What are the key lessons learned from ASH that need to be carried forward to ensure success of a regional project?
 18. Do you think the ASH framework is still relevant? If so, why? If not, why not?
 19. How are priorities set for ASH programming?
 20. Has the project deviated from the original design? If so, please explain.

SPECIFIC QUESTIONS FOR USAID AFR/TR COR AND USAID/W ASH DESIGN AND USAID CORE TEAM

1. In your view, is the project as currently designed responsive to the political and economic development landscape and realities that the AFR/TR team faces today? If so, why; if not, why not? What is missing and what are the Bureau's chief technical assistance and support needs? Does the current mechanism have enough capacity to meet unexpected requirements such as meetings and conferences? In the last year of the project, is there a way to program for unexpected meetings and other needs?
2. Has the ASH Project helped to inform the Africa Bureau's investment and programming decisions?
3. What factors led USAID to use a contract rather than a cooperative agreement mechanism for this project? Is the structure flexible enough to meet the Bureau's need for support and short-term expertise on key topics?
4. Why did the design exclude a specific capacity for mission field support buy-ins?
5. Can you describe some of the organizational structure issues that occurred as a result of the project design? If you could redesign the project, what changes would you make in the way the project is structured? For example, should they have a field office, should they be able to deploy advisors to the field on a longer-term basis?
6. Has the MSH footprint and extensive presence in bilateral country offices led to a more rapid response to requests by your bureau for technical support and technical assistance, such as the MSH work on the "Call to Action" meeting in Addis? If not, why not?
7. MSH noted that the first year of funding was so limited compared with what was needed that they were unable to make field visits. In your view, how did the shortfall in funding by the Bureau shape the first years of the project? How difficult has it been to obtain Global Bureau support for ASH and other AFR Bureau health project funding? If you had more funding where would you allocate it?
8. Given the funding level, was it realistic to expect the project to meet all three IRs? What are the key institution-strengthening actions and interventions the project has completed to date? Please describe the specific ways African institutions have changed as a result of the ASH work. Should a future project address all three IRs?
9. The project indicators in the PMP are all process indicators. What was the rationale for excluding any quantitative indicators such as the number of users for materials and literature?

10. What are the specific contributions that ASH has made to the IDSR field? Has the project served to advance AFR and CDC collaboration on disease surveillance?
11. What are the key results you can highlight concerning ASH's work on institution building?
12. We understand that the project has tackled some controversial studies such as a look at the health status of 5-9 year-olds in Africa and potential investments in school health. What is the process that the Africa Bureau team follows to identify new ASH research priorities? What has been the reaction to these studies by other parts of the Agency?
13. Has the Bureau considered extending this project beyond the five years?

INTERVIEW GUIDE FOR USAID MISSION HEALTH STAFF

Person Interviewed:

USAID/W Organization:

Title:

Date:

Relationship to the ASH Project:

GENERAL USAID QUESTIONS

1. Describe how ASH collaborated with other USAID (DC and missions) projects or other donor projects.
2. Describe how ASH has contributed to global leadership on health issues in AFR.
3. From your perspective, does the project respond well to the region's priority health problems and needs?
4. Describe the role ASH played in evaluation/research and disease surveillance.
5. Do the goals and intermediate results designed in 2011 align with USAID current programmatic realities and changing landscape? (The intermediate results are: **knowledge, advocacy, strategy, leadership and institutional strengthening.**)
6. What are the objectives of this project, and what role does it play?
7. What do you perceive to be the benefits of having the project based in DC?
8. Can you cite a few of the top results of this project by IR (knowledge, consensus building and advocacy, and institution strengthening)—highlight by IRs and/or health areas (MNCH, TB, malaria, health systems strengthening)? Is there evidence that the project has had an impact?
9. What is the optimal ASH staffing mix given funding?
10. What is the comparative advantage of an African regional project relative to other global or country projects?
11. What health gaps in Africa has ASH addressed?
12. Has the ASH model of using a DC home office and MSH country offices facilitated implementation?
13. Name the 3 top achievements of ASH and the key outputs and products:
 - By health areas
 - By management, support and technical assistance
 - By IR (knowledge, advocacy, strategy, leadership and institutional strengthening)
14. What was missing from ASH that you wish it had tackled? What prevented this activity or activities from being carried out?

15. What has been the most attractive feature/products of ASH? At the following levels:
- Missions
 - Africa/TR
 - Other USAID/W offices
 - USAID/ Africa regional missions
 - Participants
 - Stakeholders
 - Users of ASH products
16. If you were designing a regional AFR program, what elements would you add to or omit from those in the current ASH project?
17. What are the key lessons learned from ASH that need to be carried forward to ensure success of a regionally project?
18. Do you think the ASH framework is still relevant? If so, why? If not, why not?
19. How are priorities set for ASH programming?
20. Has the project deviated from the original design? If so, please explain.
21. What are the specific contributions that ASH has made to the IDSR field? Has the project served to advance AFR and CDC collaboration on disease surveillance?
22. What are the key results you can highlight concerning ASH's work on institution building?

INTERVIEW GUIDE FOR MSH COUNTRY OFFICE TEAM LEADERS

Person Interviewed:

Organization:

Title:

Date:

Relationship to the ASH Project:

We would like to ask you a few questions related to ASH's work with Country MSH Offices.	
1.	Are you familiar with the objectives and activities of the ASH Project?
2.	What are the specific activities your MSH Country Office has developed together with ASH? Could you describe them?
3.	Could you describe how these joint activities between your country MSH office and ASH were identified?
4.	Has the ASH project's involvement helped the MSH Country Office to interpret the health needs in your country? Are there ways that the findings from this work could benefit the region?
5.	Could you describe the ways in which your MSH Country Office has collaborated and partnered with ASH?
6.	In general, have these joint activities facilitated and generated new knowledge, improved local institutional capacity or improved strategic planning, monitoring and evaluation, or the advocacy and communications of new and important health tools or trends?

7. Has the ASH Project led to better investment decisions or priority-setting of health programs by the host country, donors or the private sector? Has it leveraged non-USAID resources for specific new health approaches and ideas?
8. Please provide your overall impression about the ASH project, its role and its results.
9. What, if anything, is missing from the ASH mechanism that you wish it had offered?

ANNEX VI. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

<u>Betsy H. Brown</u>	<u>4/9/2015</u>
Signature	Date
<u>Betsy H. Brown</u>	<u>International Public Health</u>
Name	Title <u>consultant.</u>

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature 

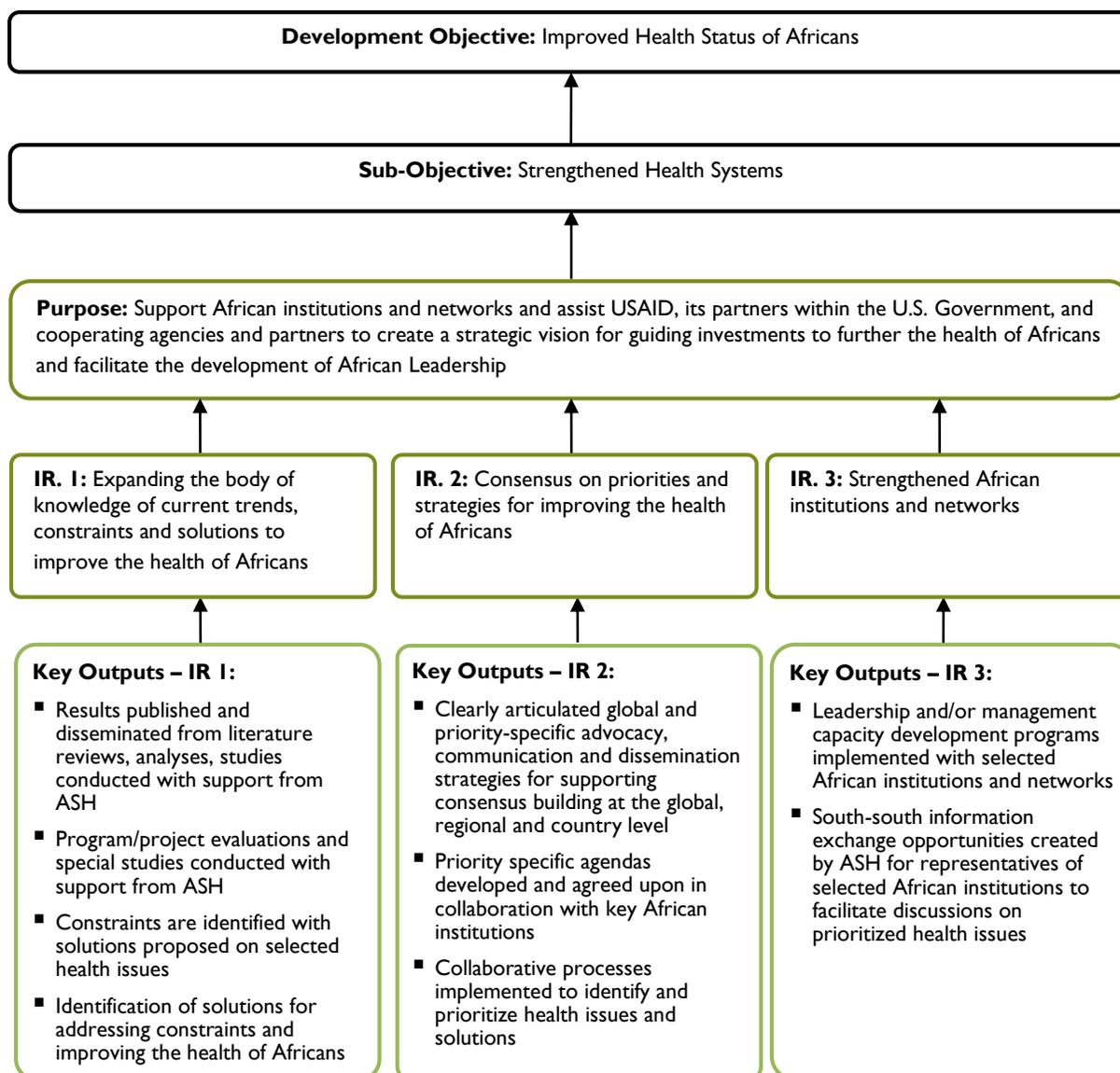
Date **1/3/2015**

Jaime Benavente
Name

Title

ANNEX VII. ASH RESULTS FRAMEWORK, LOGFRAME, PERFORMANCE MANAGEMENT PLAN AND PERFORMANCE ON 50 ACTIVITIES

ASH RESULTS FRAMEWORK



ASH LOGFRAME

Impact	Intended Outcomes	Outcome Indicators	Key Outputs	Output Indicators
Def.: Long-term population-level changes; outside ASH's sphere of influence	Def.: More immediate effect caused by or attributable to ASH, program or policy (change in behavior or practice with influence from ASH)		Def.: Products, goods and services (almost completely under ASH's control)	
IR 1. Expanding the body of knowledge of current trends, constraints and solutions to improve the health of Africans				
<p>ASH Goal: Improved Health Status of Africans</p> <p>-MDG 4: Reduced child mortality</p> <p>-MDG 5: Reduced maternal mortality</p> <p>-MDG 6: Lower HIV prevalence</p> <p>(*Important note: ASH will track these selected indicators for informative purpose only as they relate to work performed under key technical areas of the project. ASH does not intend to have a direct effect on these selected indicators)</p>	<p>Increased availability and use of key findings from ASH-supported analyses of trends, constraints and solutions for the improvement of the health of Africans</p> <p>Enhanced understanding of constraints preventing progress in African health status</p>	<p>1.A. Percentage of users who report knowledge gained from an ASH publication or service (as a measure of user satisfaction)</p>	<p>Results published and disseminated from literature reviews, analyses, studies conducted with support from ASH</p> <p>Program/project evaluations and special studies conducted with support from ASH</p> <p>Constraints and/or solutions identified and proposed on selected health issues</p> <p>Analysis of constraints and/or solutions for improving the health of Africans</p>	<p>1.1. Number of publications produced and disseminated that focus on trends, constraints, and solutions for improved African Health</p> <p>1.2. Number of program/project evaluations and special studies completed with support from ASH</p> <p>1.3. Number of constraints identified by ASH and formally proposed to USAID</p> <p>1.4. Number of meetings in which ASH team members participated in discussions to identify constraints and solutions with other technical experts</p> <p>1.5. Number of solutions, constraints and innovative practices identified and analyzed</p>
	IR 2. Consensus on priorities and strategies for improving the health of Africans			
	<p>Broad consultation and engagement of key stakeholders resulting in agreements on priorities and strategies for improving the health of Africans</p>	<p>2.A. % of ASH-assisted consensus building processes resulting in an agreement</p> <p>2.B. Changes to African policies, programs, or approaches as a result of ASH work</p> <p>2.C. Changes to USAID policies, programs, or approaches as a result of ASH work</p>	<p>Clearly articulated global and priority-specific advocacy, communication and dissemination strategies for supporting consensus building at the global, regional and country levels</p> <p>Priority specific agendas developed and agreed upon in collaboration with key African institutions</p>	<p>2.1. Number of consensus-building processes supported by ASH on prioritized health issues</p> <p>2.2. An ACD strategy produced and reviewed annually</p>

Impact	Intended Outcomes	Outcome Indicators	Key Outputs	Output Indicators
	IR 3. Strengthened African institutions and networks			
	<p>Improved leadership, management, and technical capacity within African institutions</p> <p>Enhanced technical capacity in African institutions and networks for assessing, prioritizing and responding to health issues</p> <p>Improved networking among African institutions</p>	<p>3.A. Percent difference in organizational capacity assessment score (pre/post) for ASH-supported African institutions and networks</p> <p>3.B. Level of interaction between selected African institutions and networks participating in information exchange opportunities supported by ASH (3-point scale: low, medium, high)</p>	<p>Leadership, technical and/or management capacity development programs implemented with selected African institutions and networks</p> <p>Collaborative activities implemented to identify and prioritize health issues and solutions</p> <p>South-to-south information exchange opportunities supported by ASH for representatives of African institutions to facilitate discussions on prioritized health issues</p>	<p>3.1. Number of African institutions participating in ASH-supported capacity development programs focusing on leadership, technical and/or management areas</p> <p>3.2. Number of African institutions participating in collaborative activities with ASH to identify and prioritize health issues and solutions</p> <p>3.3. Number of ASH-supported south-to-south information exchange opportunities (in-person or remote) between selected African institutions</p>

ASH PERFORMANCE MANAGEMENT PERFORMANCE PLAN (PMP)

(dated November 25, 2014)

	RESULT TO WHICH THE INDICATOR RESPONDS	UNIT OF MEASURE	ANNUAL TARGET				
			Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
PROCESS MILESTONES							
1. M&E Plan produced and annual assessment of performance against M&E Plan	None (contractually required indicator)	Document submitted and approved annually	1	1	1	1	1
2. Annual work plans	None (contractually required indicator)	Work plan submitted and approved	1	1	1	1	1
3. Progress and financial reports	None (contractually required indicator)	Monthly reports submitted and approved	12	12	12	12	12
OUTPUT INDICATORS							
1.1. Number of publications produced and disseminated that focus on trends, constraints and solutions for improved African Health	IR 1 (contractually required indicator)	Document submitted (publications)	3	12	10	10	10
1.2. Number of program/project evaluations and special studies completed with support from ASH	IR 1 (contractually required indicator)	Document submitted (final evaluation report)	0	1	1	1	1
1.3. Number of constraints identified by ASH and formally proposed to USAID	IR 1 (contractually required indicator)	Records documenting the proposal	21	10	5	5	5
1.4. Number of meetings in which ASH team members participated in discussions to identify constraints and solutions with other technical experts	IR 1 (contractually required indicator)	Notes from the meeting	98	70	50	50	50
1.5. Number of solutions, constraints and innovative practices identified and analyzed	IR 1 (contractually required indicator)	Document submitted (final report of the analysis)	14	5	3	3	3
2.1. Number of consensus-building processes supported by ASH on prioritized health issues	IR 2 (contractually required indicator)	Records documenting ASH's role in the consensus-building process	1	1	1	1	1
2.2. An ACD strategy produced and reviewed annually	IR 2 (contractually required indicator)	Document submitted and reviewed	1	1	1	1	1

	RESULT TO WHICH THE INDICATOR RESPONDS	UNIT OF MEASURE	ANNUAL TARGET				
			Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
3.1. Number of African institutions participating in ASH-supported capacity development programs focusing on leadership, technical and/or management areas	IR 3 (contractually required indicator)	Document submitted (activity report)	0	1	1	1	1
3.2. Number of African institutions participating in collaborative activities with ASH to identify and prioritize health issues and solutions	IR 3 (contractually required indicator)	Records documenting the collaborative activities	1	1	1	1	1
3.3. Number of ASH-supported south-to-south information exchange opportunities (in-person or remote) between selected African institutions	IR 3 (contractually required indicator)	Records documenting of information exchange opportunity	0	2	2	2	2
OUTCOME INDICATORS							
1.A. Percentage of users who report knowledge gained from an ASH publication or service (as a measure of user satisfaction)	IR 1	Percent based on respondent feedback	n/a	70%	80%	80%	80%
2.A. Percentage of ASH-assisted consensus building processes resulting in an agreement	IR 2	Percent based on records documenting agreement	n/a	60%	60%	60%	60%
2.B. Changes to African policies, programs, or approaches as a result of ASH work*	IR 2	Records documenting the policy/programmatic change	n/a	n/a	n/a	n/a	n/a
2.C. Changes to USAID policies, programs, or approaches as a result of ASH work*	IR 2	Records documenting the policy/programmatic change	n/a	n/a	n/a	n/a	n/a
3.A. Percent difference in organizational capacity assessment score (pre/post) for ASH-supported African institutions and networks	IR 3	Percent based on (pre/post) OCA scores	n/a	40%	40%	40%	40%
3.B. Level of interaction between selected African institutions and networks participating in information exchange opportunities supported by ASH*	IR 3	3-point scale (low, medium, high) based on respondent feedback	n/a	n/a	n/a	n/a	n/a

African Strategies for Health – Results on Performance Indicators (year to date)		
PERFORMANCE INDICATOR	TARGET	RESULT
IR. I: Expanding the body of knowledge of current trends, constraints and solutions to improve the health of Africans		
1.1. Number of publications produced and disseminated that focus on trends, constraints, and solutions for improved African Health	71	62
MNCH 1. Compilation: Country-specific tables for AU CARMMA's African Health Statistics web site 2. Report: "A Systematic Review of Interventions to Reduce Mortality among HIV-Infected Pregnant and Postpartum Women" 3. Report: "A Systematic Review of Demand-Side Factors Affecting ART Initiation and Adherence For Pregnant And Postpartum Women with HIV" 4. Report: "A Systematic Review of Health System Barriers to and Enablers of ART for Pregnant and Postpartum Women with HIV" 5. Report, "HIV-Related Maternal Mortality In the ART Era: A Synthesis of Three Systematic Reviews" 6. Presentation at Maternal Health and HIV: Examining Research through a Programmatic Lens symposium: "HIV and Maternal Mortality: What Works, What Helps and What Gets in the Way" 7. Presentation at Global Maternal Health Conference: "Missed Opportunities for IPTp in Malawi: Client and facility characteristics" 8. HIV and maternal mortality briefer with literature review 9. Oral rehydration therapy use literature review ID 10. Pediatric TB literature review 11. Pediatric TB presentations (TB Union Conference, MSH & USAID) 12. Peer-Reviewed Article: "A Systematic Review of Interventions to Reduce Mortality Among HIV-Infected Pregnant and One Year Postpartum Women" 13. Peer-Reviewed Article: "A Systematic Review of Health Systems Barriers to and Enablers of Antiretroviral Therapy for Pregnant and Postpartum Women with HIV" 14. Poster presentation: "Effective interventions for HIV+ pregnant and postpartum" for 2014 International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) Conference 15. Poster presentation: "System factors" 16. Poster presentation: "Demand-side factors" 17. Report: Review of U.S. Government-supported Global Fund Technical Assistance for Malaria Funding Investment	31. Report: Strengthening the Capacity of African Evaluators to Conduct High Quality Health Evaluations 32. Report: USAID/WHO collaboration in Africa: A qualitative snapshot of the relationship 33. Report: WHO AFRO Joint Mid-term Review 34. Report: IDSR AFENET 2013 Pre-Conference Workshop 35. Report: "Investing in Technology and Innovations for Human Development in Africa: Joint USAID-African Development Bank Ministerial Meeting" 36. Presentation: "Technology and Health Financing" for USAID Tanzania Healthcare Financing Training 37. Presentation: "Mobile Technology: Bringing the Community and Health System Together" presentation for 2013 International Conference on Family Planning 38. Presentation: "ICT for Health Care Financing in Nigeria" 39. Report: "Landscape Analysis and Business Case for mHealth Investment in Angola" 40. Presentation: "Landscape Analysis and Business Case for mHealth Investment in Angola" 41. Presentation: "Results of Core Technical Team Year 3" 42. Technical Report: Scaling Up Mobile Technology Applications for Accelerating Progress on Ending Preventable Maternal and Child Deaths 43. Report: Leveraging Private Sector Companies Contributing to the African Health Sector (Phase I) 44. Presentation: Mobile Technology: Bringing the Community and Health System Together" for the 2013 International Conference on Family Planning 45. Profiles: African organizational profiles for the Regional Landscape Analysis 46. Country briefer: Zambia 47. Report: Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	

<p>18. Report: Situational Analysis of Cross-border HIV and Health Services in the SADC region for the development of the Regional Minimum Standards</p> <p>19. Report: “USAID/Tanzania Vector Control Scale-up Project-Mid Term Review”</p> <p>20. Malaria Financing literature review</p> <p><u>HSS</u></p> <p>21. Compendium: mHealth (Volume 1)</p> <p>22. Compendium: mHealth (Volume 2)</p> <p>23. Compendium: mHealth (Volume 3)</p> <p>24. Compendium: mHealth (Volume 4)</p> <p>25. Compendium: mHealth (Volume 5)</p> <p>26. mHealth Database (online)</p> <p>27. Technical Brief: Ethiopian Health Care Financing Reforms-On the Path to Universal Health Coverage</p> <p>28. Technical Presentation: Ethiopian Health Care Financing Reforms-On the Path to Universal Health Coverage</p> <p>29. Technical Paper: Ethiopian Health Care Financing Reforms- On the Path to Universal Health Coverage</p> <p>30. Presentation: “The USAID Evaluation Policy: Quality Standards, Lessons Learned and Experiences” for the 7th International AfrEA Conference</p>	<p>48. Technical brief: Cost-Effectiveness of Reproductive Health Vouchers And Community based Health Insurance in Uganda</p> <p>49. Action brief: Cost-Effectiveness of Reproductive Health Vouchers And Community based Health Insurance in Uganda</p> <p>50. Technical brief: Use Of Technology In The Ebola Response In West Africa</p> <p>51. Technical brief: AGOA Forum Brief</p> <p>52. Report: “Rwanda Health Private Sector Engagement (PSE) Assessment”</p> <p>53. Banners: Regional mHealth meeting (Malawi)</p> <p>54. Postcard: Regional mHealth meeting (Malawi)</p> <p>55. Questionnaire: health care financing training</p> <p><u>Cross-cutting</u></p> <p>56. Report: “A Corridor of Contrasts”</p> <p>57. Postcards: Urbanization and Health in West Africa</p> <p>58. Banners: Urbanization and Health booth at ICUH meeting (Bangladesh)</p> <p>59. Review of USAID’s FP programs in Africa</p> <p>60. Technical brief: health and trade (AGOA)</p> <p>61. Presentation-health and trade (AGOA)</p> <p>62. Report: Community strategies</p>	
<p>1.2. Number of program/project evaluations completed with support from ASH</p>	<p>6</p>	<p>3</p>
<p><u>ID</u></p> <p>1. Review of U.S. Government-supported Global Fund Technical Assistance for Malaria Funding Investment</p> <p>2. Tanzania IRS Mid-term Assessment</p>	<p><u>HSS</u></p> <p>3. WHO AFRO Joint Mid-term Review</p>	
<p>1.3. Number of special studies completed with support from ASH</p>	<p>33</p>	<p>18</p>
<p><u>MNCH</u></p> <p>1. Special Study: Systematic Review of Interventions to Reduce Mortality among HIV-Infected Pregnant and Postpartum Women</p> <p>2. Special Study: Systematic Review of Health System Barriers to and Enablers of Art for Pregnant and Postpartum Women with HIV</p> <p>3. Special Study: Systematic Review of Demand-Side Factors Affecting Art Initiation and Adherence For Pregnant And Postpartum Women with HIV</p> <p><u>ID</u></p> <p>4. Special Study: Supporting SADC to Develop Minimum Package of Services for Populations along the Transport Corridor of Southern Africa (Phase I, Phase 2)</p> <p>5. Special Study: TB childhood Landscape Analysis (Phase I—completion of document review and majority of Round I key informant interviews of USAID staff)</p> <p>6. Special Study: IPTp Facility Assessments</p> <p>7. Malaria Financing: Literature Review (Phase I)</p>	<p>10. Special Study: Conceptual framework paper - Identifying operational level strategies, interventions and activities aimed at increasing the coverage for two doses of IPT in Malawi</p> <p>11. Special Study: CBHI Voucher cost-effectiveness analysis</p> <p>12. Special Study: Landscape Analysis of Key Regional Organizations in the African Health Sector</p> <p>13. Special Study: Family Planning Review Research and Data Analysis</p> <p>14. Special Study: Online qualitative survey to assess partnerships between USAID and WHO</p> <p>15. Special Study: Leveraging Private Sector Companies Contributing to the African Health Sector (Phase I)</p> <p><u>Cross-Cutting</u></p> <p>16. Special Study: Review of literature on the relationship between health, economic development and trade</p>	

<u>HSS</u> 8. Special Study: Review of past USAID evaluations 9. Special Study: Review of management training activities for health care workers in Africa	17. Special Study: Review of Capacity Building Approaches for Parliamentarians in Africa 18. Special Study: Review of literature on existing evidence on the relationship between dependency ratio and income per capita, as well as on the effectiveness of youth livelihood programs
1.4. Number of ideas and opportunities identified and explored within ASH-USAID Core Technical Team	
58	54
<u>MNCH</u> 1. Identifying how CHWs can be best supported to improve effectiveness 2. Development of a tool to evaluate health system readiness for PMTCT and MNCH integration 3. Studies on HIV and maternal and/or newborn health, such as a systematic review of literature on effects of ART on birth outcomes 4. Evaluation of linkages between SRH, FP and MCH services with PMTCT programs 5. Development of guidelines for programs on integrating HIV and reproductive & maternal health services 6. Assessment of gender components in MNCH and HIV strategies in Africa 7. Present ASH Summary Key Points from Third Global Forum on HRH, Side Session: Moving from Fragmentation to Synergy (CHWs) 8. Participation in Survive and Thrive GDA activity 9. Promoting child health and prevention services to support 5-15 year-olds 10. Potential case studies for MDSR 11. Conduct country-level case studies to document varying strategies for implementing community-based MNC packages 12. Conduct a cost-effectiveness study of CHWs providing postnatal care home visits 13. Review of Antenatal Corticosteroids Programs in Africa region; documenting key components from successful programs <u>ID</u> 14. Contribute research questions for childhood TB landscape analysis 15. Investigate the causes and costs of underutilization of iCCM Services and document best practices for overcoming barriers impacting uptake of services 16. Review of PMI Malaria Operational Plans 17. Development of technical brief for (2014) World AIDS Day 18. Strengthening regional efforts to accelerate HIV prevention efforts including PMTCT, MC, ART and condoms <u>HSS</u> 19. Perform a costs-benefit analysis of investing in electronic HIS to determine value for money	<u>HSS (continued)</u> 29. Conduct impact evaluation of the pilot SMS Mother Reminder System, Uganda 30. Participate in 2013 mHealth Summit meeting 31. Conduct impact evaluation of Uganda's mhealth NHRP Pilot 32. Carry out Phase II of Private Sector Health study 33. Develop database for CHW, providing key descriptive information on CHWs 34. Draft report outlining preliminary findings exploratory review on health focused CSR Initiatives in Africa 35. Develop concept note on Cost Effectiveness Analysis of a mobile application used for MCH activities in Rwanda and met with MOH Director of eHealth 36. Provide technical guidance mHealth Stakeholder mapping and strategy development in Angola 37. Organize and coordinate the USAID/AfDB ICT Ministerial meeting "Investing in Technology and Innovations for Human Development" in Rabat, Morocco 38. Participate in the West Africa Regional Private Sector and mHealth Dissemination workshop 39. Hold discussions with AfrEA about potentially supporting future activities 40. Explored localization of health services with Johns Hopkins University School of Public Health 41. Rwanda mHealth Study 42. Technology Health Financing presentation to USAID Tanzania Healthcare Financing Team 43. USAID's contribution to an AIDS-Free Generation (AFG): 5 agenda point briefers 44. Conduct CBHI Feasibility Assessment in Uganda 45. CHW Incentive Study 46. Potential dissemination activities for CBHI study results <u>M&E</u> 47. Through AfrEA, identify and review evaluations conducted on health interventions

<ul style="list-style-type: none"> 20. Develop an HIS software selection checklist to help countries select best software solutions for HIS 21. Develop a technical brief on the advantages of open source HIS software versus commercial HIS software products 22. Evaluation of the implementation of WAHO's 2009-2013 Strategic Plan 23. Costing of essential community activities that promote and maintain community participation in 2-3 countries 24. Development of guidelines for effective community-based participation, approaches and actions for health 25. Identify best practices related to the use of score cards and assess how various score cards might be harmonized 26. Document regional best practices (i.e. African Solutions) to transnational problems (HSS related topics TBD) 27. Organize a stakeholder meeting of key US-based organizations playing a role in health sector regionalization and regional programming in Africa 28. Conduct analysis on IDSR landscape activities in the Africa region 	<p>and summarize common issues affecting implementation</p> <ul style="list-style-type: none"> 48. Survey members of evaluation networks in Africa to identify gaps in skills and resources for conducting effective evaluations, DQAs and performance assessments in health. Develop and disseminate a resource and skills directory listing training opportunities and resource materials 49. Conduct a review of target setting approaches used by health programs of USAID missions to identify factors considered by missions when setting programmatic targets on indicators <p><u>Cross-Cutting</u></p> <ul style="list-style-type: none"> 50. Conduct a review of the linkages between urbanization, poverty and the growing burden of diseases 51. Produce 15 country briefs 52. Discussions on developing activities related to urban health 53. Links between climate change and health 54. Hold discussions with fragile states expert and presentation on fragile states and health in Africa in ASH quarterly meeting
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IR. 2: Consensus on priorities and strategies for improving the health of Africans

2.1. Number of consensus-building processes supported by ASH on prioritized health issues	12	22
<p><u>MNCH</u></p> <ul style="list-style-type: none"> 1. African Leadership for Child Survival—A Promise Renewed conference for ministers of health across Africa 2. RBM's Malaria in Pregnancy Working Group Annual Meeting <p><u>ID</u></p> <ul style="list-style-type: none"> 3. Participated in ICASA satellite sessions on HIV-MNCH integration 4. SADC meeting for consensus building around Regional minimum Package of HIV Services 5. Development of IDSR Logic model with CDC 6. The Union World Conference on Lung Health 7. Childhood TB meeting in South Africa 8. AFENET Pre-Conference workshop <p><u>HSS</u></p> <ul style="list-style-type: none"> 9. China HSR satellite meeting on Ethiopia's healthcare financing reforms and its path to Universal Health Coverage 10. Coordinated mHealth "Scaling Up Mobile Technology Applications for Accelerating Progress on Ending Preventable Maternal and Child Deaths" workshop during 2013 International Family Planning Conference 	<ul style="list-style-type: none"> 11. Chaired 4th session of West Africa Regional Private Sector and mHealth Dissemination workshop 12. Organized and coordinated IDSR session during the 2013 AFENET Conference; facilitated testing of online IDSR eLearning tool during AFENET Conference 13. Joint Work Planning (WHO AFRO, CDC & ASH) for IDSR 14. Development of the AU CARMMA Indicator Guide 15. Regional mHealth meeting (Malawi) 16. Joint USAID-African Development Bank Ministerial Meeting <p><u>Cross-cutting</u></p> <ul style="list-style-type: none"> 17. International Family Planning meeting (Ethiopia) 18. USAID Regional Missions coordination and joint work planning meeting 19. Support to AGOA Health Session on Health and Trade (flyer, speech) 20. IDSR Workshop and 21. IDSR Conference Booth 22. International Conference on Urban Health (Bangladesh) 	

2.2. An Advocacy, Communication and Dissemination (ACD) strategy produced and reviewed annually for each activity		28	24
<p>*This indicator was originally stated as “An Advocacy, Communication and Dissemination (ACD) strategy produced and reviewed annually.” However, based on feedback received from USAID/AFR/SD in June 2013, ASH specified that an ACD strategy should be produced and reviewed “for each activity.”* Prior to receiving feedback from USAID, ASH produced:</p> <ol style="list-style-type: none"> 1. An overall ACD strategy, and later; 2. An ACD plan for the activity: Systematic Review of HIV-Related Maternal Mortality. <p>*Since this indicator was modified late in the year, the target was set retroactively at the time of annual reporting. This target assumes that the following activities should have had an ACD strategy:</p> <ol style="list-style-type: none"> 1. HIV-MM Systematic Reviews 2. AGOA technical brief–health and trade 3. Elected officials paper and management training paper 4. Identifying operational level strategies for increasing the coverage for two doses of IPT 5. mHealth Compendiums 6. Technical Brief: Ethiopian Health Care Financing Reforms-On the Path to Universal Health Coverage <ol style="list-style-type: none"> 1. Analyzing the potential for leveraging private sector companies contributing to the health sector in African countries (Phase 2) 2. Best Practices of CHW programs; volunteer and various remuneration systems–comparing and contrasting 3. Pediatric TB Landscape Analysis: Development of tracker, Country Profiles, and participation in conferences such as 45th TB Union Conference 4. Three systematic reviews of HIV and Maternal Mortality, exploring programmatic, consumer and health system factors 5. mHealth Compendium (3rd and 4th editions) 6. Supporting SADC to Develop Minimum Package of Services for Populations along the Transport Corridor of Southern Africa (Phase 1) 7. WHO AFRO Joint Mid-term Review 8. IDSR AFENET 2013 Pre-Conference Workshop 9. Promoting child health and prevention services to support 5-15 year-olds 10. Investigate the causes and costs of underutilization of iCCM services and document best practices for overcoming barriers impacting uptake of services 11. Supporting the AU's CARMMA in Policy Advocacy, Monitoring and Evaluation (translation of Health Stats web site) 12. Assessing Malaria Financing Models 13. Development of mHealth Compendium Vol 5 14. Providing Technical Inputs for the USAID Family Planning Review and Analyzing the Linkages Between Health, Poverty and Equity of Access to Family Planning Services 15. Rwanda Private Sector Engagement Assessment 16. Supporting the development of special edition of the AfrEA Journal 17. Collaborating with WHO/AFRO and CDC on IDSR Implementation and Advocacy (trip to Brazzaville) 18. Developing Country Profiles on Pediatric TB 			
IR. 3: Strengthened African institutions and networks			
3.1. Number of African institutions participating in ASH-supported capacity development programs focusing on leadership, technical and/or management areas		10	7
MNCH			
<ol style="list-style-type: none"> 1. Leadership and Management Capacity Building of Regional Health Professional Associations (42 health professional associations from 16 countries in the ECSA region participated in the capacity building 		<ol style="list-style-type: none"> 4. SADC (Completed Phase 1 & 2 of support to SADC for Regional Minimum Standards for Transport Corridors) 5. EAC (EAC representation in the SADC consensus building around Regional Minimum Package of HIV Services) 	

<p>workshop co-developed and led by ASH at the regional forum on maternal and newborn health)</p> <p>2. African Union (AU CARMMA M&E Team Capacity Development)</p> <p><u>ID</u></p> <p>3. Applied a learning-by-doing approach to develop the capacity of the Botswana MoH to evaluate their IDSR</p>	<p><u>Cross-Cutting</u></p> <p>6. Kinshasa School of Public Health (grant and mentoring, building capacity in financial management)</p> <p>7. AfrEA (Supported AfrEA Capacity Building Workshop and Mentoring for African Evaluators)</p>		
<p>3.2. Number of African institutions participating in collaborative activities with ASH to identify and prioritize health issues and solutions</p>		<p>9</p>	<p>17</p>
<p><u>MNCH</u></p> <p>1. ASH MNCH advisor led work planning session for roll out of new WHO guidelines for IPTp with the country team from Zambia comprised of national MNCP and RH program representatives during the PATH/WHO/Gates Malaria in Pregnancy Workshop</p> <p>2. Collaborated with ECSA and the Regional Center for Quality Health Care (RCQHC) to plan the capacity building session for health professional associations during the August regional forum on maternal and newborn health</p> <p>3. AU</p> <p>4. RCQHC</p> <p><u>ID</u></p> <p>5. Development of a Pediatric TB Framework for Africa</p>	<p>6. SADC</p> <p>7. East African Community (EAC)</p> <p>8. University of Stellenbosch</p> <p><u>HSS</u></p> <p>9. AfDB</p> <p>10. AfrEA</p> <p>11. Makerere University</p> <p>12. ECSA-HC</p> <p>13. Ethiopia MOH</p> <p>14. Malawi MOH</p> <p>15. Uganda MOH</p> <p>16. Rwanda MOH</p> <p>17. Madagascar MOH</p>		
<p>3.3. Number of ASH-supported south-to-south information exchange opportunities (in-person or remote) between selected African institutions</p>		<p>7</p>	<p>8</p>
<p><u>MNCH</u></p> <p>1. Workshop on Capacity Building for health professional associations in the ECSA region included in-person south-to-south information exchanges between association representatives via structured discussions and panel presentations</p> <p>2. African Leadership for Child Survival—A Promise Renewed conference included discussion among the participants on implementation challenges and solutions</p> <p>3. PATH/WHO/Gates Malaria in Pregnancy Meeting included presentations from country teams and discussion of relevant topics</p>	<p><u>ID</u></p> <p>4. Participation of representative from EAC to SADC Consensus building for Regional Minimum Standards</p> <p>5. IDSR sessions during the 2013 AFENET Conference</p> <p>6. Childhood TB meeting in South Africa</p> <p><u>HSS</u></p> <p>7. 7th International AfrEA Conference</p> <p>8. ICT Ministerial meeting</p>		

LIST OF THE TOP 50 TOP ASH TECHNICAL ACTIVITIES

Analyzed by Technical Area and by Intermediate Results (IRs)

ASH-IMPLEMENTED ACTIVITIES						
The list was drawn from those suggested by the ASH Management and those that were verifiable by the evaluation team.						
	Activity	Area	IR	Level of Result		Activity Status
				Output	Outcome	
1	Analysis of client data related to IPTp from Malawi	MNCH	IR 1	√		TBD
2	Working relationships with PMI & JHPIEGO on scope and design of ASH facility-level case studies for facility-level implementation of IPTp	MNCH	IR 1	√		Field work completed
3	Support to AU on finalizing 2012 Report on MNCH status to assist African Ministries of Health establish regional and national priorities for MNCH	MNCH	IR 1-2	√		Report done
4	Analysis of client data related to IPTp from Malawi	MNCH	IR 1	√		Done
5	Working relationships with PMI & JHPIEGO on scope and design of ASH facility-level case studies for facility-level implementation of IPTp.	MNCH	IR 1	√	√	Field work completed
6	Support to AU on finalizing 2012 Report on MNCH status to assist African Ministries of Health establish regional and national priorities for MNCH	MNCH	IR 1-IR 2	√	√	Report done
7	Joint work plan with CDC in four key activity areas: IDSR in 2-3 countries; communication for IDSR; Kenya Integrated Cholera Plan; eLearning component for IDSR	IDSR	IR 1	√		Done
8	Development of template for mHealth Compendium	HSS	IR 1	√		Done
9	Document best practices and lessons learned regarding development and implementation of eHealth strategies	HSS	IR 1	√		Collection of best practices
10	Development of database of potential African-based consultants and consulting organizations	HSS	IR 2-IR 3	√		Not completed
11	Mapping of activities in USAID-funded countries that provide management training for HCWs	HSS	IR 1	√		Mapping completed
12	Literature review initiated for identifying key factors for improving community involvement in health services	CC/CS	IR 1	√		Literature Review
13	Identification of 60 projects that train parliamentarians and elected officials	CC/CS	IR 1	√		TBD
14	Identification of lessons learned from interviews and 65 relevant publications	CC/CS	IR 2-IR 3	√		ID of lessons learned
15	Researching, assessing and disseminating findings to improve services for pregnant and post-partum women with HIV	MNCH	IR 1	√		Report completed
16	Tool to improve service delivery for IPTp, disseminating evidence-based findings for Malaria/Pregnancy policies	MNCH	IR 1	√	√	TBD
17	Documenting and disseminating trends in MNCH and support to AU/CARMMA	MNCH	IR 1	√		Documentation done
18	Tracking USAID's contributions to TB control	IDSR	IR 2	√		Literature Review and brief done

19	Support development of a pediatric TB framework in Africa	IDSR	IR 1-IR 2	√		TBD
20	Strengthening TA for National Malaria Control Program	IDSR	IR 1-IR 2	√		Document prepared
21	Supporting WHO/AFRO with development of an IDSR advocacy strategy	IDSR	IR 2	√	√	Advocacy facts for AFRO (strategy/policy)
22	Supporting the design, implementation and testing of IDSR evaluation methods in Botswana	IDSR	IR 1-IR 2	√		
23	Making the case for greater investment in the health sector	HSS	IR 1	√		Technical paper
24	Identifying innovative mobile health technologies to aid African missions	HSS	IR 1	√		Technical paper
25	Building consensus on promising health financing approaches for achieving universal health coverage	HSS	IR 1-IR 2	√		TBD
26	Harmonizing HIS development policies and strategies in West Africa	HSS	IR 2-IR 3	√		TBD
27	Developing capacity building initiatives in health advocacy and informed decision-making for African parliamentarians	CC/CS	IR 3	√		Technical paper
28	Enhancing awareness of current community health interventions for achieving MDGs	CC/CS	IR 1	√	√	Technical paper
29	Acceptance of 2 peer-reviewed articles on HIV and MM for journal publication	MNCH	IR 1	√		Technical paper
30	Family Planning Review and Research Data Analysis	MNCH	IR 1	√		Technical paper
31	5-15 Year-Olds Data Analysis	MNCH	IR 1	√		Done
32	Disseminating findings and building consensus to improve service delivery for pregnant and post-partum women	MNCH	IR 1-IR 2	√	√	Done?
33	Indicator Reference Guide for AU/CARMMA	MNCH	IR 1-IR 2	√		Completed
34	Supported SADC to conduct a situational analysis of HIV another health services along regional transport corridors	MNCH	IR 1	√		Situational Analysis Conducted
35	Supported SADC to develop Regional Minimum Standards for Transport Corridors, East Africa	MNCH	IR 3	√		Done
36	Facilitated EAC participation in a consensus building meeting for SADC Regional Minimum Standards	MNCH	IR 3	√		Conference organized
37	Supported the IDSR AFENET Pre-Conference workshop	IDSR	IR 2	√		Workshop conducted
38	Final Report for the Tanzania mid-term review	IDSR	IR 1	√		Report done
39	Exploratory phase (I) report of health-focused corporate social responsibility initiatives in Africa	MNCH	IR 1	√		Exploration done
40	mHealth Compendium Volumes Three and Four	MNCH	IR 1	√		Completed
41	West Africa Regional Private Sector and mHealth Dissemination Workshop	MNCH	IR 1	√		Workshop done
42	Provided KSPH with technical support and mentorship for financial management activities	MNCH	IR 3	√		Support provided
43	Landscape Analysis of Regional Health Sectors in Africa	MNCH	IR 2-IR 3	√		Secondary data analysis
44	Designed SMS Mother Reminder RCT with Cost-Effectiveness Analysis	MNCH	IR 1	√		Field work completed

45	Co-facilitated USAID evaluation training workshop and organizing the Health Evaluation strand of the AfrEA conference.	MNCH	IR 3	√		Field work completed
46	Provided Technical & Logistical Support for the Joint Review of the USAID Grant to WHO/AFRO	MNCH	IR 3	√		Report done
47	Analysis-specific results and program-level inputs	MNCH	IR 1	√		To be done
48	mHealth Compendium Volumes Five and Six	MNCH	IR 1	√		Completed
49.	Demand side, Health financing: CHWs	HSS	IR 1	√		To be implemented
50	Health financing: CBHI and vouchers and iCCM.	HSS	IR 1	√		To be implemented

Description of Activities that Produced Regional Results:

1. Support to the AU for its CARMMA database and scorecard that assembled indicators across all 54 AU member states. The scorecard provides data for RMNCH advocacy decisions. ASH supported the AU is setting up the on line African Health Stat data platform that includes data visualization tools for policymakers;
2. Support to WHO/AFRO for development of IDSR and MDSR planning, in partnership with CDC, with an emphasis on the country response to disease surveillance information. ASH will support mapping of MDSR implementation across the region and document country-level experiences and the best practices and lessons learned;
3. Support to WHO/AFRO and global health on pediatric TB global profiles meetings and planning follow-up;
4. Strengthening SADC norms and standards for primary health care services in the southern African region for high risk transport workers and other groups to prevent HIV and other sexually transmitted diseases;
5. Strengthening financial management of KSPH ability for financial reporting and administration of USAID-financed scholarships for Masters in Public Health degree candidates;
6. ASH evaluations are being used as a tool to make key organizational decisions. These include the RBM network evaluation currently in use by the RMB board, and the WHO /AFRO mid-term evaluation. WHO/AFRO appreciates the constructive feedback provided in this evaluation. ASH participation was also appreciated by WHO/AFRO on the IDSR evaluation in Botswana;
7. The African Development Bank, with USAID and ASH support for the October 2014 Second Ministerial Forum on Science, Technology and Innovation, promoted south-to-south information exchange to decisionmakers in both the public and private sectors through a one-day pre-forum meeting. This conference enabled a high-level dialogue and widespread exposure to the technologies and pointed to good investments. The State Department and USAID attended this conference.

ANNEX VIII. SUMMARY TABLES FROM KEY INFORMANT INTERVIEWS FROM USAID, PARTNERS, HOST COUNTRIES AND CONTRACTORS

Key Informants by Institutions/Agencies

Source of Information (Abridged)	Freq.	%
USAID Units	28	44%
MSH & Subcontractors	18	28%
AFRO/WHO & AU	12	19%
Partners/Beneficiaries	6	9%
TOTAL	64	100%

Key Informants by Organizational Unit

Source of Information (Detailed)	Freq.	%
1=USAID/AFR/SD/H	11	17%
2=USAID/GH	11	17%
3=USAID Missions	6	9%
4=ASH/MSH	5	8%
5=MSH Headquarters	3	5%
6=MSH Field Office	6	9%
7=WHO/AFR/AU	12	19%
8=Partners/Beneficiaries	6	9%
9= Subcontractor	4	6%
TOTAL	64	100%

Factors Contributing to ASH Changes during 2012-13

Specific Factor	Including NA cases		Excluding NA cases	
	Freq.	%	Freq.	%
1=Chief of Party Shortcomings (Interaction AFR/SD)	1	2%	2	7%
2=AFR/SD Leadership (Guidance to ASH)	1	2%	1	3%
3=MSH Supervision (Lack of presence)	1	2%	1	3%
5=Team Shortcomings (Too senior/too junior)	3	5%	3	10%
4=ASH IRs/Objectives (Focus in IRs)	1	2%	1	3%
6=Design Shortcomings	2	3%	2	7%
8=Budget Shortfall	2	3%	2	7%
9=Multiple Factors	17	27%	17	59%
7=NA	36	56%		
TOTAL	64	100%	29	100%

USAID-Only Data on Factors Contributing to ASH Changes 2012- 2013

Specific Factor	Including NA cases	
	Freq.	%
1=Chief of Party Shortcomings (Interaction AFR/SD)	4	15%
2=AFR/SD Leadership (Guidance to ASH)	2	7%
3=MSH Supervision (Lack of presence)	2	7%
5=Team Shortcomings (Too senior/too junior)	4	15%
4=ASH IRs/Objectives (Focus in IRs)	3	11%
6=Design Shortcomings	2	7%
8. Budget Shortfall	2	7%
9= Multiple Factors	8	30%
TOTAL	27	100%

4. Interviewees' Knowledge of ASH Project

Knowledge of ASH	Freq.	%
1=Excellent/Detailed	11	17%
2=Specific/Punctual	13	20%
3=Specific Program Areas	24	38%
4=Only in Management	1	2%
5=Marginal	7	11%
6=NA	8	13%
TOTAL	64	100%

4a. Interviewees' Knowledge of ASH Project

Knowledge of ASH	Freq.	%
1=Excellent/Detailed	7	29%
2=Specific/Punctual	6	25%
3=Specific Program Areas	6	25%
4=Only in Management	0	0%
5=Marginal	4	17%
6=NA	1	4%
TOTAL	24	100%

ASH Project Initial Performance

PERFORMANCE	Freq.	%
1=Outstanding	12	20%
2=Overall OK	16	25%
3=OK in Some Areas	16	30%
4=Needed Improvement	6	9%
5=Need TA	2	4%
6=NA	8	9%
7=Multiple Factors	4	7%
TOTAL	64	100%

USAID Views on ASH Project Initial Performance AID Officers

PERFORMANCE	Freq.	%
1=Outstanding	3	13%
2=Overall OK	6	25%
3=OK in Some Areas	7	29%
4=Needed Improvement	0	0%
5=Need TA	2	8%
6=NA	1	4%
7=Multiple Factors	4	17%
TOTAL	24	100%

6 & 7. How has ASH Aligned with Regional & AFR/SD Priorities?

Is ASH Meeting Its Objectives Now?

Meeting Objectives	Including NA cases		Excluding NA cases	
	Freq.	%	Freq.	%
1=Yes	15	23%	15	36%
2=To some extent	20	31%	20	48%
3=No	7	11%	7	17%
4=NA	22	34%		
TOTAL	64	100%	42	100%

10. What are the Best Features of ASH?

Best ASH Feature	Including NA cases		Excluding NA cases	
	Freq.	%	Freq.	%
1=The Contract	15	23%	15	32%
2=Increased Budget	5	8%	4	9%
3=New Tasks (Buy in)	17	27%	17	36%
4=Marginal	5	8%	5	11%
5=None	3	5%	2	4%
7=Multiple Factors	4	6%	4	9%
6=NA	15	23%		
TOTAL	64	100%	47	100%

II. Views on Main Contributions of ASH to Missions, AFR/SD and Beneficiaries

ASH ASSISTANCE TO USAID	Including NA cases		Excluding NA cases	
	Freq.	%	Freq.	%
1=Leadership Contribution	1	2%	1	2%
2=Technical Support	10	16%	10	20%
3=Management Support	2	3%	2	4%
4=Technical Innovation	2	3%	2	4%
5=Dissemination	5	8%	5	10%
6=Respond to AFR/SD	4	6%	4	8%
7=Procurement Mechanism	9	14%	9	18%
9=Multiple Factors	18	28%	18	35%
8=NA	13	20%		
TOTAL	64	100%	51	100%

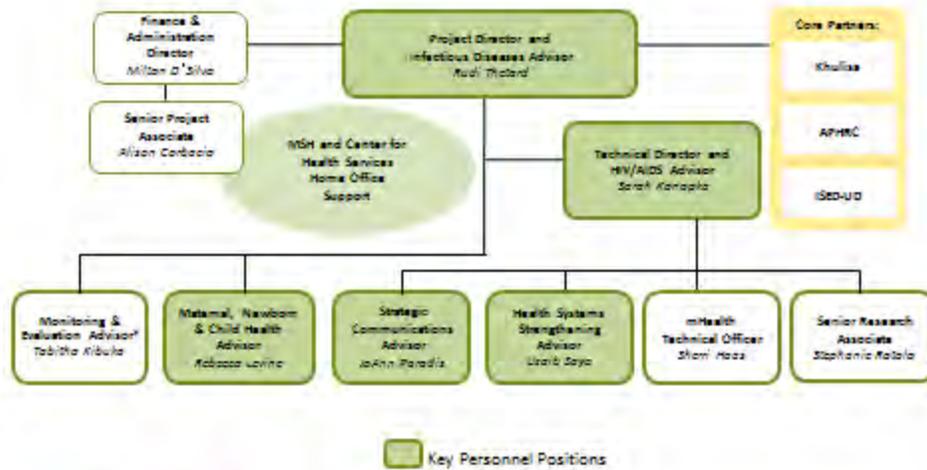
Interventions by Intermediate Results

Views on Most Important Contributions of ASH by Intermediate Results (IRs)

Area of Interventions	Column 12		Column 13		Column 14	
	IR 1		IR 2		IR 3	
	KNOWLEDGE		ADVOCACY		INST. STRENGTH.	
	Freq.	%	Freq.	%	Freq.	%
1=mHealth	14	22%	2	4%	4	7%
2=Evaluation	4	6%	3	5%	6	11%
3=Pediatric TB	8	13%	3	5%	0	0%
4=Landscape Studies	3	5%	2	4%	0	0%
5=EPI Studies	5	8%	2	4%	2	4%
6=HIV Studies	3	5%	3	5%	4	7%
7=Malaria Studies	3	5%	0	0%	0	0%
8=Management & OrgDev	7	11%	4	7%	6	11%
9=Urban Health Studies	7	11%	3	5%	0	0%
10=Infectious Disease	4	3%	1	2%	0	0%
11=NA/DR	3	5%	31	55%	36	63%
12=Multiple Factors	3	5%	2	4%	1	2%
TOTAL	64	100%	56	100%	57	100%

ANNEX IX. ASH ORGANIZATIONAL CHART

ASH ORGANIZATIONAL CHART



African Strategies for Health

ANNEX X. ASH BUDGET AND FUNDING OBLIGATIONS 2011-2015

ASH OBLIGATION BY YEAR						
Funding Stream	Year 1 10/11-09/12	Year 2 10/12-9/13	Year 3 10/13-9/14	Year 4 Received 7/1/15	Year 5 Expected	Total Expected Obligation
AFR/SD Funds:						
MCH	\$1,725,038	\$2,233,213	\$1,759,129	\$1,126,812	\$396,000	\$7,240,192
HIV/AIDS	\$100,000	\$545,000	\$250,000			\$895,000
TB	\$632,441	\$706,035	\$862,083	\$109,600	\$61,000	\$2,371,159
FP	\$200,000	\$622,787	\$471,177	\$573,429	\$400,000	\$2,267,394
Malaria		\$162,020	\$379,297	\$334,558	\$250,000	\$1,125,875
GH/HIDN		\$0	\$30,000			\$30,000
Sub-total AFR/SD Funds:	\$2,657,479	\$4,269,056	\$3,751,686	\$2,144,399	\$1,107,000	\$13,929,620
Field Support:						
Angola		\$0	\$20,000			\$20,000
AusAID		\$92,250	\$0			\$92,250
DRC		\$686,061	\$485,000			\$1,171,061
GH-HIDN SNR Evaluation		\$85,000	\$0			\$85,000
Rwanda Mission - Expected				\$330,849		\$330,849
Tanzania PMI Evaluation		\$196,593	\$0			\$196,593
Uganda Mission		\$0	\$175,000	\$77,000		\$252,000
Sub-total FS Funds:	\$0	\$1,059,904	\$680,000	\$407,849	\$0	\$2,147,753
TOTAL	\$2,657,479	\$5,328,960	\$4,431,686	\$2,552,248	\$1,107,000	\$16,077,373

ANNEX XI. ASH TRACKING TOOLS

ASH COR LETTER TRACKING SHEET

COR Letter	Activity Name	Date Submitted	Date Approved	Activity Status
Fiscal Year 2011-2012				
1.	Attend International Conference on Family Planning – <i>Davy Chikamata</i>	11/15/2011	11/15/2011	Complete
2.	Attend the AFENET Conference in Dar-es-Salaam, Tanzania – <i>Rudi Thetard</i>	11/18/2011	11/18/2011	Complete
3.	Visit to Khulisa, South Africa – <i>Bali Andriantsheno</i>	11/21/2011	11/28/2011	Complete
4.	Attend the mHealth Conference in Washington DC – <i>Godfrey Sikipa</i>	12/04/2011	12/05/2011	Complete
5.	<i>Prepared but not submitted after discussion internally with strategic team</i>			
6.	<i>Prepared but not submitted after discussion internally with strategic team</i>			
7.	Participation in Task Force for Global Health and Partners in Health to Convene Coalition for Cholera Prevention and Control – <i>Rudi Thetard</i>	02/24/2012	02/27/2012	Complete
8.	The 2nd Congress of Health Systems Governance in Kampala Uganda – <i>Godfrey Sikipa</i>	03/16/2012	03/20/2012	Complete
9.	Development of an Institutional Capacity Building (ICB) Strategy – <i>Suzzane McQueen</i>	04/02/2012	04/06/2012	Complete
10.	Participation in the Global Pediatric Research Symposium: The Global Crisis of Childhood Diarrhea – <i>Edna Jonas</i>	03/30/2012	04/06/2012	Complete
11.	Courtesy call to variety of organizations during personal vacation to South Africa. While the main purpose of the travel is for vacation, Dr. Thetard will be available to meet potential partner organizations as he will be in Durban, Cape Town and Pretoria during May – <i>Rudi Thetard</i>	04/24/2012	05/01/2012	Complete
12.	Participation in the HHA meeting of African Ministers of Health and Ministers of Finance July 4 – 5, 2012 and visit to ASH partner ISED and collaborators in West Africa – <i>Godfrey Sikipa</i>	05/17/2012	05/06/2012	Complete
13.	Technical Support for HSS and ACD Activities – <i>Suzzane McQueen</i>	06/12/2012	06/13/2012	Complete
14.	Revising the African Union 2012 Status Report on Maternal, Newborn and Child Health – <i>Edna Jonas</i>	06/18/2012	06/18/2012	Complete
15.	Community Strategies to Achieve MDGs – <i>Godfrey Sikipa</i>	06/27/2012	07/02/2012	Complete
16.	Travel to Atlanta to refine ASH's Scope of Work for IDSR – <i>Rudi Thetard</i>	07/24/2012	07/24/2012	Complete

COR Letter	Activity Name	Date Submitted	Date Approved	Activity Status
17.	Development of HMIS Study Protocol – <i>Suzzane McQueen</i>	07/25/2012	07/30/2012	Complete
18.	(1) Representing USAID AFR at the HHA planning meeting in Harare Zimbabwe. (2) ASH Team visit to Brazzaville to meet with the WHO AFRO Regional Team. – <i>Godfrey Sikipa</i>	08/17/2012	08/22/2012	Complete
19.	ASH Team Visit to Brazzaville for WHO Meeting - <i>Godfrey Sikipa</i>	08/18/2012	08/25/2012	Complete
20.	Support for Satellite Meeting at the Second Global Symposium on Health Systems Research – <i>Suzzane McQueen</i>	08/20/2012	08/22/2012	Complete
21.	General Project Financial Management and HSS – DR Congo and Ethiopia – <i>Milton D'Silva; Suzzane McQueen</i>	08/29/2012	08/29/2012	Complete
Fiscal Year 2012-2013				
22.	eHealth & Tele-Medicine Conference in Nigeria – <i>Suzzane McQueen</i>	10/15/2012		Cancelled
23.	Participation in TB Conference in Kuala Lumpur – <i>Rudi Thetard</i>	10/12/2012	10/15/2012	Complete
24.	3 rd Regional USAID Meeting on mHealth in Dar-es-Salaam, Tanzania – <i>Gwendolyn Morgan</i>	10/24/2012	10/31/2012	Complete
25.	Gwen Visit to APHRC – Kenya – <i>Gwendolyn Morgan</i>	11/01/2012	11/01/2012	Complete
26.	Call to Action – Ethiopia – <i>Edna Jonas</i>	11/19/2012	11/20/2012	Complete
27.	Participation in the Regional HIS Forum by WAHO B/Faso – <i>Lungi Okoko</i>	11/26/2012	11/28/2012	Complete
28.	Maternal Health & HIV Review (A modified COR letter was submitted on 2/19/2013 and approved on 2/27/13) – <i>Edna Jonas</i>	01/18/2013 02/19/2013	01/29/2013 02/27/2013	Complete
29.	Edna to Global Maternal Health Conference and Roll Back Malaria, Paths Meeting in Tanzania – <i>Edna Jonas</i>	12/26/2012	01/03/2013	Complete
30.	Call to Action Ethiopia Prep – <i>Edna Jonas</i>	12/20/2012	01/03/2013	Complete
31.	Call to Action Ethiopia Meeting Expenses – <i>Edna Jonas</i>	01/02/2013	01/03/2013	Complete
32.	Support for and Participation in USAID Africa Regional Missions Work Planning and Coordination Meeting, Kenya – <i>Godfrey Sikipa</i>	01/08/2013	01/09/2013	Complete
33.	Consultation with East Africa Health Institutions – <i>Godfrey Sikipa</i>	01/16/2013	01/22/2013	Cancelled
34.	2013 Review of USAID FP Programs – <i>Gwendolyn Morgan</i>	02/01/2013	02/11/2013	Complete
35.	CDC Atlanta – <i>Rudi Thetard</i>	02/19/2013	02/19/2013	Complete

COR Letter	Activity Name	Date Submitted	Date Approved	Activity Status
36.	IDSR Consultant – <i>Rudi Thetard</i>	02/21/2013	02/22/2013	Complete
37.	AGOA Consultant – <i>Gwendolyn Morgan</i>	03/27/2013	04/03/2013	Complete
38.	mHealth Compendium Edition 2 Consultant – <i>Lungi Okoko</i>	03/22/2013	03/26/2013	Complete
39.	Malaria in Pregnancy Annual Meeting - <i>Edna Jonas</i>	04/16/2013	04/16/2013	Complete
40.	Women Deliver Conference – <i>Edna Jonas</i> : Not submitted – cancelled.	Not Approved	Not Approved	Cancelled
41.	Review of U.S. Government-supported Global Fund Technical Assistance for Malaria Funding Investments – <i>Rudi Thetard</i>	04/15/2013	04/16/2013	Complete
42.	IRS Evaluation Tanzania – <i>Rudi Thetard</i>	05/01/2013	05/20/2013	Complete
43.	Botswana IDSR – <i>Rudi Thetard</i>	08/01/2013	09/01/2013	Complete
44.	Landscape Analysis of Key Regional Organizations in the African Health Sector – <i>Lungi Okoko</i>	05/09/2013	07/10/2013	Ongoing
45.	Technical Consultation on HIV/Maternal Mortality in Boston – <i>Edna Jonas</i>	05/10/2013	05/20/2013	Complete
46.	IDSR Trip: Brazzaville – <i>Rudi Thetard</i>	06/06/2013	06/11/2013	Complete
47.	Professional Associations Capacity Building – Regional Forum – <i>Edna Jonas</i>	07/15/2013	07/24/2013	Complete
48.	IPTP Facility Assessments & Tool – <i>Rudi Thetard & Edna Jonas</i>	07/22/2013	10/01/2013	Ongoing
49.	[Addendum] Professional Associations Capacity Building – Regional Forum – <i>Edna Jonas</i>	08/13/2013	08/13/2013	Complete <i>Sponsored by another org.</i>
50.	Coordinate and co-facilitate the AFENET pre-conference session on IDSR in collaboration with WHO AFRO and CDC – <i>Sarah Konopka</i>	09/20/2013	09/27/2013	Complete
51.	Joint Strategic Review of USAID grant to WHOAFRO - <i>Lungi Okoko</i>	09/24/2013	09/27/2013	Ongoing
	Joint Strategic Review of USAID grant to WHOAFRO - <i>Lungi Okoko – Mod I</i>	03/25/2014	03/25/2014	
52.	mHealth Compendium V3 – <i>Lungi Okoko</i>	09/25/2013	09/26/2013 09/25/2013	Complete
Fiscal Year 2013 -2014				
53.	ICASA Conference – <i>Sarah Konopka</i>	10/17/2013	10/21/2013	Complete

COR Letter	Activity Name	Date Submitted	Date Approved	Activity Status
54.	Intl Conference on Family Planning and African Union Technical Support in Addis Ababa – <i>Lungi Okoko</i>	10/04/2013	10/08/2013	Complete
55.	Participate in side session at HRH Forum, Brazil; Moving from Fragmentation to Synergy to Achieve Universal Health Coverage – <i>Edna Jonas</i>	10/28/2013	10/30/2013	Cancelled
56.	2013 mHealth Summit - <i>Lungi Okoko</i>	12/02/2013	12/02/2013 12/01/2013	Complete
57.	AfrEA Strengthening - <i>Lungi Okoko</i>	12/24/2013	12/24/2013	Complete
58.	Printing and Translating the mHealth Compendium (Volume 3) - <i>Lungi Okoko</i>	01/09/2014	01/17/2014	Complete
59.	IDSR Planning meeting in Brazzaville, 2014 - <i>Rudi Thetard</i>	01/22/2014	01/24/2014	Complete
60.	SADC Minimum Package of HIV Services – <i>Sarah Konopka</i>	02/18/2014	02/18/2014 02/14/2014	Complete
61.	Technical Assistance to Kinshasa School of Public Health (KSPH), DR Congo – <i>Milton D’Silva</i>	02/03/2014	02/06/2014	Complete
62.	Impact Evaluation of Uganda’s mHealth NHRP Pilot - <i>Lungi Okoko</i>	03/06/2014	03/24/2014	Ongoing
63.	Phase II: Private Sector Health – <i>Bill Newbrander</i>	04/16/2014	04/17/2014	Ongoing
64.	USAID West Africa Regional Private Sector and mHealth Assessment Dissemination Workshop in Accra, Ghana – <i>Lungi Okoko</i>	04/16/2014	04/16/2014	Complete
65.	CHW Incentive Study – <i>Bill Newbrander</i>	08/25/2014	08/27/2014	Ongoing
66.	Assessment of the Feasibility of Subsidizing Health Insurance in Uganda – <i>Lungi Okoko</i>	05/01/2014	05/05/2014	Ongoing
67.	Printing the IDSR Workshop Report – <i>Sarah Konopka</i>	07/15/2014	07/15/2014	Complete
68.	Supporting the Southern African Development Community (SADC) to Establish Regional Minimum Standards of Services for HIV Prevention and Management for the Road Transport Sector – Phase 2 – <i>Sarah Konopka</i>	06/22/2014	07/10/2014	Complete
69.	Angola mHealth Technical Assistance to USAID – <i>Lungi Okoko</i>	06/16/2014	06/19/2014 06/17/2014	Complete
70.	Urban Health – <i>Gayle Mendoza</i>	12/18/2014	12/18/2014	Ongoing
71.	Finalizing the Demand-side Factors for ART in HIV+ Pregnant and Postpartum Women Article for Journal Submission – <i>Sarah Konopka</i>	07/08/2014	07/08/2014	Complete
72.	Pediatric TB Meeting in Zimbabwe – <i>Rudi Thetard</i>	07/03/2014	04/07/2014	Postponed

COR Letter	Activity Name	Date Submitted	Date Approved	Activity Status
73.	Joint AFDB USAID mHealth & ICT Forum	08/27/2014	08/28/2014	Complete
74.	HSR Symposium	09/19/2014	09/22/2014	Cancelled
75.	mHealth Compendium Printing V4	09/23/2014	09/25/2014	Complete
76.	Union Meeting Barcelona	09/29/2014	10/07/2014	Ongoing

ASH DELIVERABLES TRACKER

Activity Information			Deliverable Information						
Work Plan Year	Technical Area	Activity Name	Deliverable Type	Deliverable Title	COR Requirement?	COR #	ASH Lead	Deliverable Status	Location
I	HSS	Attend the mHealth Conference in Washington DC	Information into ASH Mapping Matrix			4	Godfrey Sikipa	Missing	Rudi
I	CS	Development of Khulisa Year I Work Plan	Trip Report	Trip Report: COR Letter #4 Attend staff orientation at Khulisa Headquarters	Yes	3	Balsama Andriantseho	Finalized	Tabitha
I	CS	Development of Khulisa Year I Work Plan	Draft PMP	Draft PMP - Khulisa Year I Work plan	Yes	3	Balsama Andriantseho	Finalized	P: drive - COR Letter Pack #3
I	MNCH	Literature review and briefer on HIV and MM	Powerpoint presentation			N/A		Finalized	
I	MNCH	Analysis of Malawi IPTp data	Powerpoint presentation	Factors associated with completion of IPTp for malaria among pregnant women in Malawi		N/A		Finalized	P: drive - Technical Activities - Malaria - Malawi IPTp Analysis
I	MNCH	Analysis of Malawi IPTp data	Draft Report	Factors associated with completion of IPTp for malaria among pregnant women in Malawi		N/A		Finalized	P: drive - Technical Activities - Malaria - Malawi IPTp Analysis
I	ASH Mgmt	ASH Annual Report	Annual Report	ASH Project Annual Report Year One: 2011 - 2012		N/A		Finalized	P: drive - Reports - Annual Reports Web site

I	CS	Attend International Conference on Family Planning	Trip Report	Trip Report: COR Letter #1 Davy Chikamata 2nd Int'l Conference on Family Planning/Dakar, Senegal	Yes	1	Davy Chikamata	Finalized	P: drive - COR Letter Pack #1
I	ID	Attend AFENET Conference in Dar Es Salaam, Tanzania	Trip Report	Trip Report: COR Letter #2 Rudi Thetard AFENET Conference Dar Es Salaam	Yes	2	Rudi	Finalized	P: drive - COR Letter Pack #2
I	ID	Participation in Task Force for Global Health and Partners in Health to Convene Coalition for Cholera Prevention and Control	Trip Report	Trip Report: COR Letter #7 Rudi Thetard Cholera meeting	Yes	7	Rudi	Finalized	P: drive - COR Letter Pack #7
I	ID	Participation in Task Force for Global Health and Partners in Health to Convene Coalition for Cholera Prevention and Control	Presentation to USAID	N/A	Yes	7	Rudi	Activity did not proceed	N/A
I	CS	The 2nd Congress on Health Systems Governance in Kampala, Uganda	Trip Report	Trip Report: COR Letter #8 Godfrey Sikipa...	Yes	8	Godfrey	Finalized	P: drive - COR Letter Pack #8
I	CS	The 2nd Congress on Health Systems Governance in Kampala, Uganda	List of African institutions working in health systems governance	Trip Report: COR Letter #8 Godfrey Sikipa...	Yes	8	Godfrey	Finalized	P: drive - COR Letter Pack #8 (Included in trip report)

I	CS	Development of an Institutional Capacity Building (ICB) Strategy	Strategic Plan (Draft + Revised)		Yes	9	Suzzane McQueen	Missing	Rudi emailed consultant (Jane Ntumba) about copy of document. Also, look for email from USAID agreeing that ASH would not pursue institutional CB assessments.
I	MNCH	Participation in the Global Paediatric Research Symposium: The Global Crisis of Childhood Diarrhea	Trip Report	Trip Report: COR Letter #10 Edna Jonas PGPR State of the Art Plenary and Workshop/Boston	Yes	10	Edna Jonas	Finalized	P: drive - COR Letter Pack #10
I	CS	Courtesy call to various organizations during personal vacation to South Africa	Trip Report	Trip Report: COR Letter #11 Rudi Thetard Meeting with Various Stakeholders in South Africa	Yes	11	Rudi	Finalized	P: drive - COR Letter Packs #11
I	CS	Participation in the HHA meeting of African Ministers of Health and Ministers of Finance and visit to ASH partner ISED and collaborators in West Africa	Trip Report	Trip Report: COR Letter #12 Godfrey Sikipa Special Joint Conference of African Ministers of Finance and Health in Tunis	Yes	12	Godfrey	Finalized	P: drive - COR Letter Packs #12
I	HSS	Assistance with implementation of HSS and ACD Scopes of Work	Draft management training report	Management Training in Sub-Saharan Africa	Yes	13	Suzzane McQueen	Finalized	P: drive - COR Letter Pack #13
I	HSS	Assistance with implementation of HSS and ACD Scopes of Work	Key informant interviews	various	No	13	Suzzane McQueen	Finalized	P: drive - COR Letter Packs #13

I	HSS	Assistance with implementation of HSS and ACD Scopes of Work	Draft eHealth Compendium	mHealth Compendium Volume I	Yes	13	Suzanne McQueen	Finalized	P: Drive - Technical Activities - HSS - mHealth Web site
I	HSS	Assistance with implementation of HSS and ACD Scopes of Work	Consultant Prototype Database		Yes	13	Suzanne McQueen		Sarah
I	MNCH	Revising and Finalizing the 2012 Status Report on Maternal Newborn Child Health for Africa	Final draft of Status Report	2012 Status Report on Maternal Newborn and Child Health	Yes	14	Edna Jonas	Finalized	P: drive - COR Letter Pack #14
I	ID	Travel to Atlanta to refine ASH's Scope of Work for IDSR	Trip Report	Trip Report: COR Letter #16 R. Thetard, Gwen Morgan IDSR Work planning; CDC Atlanta	Yes	16	Rudi	Finalized	P: drive - COR Letter Pack #16
I	ID	Travel to Atlanta to refine ASH's Scope of Work for IDSR	Concrete set of tasks and activities with assignment of responsibilities to ASH and CDC	Trip Report: COR Letter #16 R. Thetard, Gwen Morgan IDSR Work planning; CDC Atlanta	Yes	16	Rudi	Finalized	P: drive - COR Letter Pack #16 (Included in trip report)
I	M&E	Development of HMIS Study Protocol	Draft HMIS study protocol	ASH HIS Study Protocol	Yes	17	Suzanne McQueen	Finalized	P: drive - COR Letter Pack #17
I	M&E	Development of HMIS Study Protocol	Draft data collection tools	N/A	Yes	17	Suzanne McQueen	Activity did not proceed	N/A

I	HSS	(1) Representing USAID AFR at the HHA planning meeting in Harare Zimbabwe. (2) ASH Team visit to Brazzaville to meet with the WHO AFRO Regional Team. (Sikipa)	HHA follow on Trip Report	Trip Report: COR Letter #18 Godfrey Sikipa Attend HHA follow-on Meeting - Zimbabwe	Yes	18	Godfrey Sikipa	Finalized	P: drive - COR Letter Pack #18
I	HSS	(1) Representing USAID AFR at the HHA planning meeting in Harare Zimbabwe. (2) ASH Team visit to Brazzaville to meet with the WHO AFRO Regional Team. (Sikipa)	Contact List	Trip Report: COR Letter #18 Godfrey Sikipa Attend HHA follow-on Meeting - Zimbabwe	Yes	18	Godfrey Sikipa	Finalized	P: drive - COR Letter Pack #18
I	HSS	(1) Representing USAID AFR at the HHA planning meeting in Harare Zimbabwe. (2) ASH Team visit to Brazzaville to meet with the WHO AFRO Regional Team. (Sikipa)	Specific Areas of Collaboration and timeline	Follow on meeting (COR #32)	Yes	18	Godfrey Sikipa		Godfrey

I	HSS	(1) Representing USAID AFR at the HHA planning meeting in Harare Zimbabwe. (2) ASH Team visit to Brazzaville to meet with the WHO AFRO Regional Team. (Sikipa)	Next Steps	Follow on meeting (COR #32)	Yes	18	Godfrey Sikipa	Finalized	P: drive - COR Letter Pack #18 (Included in trip report)
I	CROSS	ASH Team Visit to Brazzaville for WHO Meeting	Trip Report	Trip Report: COR Letter #19 Morgan, Thetard, Jonas, McQueen, Sikipa WHO/AFRO Meeting in Brazzaville	Yes	19	Godfrey Sikipa	Finalized	P: drive - COR Letter Pack #19
I	HSS	Support for Satellite Meeting at the Second Global Symposium on Health Systems Research	Trip Report	Trip Report: COR Letter #20 Suzanne McQueen HSR Meeting/Beijing, China	Yes	20	Suzanne McQueen	Finalized	P: drive - COR Letter Pack #20
I	HSS	General Project Financial Management and HSS – DR Congo and Ethiopia	Trip Report	Trip Report: COR Letter #21 D'Silva and McQueen Ethiopia and DRC Visits	Yes	21	Suzanne McQueen and Milton D'Silva	Finalized	P: drive - COR Letter Pack #21
I	ID	Pediatric Literature Review and Mapping of institutions implementing pediatric TB activities	Joint work plan with AFRO	ASH Technical Concept Note: Expansion of Pediatric TB Care	No	N/A	Rudi	Finalized	P: drive - Technical Activities - ID - Pediatric TB
I	ID	Joint Development of regional TB strategy with AFRO	Regional TB Strategy	USAID's Draft Regional Strategy to Control Tuberculosis in the African Region	No	N/A	Rudi	Finalized	P: drive - Technical Activities - ID - Pediatric TB

2	ID	Participation in TB Conference in Kuala Lumpur	Trip Report	Trip Report: COR Letter #23 Rudi Thetard Participation in TB Conference, Kuala Lumpur	Yes	23	Rudi	Finalized	P: drive - COR Letter Pack #23
2	HSS	3rd Regional USAID Meeting on mHealth in Dar-es-Salaam, Tanzania	Trip Report	Trip Report: COR Letters #24 & #25 Gwen Morgan mHealth Meeting/Tanzania and APHRC Meeting/Kenya Using Mobile Technology to Improve Family Planning and Health Programs Meeting Report	Yes	24	Gwen Morgan	Finalized	P: drive - COR Letter Pack #24
2	MNCH	Led Leadership and Management Capacity building of regional health professional associations in ECSA region workshop (SO)	Technical Brief			N/A			Sarah
2	MNCH	Travel to Ethiopia to support USAID/Ethiopia and the Ethiopian MOH in planning the Call to Action meeting	Trip Report	Trip Report: COR Letters #26 & #30 Morgan, Jonas, Konopka, McQueen ALCS Meeting/Ethiopia	Yes	26	Edna Jonas	Finalized	P: drive - COR Letter Pack #26
2	MNCH	Travel to Ethiopia to support USAID/Ethiopia and the Ethiopian MOH in planning the Call to Action meeting	Meeting Report	Keep the Promise— Invest in A Child, Addis Ababa, Ethiopia, 16-18 January 2013, Meeting Report	No	26	Edna Jonas	Finalized	P: drive - COR Letter Pack #26 Web site

2	M&E/HIS	Participation in the Regional HIS Forum by WAHO B/Faso	Trip Report	Trip Report: COR Letter #27 Lungi Okoko West Africa Regional HIS Partners' Forum Meeting Ouagadougou, Brukina Faso	Yes	27	Lungi Okoko	Finalized	P: drive - COR Letter Pack #27
2	M&E/HIS	Participation in the Regional HIS Forum by WAHO B/Faso	Technical contribution to the first operational plan of the Regional Health Information Policy and Strategy for ECOWAS member states 2013-4		Yes	27	Lungi Okoko		Lungi
2	ID	Maternal Health & HIV Review	Preliminary reports by questions	Systematic Reviews (3)	Yes	28	Edna Jonas	Finalized	P: drive - COR Letter Pack #28
2	ID	Maternal Health & HIV Review	Final comprehensive report	Systematic Reviews (3)	Yes	28	Edna Jonas	Finalized	P: drive - COR Letter Pack #28
2	MNCH & ID	Edna to Global Maternal Health Conference and Roll Back Malaria, Paths Meeting in Tanzania	Trip Report	Trip Report: COR Letter #29; Edna Jonas Global Maternal Health Conference & Regional MIP Workshop Arusha/Tanzania	Yes	29	Edna Jonas	Finalized	P: drive - COR Letter Pack #29
2	MNCH	Call to Action Ethiopia Prep	Trip Report	Trip Report: COR Letters #26 & #30 Morgan, Jonas, Konopka, McQueen ALCS Meeting/Ethiopia	Yes	30	Edna Jonas	Finalized	P: drive - COR Letter Pack #30

2	MNCH	Call to Action Ethiopia Meeting Expenses	Procurement of Goods and Services	N/A	Yes	31	Edna Jonas	Finalized	Receipts can be found in Milton's email or by asking Procurement/A/P
2	MNCH	Call to Action Ethiopia Meeting Expenses	Meeting Minutes	"African Leadership for Survival - A Promise Renewed" Meeting Summary	Yes	31	Edna Jonas	Finalized	P: drive - COR Letter Pack #30
2	ASH mgmt	Support for and Participation in USAID Africa Regional Missions Work Planning and Coordination Meeting, Kenya	Trip Report	Trip Report: COR Letter #32 Sikipa and McQueen Regional Meeting Kenya	Yes	32	Godfrey Sikipa	Finalized	P: drive - COR Letter Pack #32
2	ASH mgmt	Support for and Participation in USAID Africa Regional Missions Work Planning and Coordination Meeting, Kenya	Document Review		Yes	32	Godfrey Sikipa		Sarah
2	ASH mgmt	Support for and Participation in USAID Africa Regional Missions Work Planning and Coordination Meeting, Kenya	Pre-meeting consultations		Yes	32	Godfrey Sikipa		Sarah
2	ASH mgmt	Support for and Participation in USAID Africa Regional Missions Work Planning and Coordination Meeting, Kenya	Draft meeting agenda		Yes	32	Godfrey Sikipa		Sarah

2	ASH mgmt	Support for and Participation in USAID Africa Regional Missions Work Planning and Coordination Meeting, Kenya	Facilitation of the three-day USAID regional work planning and coordination meeting	ASH Project - Regional Mission Meeting 2013: Notes	Yes	32	Godfrey Sikipa	Finalized	P: drive - COR Letter Pack #32
2	FP/HSS	2013 Review of USAID FP Programs	Final Report (presentation)	Equity, Efficiency, and Enterprise: New Direction in Family Planning	Yes	34	Gwen Morgan	Finalized	P: drive - COR Letter Pack #34
2	ID	Travel to Atlanta for the preparation of the IDSR evaluation scheduled for Botswana	Trip Report	Trip Report: COR Letter #35 Traveler Name: R Thetard Trip Name/Location: CDC Atlanta	Yes	35	Rudi	Finalized	P: drive - COR Letter Pack #35
2	ID	Travel to Atlanta for the preparation of the IDSR evaluation scheduled for Botswana	Draft Logic Model	IDSR Logic Model	Yes	35	Rudi	Finalized	P: drive - COR Letter Pack #35
2	ID	Systematic Review of 2nd Generation IDSR Evaluations	Draft final report	Literature Review with the Focus on Identifying the Key Issues for Emphasis in the 2nd Generation of IDSR Evaluation	Yes	36	Rudi	Finalized	P: drive - COR Letter Pack #36
2	ID	Systematic Review of 2nd Generation IDSR Evaluations	Draft checklist for 2nd generation IDSR evaluation	IDSR Program - Qualitative data from review based on logic models themes	Yes	36	Rudi		P: drive - COR Letter Pack #37
2	HSS	Briefing Paper for AGOA	Final paper	Health Economic Development and Trade (Technical Brief)	Yes	37	Gwen Morgan	Finalized	P: drive - COR Letter Pack #37

2	HSS	mHealth Compendium Edition 2	Edition 2 of mHealth Compendium	mHealth Compendium - Volume 2 - Technical Report	Yes	38	Lungi Okoko	Finalized	P: drive - COR Letter Pack #38 Web site
2	HSS	mHealth Compendium Edition 2	Infographic	mHealth Compendium Case Studies, Volumes 1 & 2	No	38	Lungi Okoko	Finalized	P: drive - COR Letter Pack #38 Web site
2	ID & MNCH	Malaria in Pregnancy Annual meeting	Trip Report	Trip Report: COR Letter #39 - Edna Jonas - RBM's Malaria in Pregnancy Working Group Annual Meeting/ Geneva	Yes	39	Edna Jonas	Finalized	P: drive - COR Letter Pack #39
2	ID	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments	Work plan		Yes	41	Rudi		
2	ID	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments	Preliminary list of key informants to be interviewed	List of Key Informants	Yes	41	Rudi	Finalized	P: drive - COR Letter Pack #41 (Annex 3 of technical report)
2	ID	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments	Interview questionnaire		Yes	41	Rudi		
2	ID	Review of U.S. Government-supported Global Fund technical	weekly progress update		Yes	41	Rudi		

		assistance for malaria funding investments							
2	ID	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments	brief exit report		Yes	41	Rudi		
2	ID	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments	Draft final report and recommendations	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments: Technical Report	Yes	41	Rudi	Finalized	P: drive - COR Letter Pack #41
2	ID	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments	Final report	Review of U.S. Government-supported Global Fund technical assistance for malaria funding investments: Technical Report	Yes	41	Rudi	Finalized	P: drive - COR Letter Pack #41
2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	A proposed timeline for evaluation period		Yes	42	Rudi	Finalized	P: drive - COR Letter Pack #42 (Contained within report)
2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	A written methodology plan and tools		Yes	42	Rudi	Finalized	P: drive - COR Letter Pack #42 (Contained within report)
2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	A proposed outline of the report		Yes	42	Rudi		

2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	A completed draft of evaluation report	Tanzania Vector Control Scale-Up Project Mid-term Performance Evaluation	Yes	42	Rudi	Finalized	P: drive - COR Letter Pack #42
2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	PowerPoint presentation of key findings, issues, and recommendations	Tanzania Vector Control Scale-Up Project Mid-term Performance Evaluation	Yes	42	Rudi	Finalized	P: drive - COR Letter Pack #42
2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	Final report incorporating team responses to Mission comments and suggestions	Tanzania Vector Control Scale-Up Project Mid-term Performance Evaluation	Yes	42	Rudi	Finalized	P: drive - COR Letter Pack #42
2	ID	Mid-term performance evaluation of RTI Tanzania Vector Control Scale-Up Project	List of all reviewed/cited sources in final report		Yes	42	Rudi	Finalized	P: drive - COR Letter Pack #42 (Contained within report)
2	HSS	Botswana IDSR Evaluation	Trip Report	Trip Report: COR Letter #43 Rudi Thetard IDSR Evaluation, Botswana	Yes	43	Rudi	Finalized	P: drive - COR Letter Pack #43
2	HSS	Botswana IDSR Evaluation	Evaluation Report	IDSR - Botswana Evaluation - August 2013	Yes	43	Rudi	Finalized	P: drive - COR Letter Pack #43
2	HSS	Botswana IDSR Evaluation	Draft IDSR evaluation tool		Yes	43	Rudi	Ongoing	
2	HSS	Landscape Analysis of Key Regional Organizations in the African Health Sector	Database of regional organizations		Yes	44	Lungi Okoko	Ongoing	

2	HSS	Landscape Analysis of Key Regional Organizations in the African Health Sector	Draft technical report		Yes	44	Lungi Okoko	Ongoing	P: drive - COR Letter Pack #44
2	HSS	Landscape Analysis of Key Regional Organizations in the African Health Sector	Final technical report		Yes	44	Lungi Okoko	Ongoing	
2	HSS	Landscape Analysis of Key Regional Organizations in the African Health Sector	Two technical briefs		No	44	Lungi Okoko	Ongoing	
2	HSS	Landscape Analysis of Key Regional Organizations in the African Health Sector	Organizational profiles		No	44	Lungi Okoko	Ongoing	Sent to USAID; awaiting final approval
2	HSS	Landscape Analysis of Key Regional Organizations in the African Health Sector	PowerPoint presentations	Landscape Analysis of Regional Health Sector Actors in Africa: Progress Update and Some Preliminary Results	No	44	Lungi Okoko	Ongoing	P: drive - COR Letter Pack #44
2	ID	Technical Consultation on HIV/Maternal Mortality in Boston	PowerPoint Presentation	HIV and Maternal Mortality: What works, what helps, and what gets in the way	Yes	45	Edna Jonas	Finalized	P: Drive - COR Letter Pack #45
2	ID	Technical Consultation on HIV/Maternal Mortality in Boston	Trip Report	Trip Report: COR Letter #45 E Jonas Maternal Health and HIV: Examining Research through a Programmatic Lens	Yes	45	Edna Jonas	Finalized	P: Drive - COR Letter Pack #45

2	ID	Participate in joint IDSR planning meeting in Brazzaville together with CDC and WHO/AFRO	Trip Report	Trip Report: COR Letter #46 R Thetard IDSR Consultation Brazzaville	Yes	46	Rudi	Finalized	P: Drive - COR Letter Pack #46
2	ID	Participate in joint IDSR planning meeting in Brazzaville together with CDC and WHO/AFRO	Refined and near final version of IDSR logic model	National Level Integrated Disease Surveillance and Response Logic Model*	Yes	46	Rudi	Finalized	P: Drive - COR Letter Pack #46
2	ID	Participate in joint IDSR planning meeting in Brazzaville together with CDC and WHO/AFRO	Draft IDSR evaluation protocol (NOTE: Finalized subsequent to meeting)		Yes	46	Rudi	Ongoing	
2	ID	Participate in joint IDSR planning meeting in Brazzaville together with CDC and WHO/AFRO	Concrete plan for the IDSR session at the AFENET conference (EMAIL)		Yes	46	Rudi	Finalized	
2	ID	Participate in joint IDSR planning meeting in Brazzaville together with CDC and WHO/AFRO	Draft outline for the monitoring and evaluation tool (NOTE: Did not proceed)	N/A	Yes	46	Rudi	Activity did not proceed	N/A
2	MNCH	Leadership & Management Capacity Building Workshop at ECSA-RCQHC Regional Maternal and Newborn Care Forum, Tanzania	Meeting Report		Yes	47	Edna Jonas		Sarah

2	MNCH	Leadership & Management Capacity Building Workshop at ECSA-RCQHC Regional Maternal and Newborn Care Forum, Tanzania	Package of reference electronic documents on PA organizational development		Yes	47	Edna Jonas	Finalized	P: Drive - COR Letter Pack #47 (Included as Annex 6 in trip report)
2	MNCH	Leadership & Management Capacity Building Workshop at ECSA-RCQHC Regional Maternal and Newborn Care Forum, Tanzania	Trip Report	Trip Report: COR Letter #47 J Rice, E Jonas, G Sikipa Regional Maternal and Newborn Care Forum	No	47	Edna Jonas	Finalized	P: Drive - COR Letter Pack #47
2	ID	IPTp Facility Assessments & Tool	Questionnaire for facility assessments		Yes	48	Rudi/Tabitha	Finalized	Tabitha
2	ID	IPTp Facility Assessments & Tool	Report on findings from the facility assessments, one for each country visited		Yes	48	Rudi/Tabitha	Ongoing	
2	ID	IPTp Facility Assessments & Tool	Managerial Quality Assurance tool for managers and providers to monitor IPTp coverage rates, factors impeding delivery and uptake		Yes	48	Rudi/Tabitha	Ongoing	

2	ID	IPTp Facility Assessments & Tool	Guidance for managers and providers on how to address implementation bottlenecks and challenges		Yes	48	Rudi/Tabitha	Ongoing	
2	ID	IPTp Facility Assessments & Tool	PowerPoint presentation - presented to USAID/Uganda Mission	IPTp Facility Assessment	No	48	Rudi/Tabitha	Finalized	P: drive - COR Letter Pack #48
2	ID	IPTp Facility Assessments & Tool	PowerPoint presentations for field team training		No	48	Rudi/Tabitha	Finalized	
2	ID	IPTp Facility Assessments & Tool	Report outline		No	48	Rudi/Tabitha	Finalized	
2	ID	IPTp Facility Assessments & Tool	Trip Report	Trip Report: COR Letter #48 Tabitha Kibuka Support of IPTp facility Assesment in Uganda	No	48	Tabitha	Finalized	P: drive - COR Letter Pack #48
2	MNCH	[Addendum] Leadership & Management Capacity Building Workshop at ECSA-RCQHC Regional Maternal and Newborn Care Forum, Tanzania	Presentation of keynote address during Capacity Building session		Yes	49	Edna Jonas		Sarah
2	HSS	Coordinate and co-facilitate the AFENET pre-conference session on IDSR in collaboration	Trip Report	Trip Report: COR Letter #50 S Konopka AFENET Pre-Conference IDSR Workshop and	Yes	50	Rudi	Finalized	P: drive - COR Letter Pack #50

		with WHO/AFRO and CDC		IDSR Conference Booth					
2	HSS	Coordinate and co-facilitate the AFENET pre-conference session on IDSR in collaboration with WHO/AFRO and CDC	Pre-conference session report	IDSR: AFENET 2013 Pre-Conference Workshop Report	Yes	50	Rudi	Finalized	P: drive - COR Letter Pack #50
2	HSS	Joint Strategic Review of USAID grant to WHO/AFRO	Draft Report	Joint Mid-term Review (2010-2012) of USAID/Africa Bureau's Grants to WHO/AFRO: A view towards improving grant management	Yes	51	Lungi Okoko	Finalized	P: drive - COR Letter Pack #51
2	HSS	Joint Strategic Review of USAID grant to WHO/AFRO	Final Report	Joint Mid-term Review (2010-2012) of USAID/Africa Bureau's Grants to WHO/AFRO: A view towards improving grant management	Yes	51	Lungi Okoko	Finalized	P: drive - COR Letter Pack #51
2	HSS	Joint Strategic Review of USAID grant to WHO/AFRO	Oral Presentation at the dissemination workshop		Yes	51	Lungi Okoko		
2	HSS	mHealth Compendium Volume 3	mHealth Compendium	mHealth Compendium Volume 3	Yes	52	Lungi Okoko	Finalized	P: drive - COR Letter Pack #52 Web site
2	HSS	mHealth Compendium Volume 3	Infographic		No	52	Lungi Okoko	Finalized	P: drive - COR Letter Pack #52 Web site

2	ID	ICASA Conference Satellite session and poster presentation	Final report from the maternal health and HIV session		Yes	53	Sarah		Sarah
2	ID	ICASA Conference Satellite session and poster presentation	Two posters for presentation at ICASA	Demand side factors; Health System; Interventions	yes	53	Sarah	Finalized	P: drive - COR Letter Pack #53
2	ID	ICASA Conference Satellite session and poster presentation	Trip Report	Trip Report: COR Letter #53 - S Konopka - ICASA Poster Presentation...	No	53	Sarah	Finalized	P: drive - COR Letter Pack #53
2	CS	Family Planning Review	Data tables	Review of USAID's FP programs in Africa			Sarah	Finalized	Sarah
2	CS	Briefing Paper for AGOA	Presentation	Africa on the Move: Health as a Driver of Sustained and Accelerated Trade and Investments	No	37	Gayle	Finalized	P: drive - COR Letter Pack #37
2	HSS	Support to HSR Conference Satellite Session	Technical Brief	Technical Brief: Ethiopian Health Care Financing Reforms- On the Path to Universal Health Coverage			Tabitha	Finalized	P: drive - Technical Activities - HSS Web site
2	HSS	Support to HSR Conference Satellite Session	Technical Paper	Technical Paper: Ethiopian Health Care Financing Reforms - On the Path to Universal Health Coverage			Sarah		
2	MNCH	Undertake Comprehensive Literature Review on Relationships between Maternal Mortality and HIV	Technical Report	Report: "A Systematic Review of Interventions to Reduce Mortality among HIV-Infected Pregnant and Postpartum Women"			Sarah	Finalized	P: drive - COR Letter Pack #28

2	MNCH	Undertake Comprehensive Literature Review on Relationships between Maternal Mortality and HIV	Technical Report	Report: "A Systematic Review of Demand-Side Factors Affecting ART Initiation and Adherence For Pregnant And Postpartum Women with HIV"			Sarah	Finalized	P: drive - COR Letter Pack #28
2	MNCH	Undertake Comprehensive Literature Review on Relationships between Maternal Mortality and HIV	Technical Report	Report: "A Systematic Review of Health System Barriers to and Enablers of ART for Pregnant and Postpartum Women with HIV"			Sarah	Finalized	P: drive - COR Letter Pack #28
2	MNCH	Undertake Comprehensive Literature Review on Relationships between Maternal Mortality and HIV	Technical Report	Report, "HIV-Related Maternal Mortality In the ART Era: A Synthesis of Three Systematic Reviews"			Sarah	Finalized	P: drive - COR Letter Pack #28
3	ID	Promoting Effective Integration of HIV and Maternal Health Services	Poster	Poster Presentation: "Effective Interventions for HIV+ pregnant and postpartum women" for 2014 ICASA Conference			Sarah	Finalized	P: drive - COR Letter Pack #28
3	ID	Promoting Effective Integration of HIV and Maternal Health Services	Poster	Poster Presentation: "System Factors affecting use of ART among HIV+ pregnant and postpartum women" for 2014 ICASA Conference			Sarah	Finalized	P: drive - COR Letter Pack #28

3	ID	Promoting Effective Integration of HIV and Maternal Health Services	Poster	Poster Presentation: "Demand-side factors Influencing use of ART among HIV+ pregnant and postpartum women" for 2014 ICASA Conference			Sarah	Finalized	P: drive - COR Letter Pack #28
2	MNCH	Analysis of Malawi IPTp data	Presentation	Presentation at Global Maternal Health Conference: "Missed Opportunities for IPTp in Malawi: Client and facility characteristics"			Rudi is doing final review	Finalized	P: drive - Technical Activities - Malaria - Malawi IPTp Analysis
2	MNCH	Undertake Comprehensive Literature Review on Relationships between Maternal Mortality and HIV	Technical Brief	HIV and maternal mortality briefer with literature review			Sarah	Ongoing	
2	MNCH		Literature Review	Oral rehydration therapy use literature review			Sarah		
3	HSS	2013 International Conference on Family Planning in Addis Ababa	Final report from conference's mHealth session	Scaling Up Mobile Technology - Applications for Accelerating Progress on Ending Preventable Maternal and CHild Deaths	Yes	54	Lungi Okoko	Finalized	P: Drive - COR Letter Pack #54
3	HSS	2013 International Conference on Family Planning in Addis Ababa	PowerPoint presentation	Mobile Technology: Bringing the Community and Health System Together	No	54	Lungi Okoko	Finalized	P: Drive - COR Letter Pack #54

3	HSS	Participate in side session at 3rd HRH Forum, Brazil; Moving from Fragmentation to Synergy to Achieve Universal Health Coverage	Trip Report	N/A	Yes	55	Bill Newbrander	Activity did not proceed	N/A
3	HSS	2013 mHealth Summit	Report containing a list of new mobile technology innovations and key issues to be considered for inclusion in the next volume of the mHealth compendium.		Yes	56	Lungi Okoko		
3	HSS	Strengthening the capacity of African Evaluators to conduct high quality evaluations	Complete list of health evaluation abstracts received and selected	P. 21 of Technical Report	Yes	57	Lungi Okoko	Finalized	P: drive - COR Letter Pack #57
3	HSS	Strengthening the capacity of African Evaluators to conduct high quality evaluations	Implement health evaluation knowledge and skills transfer workshop at AfREA Conference	Powerpoint presentation - "The USAID Evaluation Policy: Quality Standards, Lessons Learned and Experiences" for the 7th International AfrEA Conference	Yes	57	Lungi Okoko	Finalized	P: drive - COR Letter Pack #57

3	HSS	Strengthening the capacity of African Evaluators to conduct high quality evaluations	Report documenting the implementation of activities under this COR letter (see COR letter)	Strengthening the capacity of African Evaluators to conduct high quality evaluations	Yes	57	Lungi Okoko	Finalized	P: drive - COR Letter Pack #57 Web site
3	HSS	Strengthening the capacity of African Evaluators to conduct high quality evaluations		Trip Report - COR #57 - L Okoko ...	Yes	57	Lungi Okoko	Finalized	P: drive - COR Letter Pack #57
3	HSS	Printing and translating the mHealth Compendium Volume 3	300 copies of the mHealth Compendium in English	mHealth Compendium V3	Yes	58	Lungi Okoko	Finalized	Hard Copies
3	HSS	Printing and translating the mHealth Compendium Volume 4	Translated versions of Volume 3 in French and Portuguese	mHealth Compendium V3	Yes	58	Lungi Okoko	Finalized	P: drive - COR Letter Pack #58
3	HSS	IDSR Planning Meeting in Brazzaville, 2014	Database		Yes	59	Rudi	Ongoing	
3	HSS	IDSR Planning Meeting in Brazzaville, 2014	Narrative Report		Yes	59	Rudi		Rudi
3	HSS	IDSR Planning Meeting in Brazzaville, 2014	Trip Report	Trip Report - COR Letter #59 - R Thetard - IDSR Planning Meeting in Brazzaville	No	59	Rudi	Finalized	P: drive - COR Letter Pack #59
3	ID	SADC Minimum Package of HIV Services	Assessment tool		Yes	60	Sarah	Ongoing	
3	ID	SADC Minimum Package of HIV Services	Technical report (situational analysis)		Yes	60	Sarah	Ongoing	

3	ID	SADC Minimum Package of HIV Services	PowerPoint presentation	Development of Harmonized Regional Minimum Standards for Preventative Health Services along the Road Transport Corridors in Southern Africa Development Community: _x000B_Situational Analysis Report	Yes	60	Sarah	Finalized	P: Drive - COR Letter Pack #60
3	ID	SADC Minimum Package of HIV Services	Technical Brief		Yes	60	Sarah	Ongoing	
3	HSS	Technical Assistance to Kinshasa School of Public Health (KSPH), DR Congo	Trip Report	Trip Report - COR Letter #61 - M D'Silva - TA to KSPH	Yes	61	Milton	Finalized	P: Drive - COR Letter Pack #61
3	HSS	Technical Assistance to Kinshasa School of Public Health (KSPH), DR Congo	A detailed budget, list of activities, and reporting templates		Yes	61	Milton	Finalized	P: Drive - COR Letter Pack #61
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Research Protocol		Yes	62	Tabitha	Finalized	Tabitha
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	In-brief		Yes	62	Tabitha	Ongoing	Tabitha
3	HSS	iptp	Quarterly progress reports		Yes	62	Tabitha	Ongoing	Tabitha

3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Usability component report		Yes	62	Tabitha	Ongoing	
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	PowerPoint presentation		Yes	62	Tabitha	Ongoing	
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Final draft report		Yes	62	Tabitha	Ongoing	
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Final report		Yes	62	Tabitha	Ongoing	
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Cleaned data sets		Yes	62	Tabitha	Ongoing	
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Training presentation		No	62	Tabitha		
3	HSS	Impact Evaluation of Uganda's mHealth NHRP Pilot (SMS Mother Reminders)	Training report		No	62	Tabitha		

3	HSS	Phase 2: Analyzing the potential for leveraging private sector companies contributing to the health sector in African countries	Report providing lessons learned and opportunities for ministries to pursue CSR	A Review of Health-Related CSR in Africa	Yes	63	Sarah	Finalized	P: drive - Technical Activities - HSS - Private Sector Mapping
3	HSS	Phase 2: Analyzing the potential for leveraging private sector companies contributing to the health sector in African countries	Technical brief		Yes	63	Sarah	Ongoing	
3	HSS	Phase 2: Analyzing the potential for leveraging private sector companies contributing to the health sector in African countries	Dissemination of technical brief		Yes	63	Sarah	Ongoing	
3	HSS	USAID West Africa Regional Private Sector and mHealth Assessment Dissemination Workshop in Accra, Ghana	Printed copies of mHealth Compendium		Yes	64	Lungi Okoko	Finalized	Hard Copies
3	HSS	CHW Incentive Study	Desk study document		Yes	65	Becca and Uzaib	Ongoing	
3	HSS	CHW Incentive Study	case studies of three countries		Yes	65	Becca and Uzaib	Ongoing	

3	HSS	CHW Incentive Study	synthesis document comparing and contrasting countries		Yes	65	Becca and Uzaib	Ongoing	
3	HSS	CHW Incentive Study	Technical brief		Yes	65	Becca and Uzaib	Ongoing	
3	HSS	CHW Incentive Study	Framework for use by African countries		Yes	65	Becca and Uzaib	Ongoing	
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	Draft work plan with timelines		Yes	66	Uzaib and Rudi	Ongoing	
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	Draft data collection tools and models		Yes	66	Uzaib and Rudi	Ongoing	
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	Draft list of key informants to be interviewed		Yes	66	Uzaib and Rudi	Ongoing	
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	Draft technical report		Yes	66	Uzaib and Rudi	Ongoing	P: drive - COR Letter Pack #66
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target	Final report		Yes	66	Uzaib and Rudi	Ongoing	

		Groups in Uganda							
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	Technical brief		No	66	Uzaib and Rudi	Finalized	P: drive - COR Letter Pack #66
3	HSS	Assessment of the Feasibility of Subsidizing Health Insurance for Target Groups in Uganda	Action brief		No	66	Uzaib and Rudi	Finalized	P: drive - COR Letter Pack #66
3	HSS	Printing the IDSR Workshop Report	300 copies of IDSR workshop report	AFENET 2013 Pre-conference Workshop Report	Yes	67	Sarah	Finalized	P: Drive - COR Letter Pack #67 Web site
3	ID	Phase 2: SADC Regional Minimum Standards	Draft Harmonized Regional Minimum Standards		Yes	68	Sarah	Ongoing	
3	ID	Phase 2: SADC Regional Minimum Standards	Final Harmonized Regional Minimum Standards		Yes	68	Sarah	Ongoing	
3	ID	Phase 2: SADC Regional Minimum Standards	Trip Report	Trip Report - COR Letter #68 - S Konopka - Supporting SADC to develop RMS - Jo'burg SA	Yes	68	Sarah	Finalized	P: drive - COR Letter Pack #68

3	ID	Phase 2: SADC Regional Minimum Standards	Meeting Report		Yes	68	Sarah	Finalized	P: drive - COR Letter Pack #68 (Included in trip report)
3	HSS	Angola mHealth TA to USAID	work plan		Yes	69	Lungi Okoko		
3	HSS	Angola mHealth TA to USAID	Final report	Landscape Analysis and Business Case for mHealth Investment in Angola	Yes	69	Lungi Okoko	Finalized	P: drive - Technical Activities - HSS - Angola mhealth mapping
3	HSS	Angola mHealth TA to USAID	meeting with key stakeholders		Yes	69	Lungi Okoko	Missing	Rudi
3	CROSS	Highlighting Emerging Issues in Urbanization and Health: Abidjan to Lagos	National Geographic-style article		Yes	70	Rudi	Finalized	P: drive - Technical Activities - CROSS - Urbanization and Health - Final Products
3	CROSS	Highlighting Emerging Issues in Urbanization and Health: Abidjan to Lagos	Prezi-like presentation		Yes	70	Rudi	Finalized	P: drive - Technical Activities - CROSS - Urbanization and Health - Final Products

3	CROSS	Highlighting Emerging Issues in Urbanization and Health: Abidjan to Lagos	Interactive infographic		Yes	70	Rudi	Finalized	http://www.msh.org/blog/2015/05/27/a-corridor-of-contrasts-urban-health-in-west-africa
3	CROSS	Highlighting Emerging Issues in Urbanization and Health: Abidjan to Lagos	Blog post		Yes	70	Rudi	Finalized	http://www.msh.org/blog/2015/05/27/a-corridor-of-contrasts-urban-health-in-west-africa
3	CROSS	Highlighting Emerging Issues in Urbanization and Health: Abidjan to Lagos	5 postcards		No	70	Rudi	Finalized	P: drive - Technical Activities - CROSS - Urbanization and Health - Final Products - Web Versions of Postcards
3	CROSS	Highlighting Emerging Issues in Urbanization and Health: Abidjan to Lagos	6 posters		No	70	Rudi	Finalized	
3	ID	Finalizing the "Demand Side Factors..." Article for Journal Submission	Draft revised article		Yes	71	Sarah	Finalized	P: drive - Technical Activities - HIV - HIV-MM systematic Reviews
3	ID	Finalizing the "Demand Side Factors..." Article for Journal Submission	Final revised article		Yes	71	Sarah	Finalized	P: drive - Technical Activities - HIV - HIV-MM systematic Reviews

3	ID	Pediatric TB Meeting in Harare; Key Informant Interviews for IDSR	Trip Report	N/A	Yes	72	Rudi	Activity did not proceed	N/A
3	ID	Pediatric TB Meeting in Harare; Key Informant Interviews for IDSR	Documentation of pediatric TB activities ongoing in Africa	N/A	Yes	72	Rudi	Activity did not proceed	N/A
3	ID	Pediatric TB Meeting in Harare; Key Informant Interviews for IDSR	Identification of activities for incorporation into ASH Y4 work plan	N/A	Yes	72	Rudi	Activity did not proceed	N/A
3	ID	Pediatric TB Meeting in Harare; Key Informant Interviews for IDSR	Report on approaches used for expansion of IDSR in Zimbabwe	N/A	Yes	72	Rudi	Activity did not proceed	N/A
3	HSS/CROSS	Joint USAID/African Development Bank Ministerial Meeting on "Investing in Technology and Innovations for Human Development" in Rabat, Morocco	Final Meeting Report	Investing in Technology and Innovations for Human Development - Meeting Report	Yes	73	Lungi Okoko	Finalized	P: Drive - Technical Activities - HSS - Joint meeting... Web site
3	HSS/CROSS	Joint USAID/African Development Bank Ministerial Meeting on "Investing in Technology and Innovations for Human	Meeting Feedback forms		No	73	Lungi Okoko	Finalized	P: Drive - Technical Activities - HSS - Joint meeting...

		Development ⁱⁱ in Rabat, Morocco							
3	HSS	Participate in the Health Systems Research Symposium	Trip Report	N/A	Yes	74	Rudi	Activity did not proceed	N/A
3	HSS	Participate in the Health Systems Research Symposium	List of representatives met during conference	N/A	Yes	74	Rudi	Activity did not proceed	N/A
3	HSS	Printing of mHealth Compendium Volume 4	500 copies of mHealth Compendium v4		Yes	75	Lungi Okoko	Finalized	Hard Copies
3	HSS	Printing of mHealth Compendium Volume 4	100 copies of mHealth Compendium v3 in Portuguese		Yes	75	Lungi Okoko	Finalized	Hard Copies
3	MNCH	Supporting AU's CARMA in Policy, Advocacy, Monitoring and Evaluation	Data tables	Compilation: Country-specific tables for AU CARMMA's African Health Statistics web site			Sarah	Finalized	Tabitha
3	HSS		Technical Report	Report: USAID/WHO collaboration in Africa: A qualitative snapshot of the relationship			Gayle	Finalized	P: drive - Technical Activities - HSS - USAID-WHO Collaboration in Africa
3	HSS		Technical Report	Report: Leveraging Private Sector Companies Contributing to the African Health Sector (Phase I)			Tabitha	Finalized	Sarah
3	HSS		21 Technical Briefs	Country briefers	No		Tabitha	Ongoing	

4	ID	Participate in Union Conference, conduct key informant interviews of Childhood TB subgroup attendees	Trip Report	Trip Report - COR Letter #76 - K Sawyer - Union Conference	Yes	76	Rudi	Finalized	P: drive - COR Letter Pack #76
4	ID	Participate in Union Conference, conduct key informant interviews of Childhood TB subgroup attendees	Documentation of pediatric TB activities ongoing in Africa (presentation)	Childhood TB Landscape Analysis: Progress to-date	Yes	76	Rudi	Ongoing	P: drive - COR Letter Pack #76
4	ID	Participate in Union Conference, conduct key informant interviews of Childhood TB subgroup attendees	Start-up kit of best practices in childhood TB		Yes	76	Rudi	Ongoing	
4	ID	Participate in Union Conference, conduct key informant interviews of Childhood TB subgroup attendees	Technical brief		Yes	76	Rudi	Ongoing	
4	HSS	Participate in 2nd meeting on ASIGB	Trip Report		Yes	77	Rudi	Ongoing	
4	MNCH	Translation of AU Health Statistics Web site	Translated web site		Yes	78	Becca	Finalized	http://www.africanhealthstats.org/?lang=FR

4	MNCH	Review of National Level Misoprostol Policy	Synthesis Report		Yes	79	Becca	Ongoing	
4	MNCH	Review of National Level Misoprostol Policy	4 Informational Briefs		Yes	79	Becca	Ongoing	
4	MNCH	Review of National Level Misoprostol Policy	Policy Environment Recommendations (Dependent on findings)		Yes	79	Becca	Ongoing	
4	MNCH	Promoting Child Health and Prevention Services to Support 5-15 Year Olds	Technical Brief		Yes	80	Becca	Ongoing	
4	MNCH	Promoting Child Health and Prevention Services to Support 5-15 Year Olds	PowerPoint Presentation		Yes	80	Becca	Ongoing	
4	HSS	Participate in development of IDSR evaluation protocol	IDSR assessment tool		Yes	81	Rudi	Ongoing	
4	HSS	Participate in development of IDSR evaluation protocol	draft framework		Yes	81	Rudi	Ongoing	
4	HSS	Participate in development of IDSR evaluation protocol	trip Report		Yes	81	Rudi	Ongoing	
4	HSS	TA to KSPH for managing the grant for USAID-funded scholarship program	Trip Report		Yes	82	Milton	Finalized	P: drive - COR Letter Pack #82

4	HSS	TA to KSPH for managing the grant for USAID-funded scholarship program	work plan and budget		Yes	82	Milton	Finalized	P: drive - COR Letter Pack #82
4	HSS	TA to KSPH for managing the grant for USAID-funded scholarship program	Modification to existing grant		Yes	82	Milton	Finalized	With ASH Contract Officer
	HSS	TA to WHO/AFRO (Strategic Opportunity)	Financial reconciliation, data sheets, grant amendments		No	n/a	Milton	Finalized	P: drive - Technical Activities - HSS - Financial TA to WHO AFRO
4	MNCH	Review of MDSR Systems	Regional survey report outlining existing MDSR systems in Africa		Yes	83	Becca	Ongoing	
4	MNCH	Review of MDSR Systems	Protocol		No	83	Becca	Ongoing	
4	MNCH	Review of MDSR Systems	Data collection tools		No	83	Becca	Ongoing	
4	FP	Providing technical inputs for the USAID Family Planning Program Review and analyzing the linkages between health, poverty, and equity of access to FP services	Draft 2014 Family Planning Program Review Report		Yes	84	Sarah	Ongoing	

4	FP	Providing technical inputs for the USAID Family Planning Program Review and analyzing the linkages between health, poverty, and equity of access to FP services	Final 2014 Family Planning Program Review Report (electronic and print)		Yes	84	Sarah	Ongoing	
4	MNCH	Identifying the causes of under-utilization of iCCM services and best practices for overcoming the financial, non-financial, and system barriers	Synthesis report of the findings from Malawi and Madagascar including key programmatic recommendations		Yes	85	Becca	Ongoing	
4	MNCH	Identifying the causes of under-utilization of iCCM services and best practices for overcoming the financial, non-financial, and system barriers	Individual country case studies		Yes	85	Becca	Ongoing	
4	MNCH	Identifying the causes of under-utilization of iCCM services and best practices for overcoming the financial, non-financial, and system barriers	Peer-Reviewed Journal Article		Yes	85	Becca	Ongoing	

4	MNCH	Identifying the causes of under-utilization of iCCM services and best practices for overcoming the financial, non-financial, and system barriers	Protocol		No	85	Becca	Ongoing	
4	MNCH	Identifying the causes of under-utilization of iCCM services and best practices for overcoming the financial, non-financial, and system barriers	Data collection tools		No	85	Becca	Ongoing	
4	HSS	Rwanda Health Private Sector Engagement Assessment	Draft methodology, work plan, tools, draft report outline		Yes	86	Sarah	Finalized	
4	HSS	Rwanda Health Private Sector Engagement Assessment	Draft internal report	Rwanda Health Private Sector Engagement (PSE) Assessment	Yes	86	Sarah	Finalized	P: drive - Technical Activities - HSS - Rwanda Private Sector Engagement
4	HSS	Rwanda Health Private Sector Engagement Assessment	Final internal report	Rwanda Health Private Sector Engagement (PSE) Assessment	Yes	86	Sarah	Ongoing	
4	HSS	Rwanda Health Private Sector Engagement Assessment	Final public report	Rwanda Health Private Sector Engagement (PSE) Assessment	Yes	86	Sarah	Ongoing	
4	HSS	Rwanda Health Private Sector Engagement Assessment	Final technical brief		Yes	86	Sarah	Ongoing	P: drive - Technical Activities - HSS - Rwanda Private Sector Engagement

5	HSS	Rwanda Health Private Sector Engagement Assessment	Presentation (validation meeting)			86		Ongoing	
6	HSS	Rwanda Health Private Sector Engagement Assessment	Meeting report (validation meeting)			86		Ongoing	
4	HSS	ASH-Sponsored Special Edition of the AfrEA Journal entitled "Health Evaluations in Africa"	Compilation of abstracts and peer-reviewed articles resulting in Special Edition Journal		Yes	87	Tabitha	Ongoing	
4	HSS	ASH-Sponsored Special Edition of the AfrEA Journal entitled "Health Evaluations in Africa"	Updated database/list of evaluators		Yes	87	Tabitha	Ongoing	
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Literature Review		Yes	88	Rudi	Ongoing	
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Country review, based on the scan activity		Yes	88	Rudi	Ongoing	
4	ID	Assess how financial incentives can be structured to improve the quality of malaria	Stakeholders meeting and materials/presentations for that meeting		Yes	88	Rudi	Ongoing	

		diagnosis and case management							
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Set of recommendations and proposal for generating up to five ideas to test financial incentives		Yes	88	Rudi	Ongoing	
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Article on setting the agenda for future research priorities and action, prepared for peer review		Yes	88	Rudi	Ongoing	
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Technical brief		Yes	88	Rudi	Ongoing	
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Internal Powerpoint Presentation	Assess how financial incentives can be structured to improve the quality of malaria case management	No	88	Rudi	Finalized	P: drive - COR Letter Pack #88
4	ID	Assess how financial incentives can be structured to improve the quality of malaria diagnosis and case management	Concept note		No	88	Rudi	Finalized	P: drive - COR Letter Pack #88

4	MNCH	Participation in AU Leadership Meeting on key health strategic documents	Trip Report	Trip Report: COR Letter #89 - Participation in AU Leadership Meeting for Expiring Regional Health Strategies - Rebecca Levine	Yes	89	Becca	Finalized	P: drive - COR Letter Pack #89
4	MNCH	Participation in AU Leadership Meeting on key health strategic documents	Identification and exploration of potential opportunities for USAID/AFR and ASH		Yes	89	Becca	Ongoing	
4	MNCH	Participation in AU Leadership Meeting on key health strategic documents	Debrief presentation upon request		Yes	89	Becca	Ongoing	
4	HSS	Collaborating with WHO/AFRO and CDC on IDSR implementation and advocacy	Trip Report		Yes	91	Rudi	Ongoing	
4	HSS	Collaborating with WHO/AFRO and CDC on IDSR implementation and advocacy	Updated progress report on the completion of deliverables such as IDSR Landscape Analysis, IDSR assessment protocol and other materials		Yes	91	Rudi	Ongoing	
4	HSS	Development and Dissemination of mHealth Compendia (Volumes 2,4, and 5)	Translate Volume 2 into French and Portuguese and print 100 copies of each		Yes	92	Sarah	Finalized	P: drive - COR Letter Pack #92

4	HSS	Development and Dissemination of mHealth Compendia (Volumes 2,4, and 5)	Translate Volume 4 into French and Portuguese and print 100 copies of each		Yes	92	Sarah	Finalized	P: drive - COR Letter Pack #92
4	HSS	Development and Dissemination of mHealth Compendia (Volumes 2,4, and 5)	Develop Volume 5, translate into French and Portuguese, and print 100 copies of the French/Portuguese versions and 500 copies of the English version	mHealth Compendium Volume 5	Yes	92	Sarah	Ongoing	P: drive - COR Letter Pack #92
4	HSS	Development and Dissemination of mHealth Compendia (Volumes 2,4, and 5)	Session notes and inputs for meeting reports, as needed, for the USAID Digital Health meeting in Malawi (May 2015)		Yes	92	Sarah	Ongoing	
4	ID	Developing Country Profiles on Childhood TB and participation in Childhood TB and NTP Managers' Meetings	Trip Report		Yes	93	Rudi	Ongoing	
4	ID	Developing Country Profiles on Childhood TB and participation in Childhood TB and NTP Managers' Meetings	Presentation of Pediatric TB Guideline Review		Yes	93	Rudi	Ongoing	

4	ID	Developing Country Profiles on Childhood TB and participation in Childhood TB and NTP Managers' Meetings	Provision of materials including posters and video interviews		Yes	93	Rudi	Ongoing	
4	ID	Developing Country Profiles on Childhood TB and participation in Childhood TB and NTP Managers' Meetings	Participation of key stakeholders as agreed in collaboration with AFR/SD		Yes	93	Rudi	Ongoing	
4	ID	Presentation at MSH Brown Bag on TB Activities within MSH	PowerPoint Presentation		No	n/a	Sarah	Finalized	P: drive - Technical Activities - ID
4	HSS	Collaborating with WHO/AFRO and CDC on IDSR implementation and advocacy	Trip Report		Yes	94	Rudi	Ongoing	
4	HSS	Collaborating with WHO/AFRO and CDC on IDSR implementation and advocacy	Revised version of the IDSR assessment protocol for presentation to WHO/AFRO		Yes	94	Rudi	Ongoing	
4	HSS	ICT for Ebola Technical Brief (SO)	Technical Brief	Use of Technology in the Ebola Response in West Africa	No	n/a	Sarah	Finalized	P: drive - Technical Activities - HSS - ICT for Ebola Web site
4	HSS	Presentation at ICT for Health Care Financing	PowerPoint Presentation	ICT for Health Care Financing	No	n/a	Lungi Okoko	Finalized	P: drive - Technical Activities - HSS

		meeting in Nigeria							
4	HSS	Analyzing the potential for leveraging private sector companies contributing to the health sector in African countries	Technical Paper	A Review of Health-Related Corporate Social Responsibility in Africa			Sarah	Finalized	P: drive - Technical Activities - HSS - Private Sector Mapping

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