SUPPORT FOR INTERNATIONAL FAMILY PLANNING ORGANIZATIONS II (SIFPO2) PROJECT EVALUATION

December 2018
This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Sarah Castle PhD; Gabrielle Appleford MA, MPH; Pellavi Sharma, MPH; and Erika Houghtaling, MPH.
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December 2018

USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment Number: 563

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ABSTRACT

USAID’S Support for International Family Planning Organizations II (SIFPO2) aims to increase access to and use of high-quality, affordable family planning. In 2014, three five-year cooperative agreements were awarded to the International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), and Population Services International (PSI). This evaluation used multiple methods to assess: the extent to which the USAID global family planning core resources strengthened the capacity of the implementing partners (IPs) and their country platforms; areas for improvement; and processes and models which were used to transfer capacity to the field.

A major focus for all three IPs was the strengthening of organizational systems related to FP clinical quality and data management. IPPF focused on Health Management Information Systems, including District Health Information Software 2 pilots. MSI’s activities focused mostly on improving FP service delivery (quality and access) and significantly strengthened the Medical Development Team. PSI invested in FP clinical and data systems and their dissemination to in-country programs.

Regarding sustainability, IPPF’s decentralized structure reinforced regional capacity. MSI “embedded” systems, tools, and innovations, which became part of its “organizational DNA.” PSI created “catalytic movements” across the organization. All three IPs contributed to an improvement in method choice.

Areas for improvement include health financing, including leveraging domestic financing; a stronger commitment to gender and equity; and greater clarity of purpose of sub-recipient partnerships.

The evaluation concluded that SIFPO2 was catalytic for all three organizations, and transcended respective IPs, positively impacting the wider family planning community of practice at national and global levels.
ACKNOWLEDGMENTS

The authors would like to thank USAID staff in Washington for their clarity of guidance and constructive comments on the evaluation approaches and findings. We would like to thank Pellavi Sharma and Erika Houghtaling, program analysts with USAID, for their contributions to the evaluation. We are also grateful to Population Services International staff in Washington and International Planned Parenthood Federation and Marie Stopes International staff in London, as well as to those in Uganda and Malawi. They were most helpful and collaborative and shared valuable evidence as well as thoughtful perceptions and insights. Our thanks also go to representatives from Support for International Family Planning Organizations sub-awardees who also gave us their invaluable opinions about the project.
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABBEF</td>
<td>Burkinabé Association for Family Welfare</td>
</tr>
<tr>
<td>AOR</td>
<td>Agreement officer representative</td>
</tr>
<tr>
<td>APS</td>
<td>Annual Program Statement</td>
</tr>
<tr>
<td>ARCHES</td>
<td>Addressing Reproductive Coercion in Health Settings</td>
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<tr>
<td>ARO</td>
<td>Africa Regional Office</td>
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<tr>
<td>ATBEF</td>
<td>Association Togolaise pour le Bien-Etre Familial</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>BLM</td>
<td>Banja La Mtsogolo</td>
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<tr>
<td>CHW</td>
<td>Community health workers</td>
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<tr>
<td>CLIC</td>
<td>Client Information Center</td>
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<td>CMIS</td>
<td>Client Management Information System</td>
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<tr>
<td>CoP</td>
<td>Community of practice</td>
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<tr>
<td>CYP</td>
<td>Couple-years of protection</td>
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<tr>
<td>D2A</td>
<td>data to action</td>
</tr>
<tr>
<td>DHIS2</td>
<td>District Health Information Software 2</td>
</tr>
<tr>
<td>DMPA-SC</td>
<td>Subcutaneously-administered depot medroxyprogesterone acetate</td>
</tr>
<tr>
<td>ERC</td>
<td>Ethics Review Committee</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
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<td>GH</td>
<td>Global Health</td>
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<tr>
<td>GREAT</td>
<td>Girls, Reproductive Health, Empowerment, Access, and Transformation</td>
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<td>HMIS</td>
<td>Health Management Information Systems</td>
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<td>HNQIS</td>
<td>Health Network Quality Improvement System</td>
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<tr>
<td>ICRW</td>
<td>International Center for Research on Women</td>
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<tr>
<td>ICT</td>
<td>Information and communication technologies</td>
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<td>IP</td>
<td>Implementing partner</td>
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<td>IPC</td>
<td>Interpersonal communications</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>IT</td>
<td>Information technology</td>
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<tr>
<td>LAPM</td>
<td>Long-acting and permanent contraceptive method</td>
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<tr>
<td>LARC</td>
<td>Long-acting reversible contraceptives</td>
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<tr>
<td>LNG IUS</td>
<td>Levonorgestrel-releasing intrauterine system</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MA</td>
<td>Member Associations</td>
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<tr>
<td>MCH</td>
<td>Maternal/child health</td>
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<tr>
<td>mCPR</td>
<td>Modern contraceptive prevalence rate</td>
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<td>MII</td>
<td>Method information index</td>
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<td>MIS</td>
<td>Management information system</td>
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<tr>
<td>Acronym</td>
<td>Meaning</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<td>ORION</td>
<td>Organizational Register and Informatics Online</td>
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<td>PACE Uganda</td>
<td>Program for Accessible Health Communication Education</td>
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<tr>
<td>PM</td>
<td>Permanent methods</td>
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<tr>
<td>PPIUD</td>
<td>Postpartum intrauterine device</td>
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<td>PPP</td>
<td>Public-private partnership</td>
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<td>PRH</td>
<td>Office of Population and Reproductive Health</td>
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<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>PSS</td>
<td>Public sector strengthening</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<td>QARL</td>
<td>Quality Assurance Regional Leadership</td>
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<td>QI</td>
<td>Quality improvement</td>
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<td>QoC</td>
<td>Quality of care</td>
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<td>QTA</td>
<td>Quality Technical Assistance</td>
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<td>R4D</td>
<td>Results for Development</td>
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<td>RBA</td>
<td>Rights-based approach</td>
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<td>RH</td>
<td>Reproductive health</td>
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<td>RHU</td>
<td>Reproductive Health Uganda</td>
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<tr>
<td>SDI</td>
<td>Service Delivery Improvement</td>
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<td>SIFPO2</td>
<td>Support for International Family Planning Organizations II</td>
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<td>SOW</td>
<td>Scope of work</td>
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<tr>
<td>SP</td>
<td>Sayana Press</td>
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<td>SPIRES</td>
<td>Stanford Program for International Reproductive Education and Services</td>
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<tr>
<td>SQIS</td>
<td>Self-Regulation Quality Improvement System</td>
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<tr>
<td>SuMo</td>
<td>Success model</td>
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<tr>
<td>TA</td>
<td>Technical assistance</td>
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<tr>
<td>TMA</td>
<td>Total Market Approach</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UHC</td>
<td>Universal health coverage</td>
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<tr>
<td>UIC</td>
<td>Unique Identifier Code</td>
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EXECUTIVE SUMMARY

Support for International Family Planning Organizations II (SIFPO2) is a central mechanism managed by the USAID Office of Population and Reproductive Health (PRH) to increase access to and use of high-quality, affordable family planning (FP) and other health information, products, and services globally. In April–May 2014, the Bureau for Global Health/PRH/Service Delivery Improvement awarded three SIFPO2 projects, which are five-year cooperative agreements, to:

1. The International Planned Parenthood Federation (IPPF), with partners The Population Council and Member Associations
2. Marie Stopes International (MSI), with partners FHI360, EngenderHealth, and The Grameen Foundation

SIFPO2’s mission is to increase the uptake of FP and improve FP service delivery by strengthening the implementing partners (IPs) who have global reach and a network of FP clinics and other health platforms. This is done by making core investments at a central level to improve systems, tools, and innovations and by allocating funds to USAID country Missions for buy-in. This evaluation was concerned with addressing the impact of core investments.

SIFPO2 had two main result areas:

Result 1: Organizational capacity strengthened to deliver high-quality FP and other health services to target groups
- **Sub-Result 1.1:** Global systems that strengthen FP and other health program performance improved, streamlined, and disseminated
- **Sub-Result 1.2:** Innovations, tools, and approaches for delivering FP services to target groups tested, implemented, and disseminated

Result 2: Sustainability of country-level FP and other health programs increased
- **Sub-Result 2.1:** Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged
- **Sub-Result 2.2:** Capacity of local partners to provide high-quality FP and other health services built
- **Sub-Result 2.3:** Innovative partnerships to strengthen health service delivery networks pursued

The evaluation of SIFPO2 took place between May and August 2018 and involved data collection in Washington, DC and London, as well as country visits to Uganda and Malawi. It specifically focused on the Sub-Results 1.1 and 2.2, and sought to answer the following evaluation questions:

1a. To what extent did PRH core resources strengthen the capacity of each recipient organization as a whole in FP service delivery, including country-level platforms, by:
   - Improving organizational systems
   - Testing, implementing, and disseminating innovations, tools, and approaches
   - Improving sustainability
   - Improving service delivery
   - Strengthening partnerships
1b. What evidence exists to suggest that these improvements will be sustained?

2. What are areas in need of improvement or strengthening in FP/reproductive health service delivery at the country level or globally, and how can a central office or global project support these improvements?

3. What processes and/or models were used to transfer capacity to the field (e.g., local affiliates, Ministry of Health or other partners) and if there were differences, what were the strengths/weaknesses of each?

The evaluators used multiple methods to source data for the evaluation, and analyzed and triangulated findings to improve their objectivity and robustness. Methods included a review of key documentation, including SIFPO2 project award documents, semi-annual and annual reports, work plans, project management tools, and published articles; analyses of each IP’s self-assessment; key informant interviews with USAID staff in Washington, DC and Malawi, as well as representatives from the IPs (IPPF, MSI, and PSI) who were interviewed at their head offices; online survey questionnaires, which were administered to IP country offices and SIFPO sub-awardees (partners); field visits to Uganda and Malawi to interview field staff and to observe the implementation of activities under SIFPO2; and interviews with stakeholders at the Ministries of Health.

The evaluation found that, in general, USAID was satisfied with the way SIFPO2 had been implemented by all three organizations and that it had left an evidence-based legacy of its impact and approaches. The IPs’ contribution to the documenting of High-Impact Practices on, for example, FP mobile outreach, vouchers, and social franchising was important. Their participation in the Technical Working Groups was described as “indispensable.” Global webinars were seen to have an effect at the country level by showcasing experience and helping to motivate local staff and partners. However, USAID noted that there was some competition between the three organizations, which does not facilitate high-level or in-country collaboration or sharing. This observation was borne out by the evaluators’ field visits.

In addition, it was found that the sub-awardees’ activities did not always add significant value, tended to be costly, and did not always build local capacity. This points to the need to revisit the methods of selection and financing of IP sub-awards to improve cost-effectiveness and impact and embed learning.

The three recipient organizations implemented a range of initiatives to strengthen FP service delivery. For MSI and PSI, these efforts built upon investments initiated under SIFPO1, while IPPF did not benefit from this foundation and had to address compliance with USAID rules and regulations, which was costly and time-consuming, and significantly delayed the start of their program activities.

For all three organizations, a major focus of organizational systems strengthening related to FP clinical quality and data management and analysis to improve FP service delivery. IPPF focused on FP systems strengthening, including District Health Information Software 2 pilots to feed into Health Management Information Systems, which were rolled out across the Federation using regional “champions.” IPPF also used SIFPO2 funds to update clinical guidelines, which had not been revised since 2004. The majority of MSI’s activities under SIFPO2 focused on FP service quality, significantly strengthening the Medical Development Team, quality assurance, and adverse event management. MSI also expanded their Clinical Management Information System capabilities and developed innovative geospatial mapping to improve outreach to the poorest populations with high unmet need. PSI invested in systems, many of which were digitally based, such as the Health Network Quality Improvement System and the “Connecting with Sara” app, which address supervision and quality, as well as client follow-up. However, field visits to Uganda and Malawi noted some difficulties operationalizing the Health Network Quality Improvement System where end-users lacked capacity and connectivity to optimize its potential.

The evaluation team considered three dimensions of sustainability in line with those used in the USAID SIFPO2 Annual Program Statement. These comprise the following:
• **Programmatic sustainability:** the likelihood that projects and initiatives initially supported by SIFPO2 will continue in the absence of USAID/PRH support

• **Organizational sustainability:** the extent to which SIFPO2-supported work increased organizational capacity to continue operating and delivering high-quality FP services beyond the life of the project

• **Financial sustainability:** the extent to which SIFPO2-supported work will ensure a steady financial flow, including leverage of domestic financing, and will generate revenue for maintaining and continuing core-funded work.

It was found that IPPF’s decentralized structure facilitated community buy-in, and Member Associations’ quasi-governmental status (e.g., in Côte d’Ivoire) meant that they were eligible for government financing. The “champions” system of mentoring also reinforced regional capacity, which is likely to enhance sustainability. MSI improved a number of FP systems to make their SIFPO2 investments sustainable, including developing a global voucher Standard Operating Procedures Manual, providing business-to-business peer support, and strengthening FP mobile outreach to rural and hard-to-reach populations, which stimulates demand in a low-cost manner. MSI focused on “embedding” systems as part of their “organizational DNA,” aiding organizational sustainability. PSI referred to “creating catalytic movements” across the organization as evidenced by the “cross-fertilization” of tools across different health areas. SIFPO2 core activities, specifically around youth and gender have been incorporated into PSI’s Strategic Plan for 2018–2020, creating an organizational legacy.

Areas most in need of improvement or strengthening that emerged from the SIFPO2 evaluation cut across geographies and IPs and have significant implications for high-quality FP programming, client access and choice, and the achievement of FP2020 commitments. Health financing of FP and access to domestic financing remain a challenge, despite efforts to engage in this area, particularly by PSI and MSI. The former is promoting a Total Market Approach as part of its overall Strategic Plan, working with other partners and Ministries of Health to ensure that subsidies are directed to those most in need. For MSI, SIFPO2 built upon catalytic work done under SIFPO1, including health financing and voucher tools and assessments. Under SIFPO2, MSI produced its “4Ps” (people, package, provider, payment) paper, which synthesized findings from health financing assessments conducted with SIFPO support. The paper has been well-received by the FP community of practice (CoP) and influential with other organizations. Examples of country-level engagement were also evident. For example, in Kenya, MSI and PSI social franchises brokered franchisee accreditation into the country’s National Hospital Insurance Fund while MSI country programs as diverse as India and Papua New Guinea have been able to secure government contracts. This work needs to be further developed as access to domestic financing for FP and the inclusion of the private sector through strategic purchasing remains nascent in many contexts, particularly in sub-Saharan Africa.

Work around gender and equity also needs further engagement and support at both central office and country levels. For IPPF, a recognized leader in gender- and rights-based approaches, there was a strong interest in integrating gender, but the evaluators and USAID personnel involved in technical oversight of the gender portions of the project perceived that the point person in London, while well-qualified, was not sufficiently empowered to effectively mainstream gender approaches at the country level and that in-country oversight was lacking. For all IPs, a stronger commitment to gender that can be operationalized (and not just theorized) at the country level is needed.

Just as SIFPO has catalyzed IPs’ systems of integration of youth and adolescents, similar attention is needed to address other marginalized groups, such as the very poor, including those who live in hard-to-reach areas or fragile states. It was concluded that despite advances such as MSI’s poverty mapping, more cross-learning between FP organizations and systematic reporting on equity measures is required. As one IP respondent indicated, “[I]f you’re not serving the poor, you’re not serving the market.”
However, it should be noted that serving the poor, particularly with FP, requires resources and subsidy, and can be at odds with goals aiming for greater financial sustainability or tapping into large national health insurance programs that reach workers in the formal sector.

Last, it was noted that there were three different SIFPO mechanisms (i.e., cooperative agreements) based on the three proposals submitted to the Annual Program Statement, and each had a different performance monitoring plan. This appeared to have resulted in significant variability in the interpretation of key terms and a lack of standardization for very basic indicators, such as FP new users and adopters. In the medium and long term, these definitional differences need to be addressed and streamlined to benefit not just the individual organizations, but to enhance their wider contribution to the field. However, it is generally recognized that there are challenges with data collection at national and subnational levels and that definitional variations remain common challenges.

In terms of transferring capacity to country offices, each IP had several models. For IPPF, these included regional technical assistance and the use of “champions”—individuals who assisted team members in other contexts with adopting new initiatives and provided ongoing support. For MSI, the Success Model used co-creation to consolidate strands of innovation to transfer capacity to country teams. The model was extremely well-accepted and formed the basis for comparative and effective implementation strategies across different channels. Using SIFPO2 funding, PSI created regional movements for quality assurance, expanded its Total Market Approach, rolled out data-for-action, and expanded FP services for youth. These operated via regional platforms to provide more effective country-level support.

The evaluation concluded that SIFPO2 was catalytic for all three organizations, particularly IPPF, which had never received dedicated funding for FP systems strengthening. The funding enabled all three IPs to deliver on strategic priorities in a step-wise, not incremental, way. In some instances, the benefits have been felt outside the individual organizations and positively impacted the wider FP CoP at national and global levels.

More could have been done with SIFPO2 investment in reaching vulnerable groups; at the same time, continued and expanded work on reaching adolescents and youth—as well as greater male involvement—is needed. Although programs have increased their efforts to reach the poor and other marginalized populations, successful initiatives for FP (e.g., mobile outreach with community health workers, public sector franchising, and further application of the equity tool) can be implemented or scaled up to ensure the very poorest have access to services.

It is recommended that the SIFPO mechanism should be continued, as without this form of funding, the tremendous FP systems improvements observed would not have been possible. However, IPs should be encouraged to collaborate better and continue to disseminate learning and evidence (e.g., in the form of open source goods) in the spirit of building stronger FP service delivery platforms, national FP programs, and a global CoP. There should be realistic thresholds for quality, recognizing that third-party providers (social franchisees and the public sector) will have different constraints and incentives for quality than service channels directly managed by IPs. The e-tools need to be fit-for-purpose and, in some contexts, may necessitate models less dependent upon technology. It is also important that IP services complement—and do not replace—those ably provided through government (i.e., operationalizing “ability” is needed at country level). These services should also seek to transition from IP reliance on donor funding to shared investment through increased domestic financing.

In general, the benefits of SIFPO2 have transcended respective IPs and had a positive impact on the wider FP CoP at national and global levels. The mechanism and its partners and stakeholders can rise to the remaining challenges by drawing on the wealth of evidence and best practice already generated, documented, and shared.
I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this evaluation is to assess the Support for International Family Planning Organizations II (SIFPO2) project’s performance across all three prime implementing partners (IPs)—the International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), and Population Services International (PSI)—and to ascertain whether the core project’s activities are achieving or have achieved the intended results as outlined in the Cooperative Agreements. The primary aim of the evaluation focuses on if/how core-supported systems improved family planning (FP) service delivery among the three IPs. This includes identifying technical gaps that have prevented achievement of the project’s intended results. In addition, the evaluation identifies potential future technical directions based on accomplishments toward results and the current/anticipated environment. The evaluation also gathered information that resulted in useful recommendations for a potential future project or projects, including how to provide innovative solutions to address remaining problems, how to engage new partners, how to maximize efficient use of funds, how to further build the capacity of local organizations, and how to strategically transition from this type of assistance. The scope of work for the evaluation can be found in Annex I.

The evaluation results will be used by the Service Delivery Improvement (SDI) Division and Office of Population and Reproductive Health (PRH) leadership to inform future procurements for private sector FP service delivery. Missions are a secondary audience; this evaluation describes the role of core investments in supporting country-level outcomes. Other donors investing in these organizations are also a potential audience, as are the organizations themselves.

EVALUATION QUESTIONS

This evaluation sought to answer the following questions:

1a. To what extent did PRH core resources strengthen the capacity of each recipient organization as a whole in family planning service delivery, including country-level platforms, by:
   - Improving organizational systems
   - Testing, implementing, and disseminating innovations, tools, and approaches
   - Improving sustainability
   - Improving service delivery
   - Strengthening partnerships

1b. What evidence exists to suggest that these improvements will be sustained?

2. What are areas in need of improvement or strengthening in FP/RH [reproductive health] service delivery at the country level or globally, and how can a central office or global project support these improvements?

3. What processes and/or models were used to transfer capacity to the field (e.g., local affiliates, Ministry of Health (MOH) or other partners) and if there were differences, what were the strengths/weaknesses of each?
II. PROJECT BACKGROUND

SUPPORT FOR INTERNATIONAL FAMILY PLANNING ORGANIZATIONS II PROJECTS

The SIFPO2 projects are USAID central mechanisms managed by PRH to increase access to and use of high-quality, affordable FP and other health information, products, and services globally by strengthening international FP organizations with a global reach and network of FP clinics and other health platforms.

In April–May 2014, Global Health (GH)/PRH/SDI awarded three five-year SIFPO2 Cooperative Agreements, to:

- IPPF, with partners The Population Council and Member Associations
- MSI, with partners FHI360, EngenderHealth, and The Grameen Foundation
- PSI, with partners the Stanford Program for International Reproductive Education and Services, the International Center for Research on Women, Results for Development, and PharmAccess.

Award ceilings for the project periods were $74 million to both MSI and PSI, and $71,753,371 to IPPF. SIFPO2 works to achieve health-related impact in FP, maternal/child health (MCH), HIV/AIDS, and infectious disease. The SIFPO2 projects are a continuation of previous USAID GH investments in private sector FP service delivery, and build on lessons learned under previous activities, including the SIFPO1 awards to MSI and PSI (2010–2015). As the midterm evaluations conducted in 2013 deemed SIFPO1 projects successful, design efforts began for a set of follow-on projects that would continue to support global FP networks, primarily for FP but capable of receiving all types of funding in support of a range of activities. The SIFPO2 projects were awarded through an Annual Program Statement (APS) process.

There has been great demand for SIFPO2 in the field. In addition to core support, more than 18 USAID Missions and headquarter operating units have bought into SIFPO2. The types of funding received by SIFPO2 include FP, Ebola, MCH, HIV/AIDS, malaria, water/sanitation and hygiene, and Zika. However, this evaluation looked specifically at PRH core-funded outcomes, since each project received different levels of field support buy-in and different types of funding.

The three projects are housed and managed in PHR’s SDI Division. This is a final evaluation conducted at the end of the projects’ implementation periods.

SIFPO2 GOALS, STRATEGIC OBJECTIVE, AND RESULT AREAS

Goal: Access to and use of high-quality, affordable FP and other health information, products, and services increased globally.

Strategic Objective: International FP organizations with a global reach and network of FP clinics and other health platforms strengthened.

Result 1: Organizational capacity strengthened to deliver high-quality FP and other health services to target groups

- Sub-Result 1.1: Global systems that strengthen FP and other health programs performance improved, streamlined, and disseminated
- Sub-Result 1.2: Innovations, tools, and approaches for delivering FP services to target groups tested, implemented, and disseminated

Result 2: Sustainability of country-level FP and other health programs increased

- Sub-Result 2.1: Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged
• **Sub-Result 2.2:** Capacity of local partners to provide high-quality FP and other health services built

• **Sub-Result 2.3:** Innovative partnerships to strengthen health service delivery networks pursued

The evaluators were asked to specifically focus on Sub-Results 1.1 and 2.2. Sub-Result 1.1 supports the standardization and streamlining of quality assurance (QA) and other global systems and processes to support strong country-level FP service delivery networks, and strong overall global FP and other health program performance. It was expected that each project would institutionalize and disseminate inputs into global organizational systems and processes to improve performance of country-level platforms. Sub-Result 2.2 aims to strengthen local nongovernmental organization (NGO) affiliate technical and overall organizational capacity, where appropriate, to provide services and contribute to strengthening the broader health system. In addition, it encouraged local NGO affiliates to engage in meaningful partnerships with country-level governments to complement or expand FP/RH and other service offerings and ensure high-quality health service provision.

SIFPO2 contributes to a number of the Sustainable Development Goals and sub-goals, including 3.7 (to ensure universal access to sexual health and RH care services, including for FP, information and education, and the integration of RH into national strategies and programs) and 5.6 (ensure universal access to sexual health, RH, and reproductive rights). In addition, SIFPO2-funded activities are aligned with USAID’s Policy on Youth (2012), which recognizes that “early marriage and pregnancy and limited family planning services are major contributors to the inability of girls and young women to complete their education and achieve their full potential” (USAID 2012:4). SIFPO2 activities also dovetail with USAID’s policy on Gender Equality and Female Empowerment (2012), which seeks to reduce gender disparities and gender-based violence, as well as increase women’s capacity to realize their rights. The project also helps participating countries achieve FP2020’s goal to enable 120 million women and girls to use contraceptives by the end of the decade.

**THE PROFILES AND “ETHOS” OF THE SIFPO2 IMPLEMENTING PARTNERS**

Each of the three IPs has a very different “modus operandi” and used SIFPO2 core funds in quite different ways. The brief descriptions below sum up how they operate, their priorities, and organizational goals and objectives. It is important to understand how each IP’s ethos sets organizational priorities and contextualizes the way in which SIFPO funds are used.

**IPPF**

In 1952, eight national FP associations founded the IPPF. Sixty-five years later, the charity is a highly decentralized federation of 141 Member Associations (MAs) working in 153 countries. In addition, IPPF is active in another 18 countries where there is not currently an MA. IPPF is overseen by a Governing Council, composed of volunteers from MAs, and it appoints a director general as its chief executive officer, who is responsible for managing the affairs of the Federation. The IPPF Secretariat carries out the policies and functions as approved by the Governing Council, which comprises a central office in London and six regional offices working out of five locations: Africa (Nairobi), Arab World (Tunis), East and Southeast Asia and Oceania (Bangkok), European Network (Brussels), South Asia (Bangkok), and Western Hemisphere (New York).

MAs are IPPF-accredited organizations that provide services in-country. They are independent legal and financial entities, registered as parastatal organizations or NGOs in their own countries and affiliated to IPPF. Each usually has its own Board and governance procedures. The MAs receive funding through the IPPF Secretariat structure and independently through direct funding agreements with donors, international NGOs, and local governments. Each regional office also oversees, promotes, and distributes core funds to MAs.
Volunteerism is central to IPPF’s ethos, and millions of volunteers work with it around the world. Many of these focus on youth and, increasingly, IPPF is moving from providing youth-friendly FP services to being a “youth-focused” organization. In 2017, the Federation revised its Strategic Plan to adopt a human rights-based approach and mainstreamed a humanitarian focus, intervening in a number of emergency settings. IPPF also has a strong focus on enabling FP service delivery from third party providers, including governments and private providers. In 2017, IPPF’s total income was $125,082,000.

**MSI**

Founded in 1976, MSI provides voluntary contraception and RH services in 37 countries through its international branches, subsidiaries, and affiliated partners, which form its global partnership. From its international support office in London, it supports and oversees the impact of its members by setting the strategy, standards, and policies for the global partnership. It also provides technical assistance (TA), research, and monitoring, and promotes and fundraises for global programming. In keeping with its mission, it focuses on creating the conditions that enable the provision of sustainable high-quality services to reach as many girls, women, and men as possible.

MSI’s approach to delivering global impact is built on three interlinking pillars in its current strategy: scale and impact, quality, and sustainability. Supported by the strategy, MSI focuses on reaching high-impact clients: adolescents, those living in extreme poverty, FP adopters, and those with limited access to services. In addition to direct provision of FP and other RH and MCH services, MSI works with national governments, donors, and others to shape markets and increase access to and funding for voluntary contraception.

The MSI Board of Trustees makes decisions for the partnership, including in the areas of strategic direction, clinical practices, policies and processes, financial management, and institutional integrity. MSI’s subsidiaries have their own Boards of Trustees (or Directors), which fulfill local statutory and regulatory requirements, and provide a further layer of robust governance. Operationally, each branch and subsidiary has a senior management team headed by a country director who reports to the Global Support Office. In 2017, MSI’s total income was $296 million.

**PSI**

PSI’s mission is to make it easier for people in the developing world to lead healthier lives and plan the families they desire. It was founded in 1970 using commercial marketing strategies in the health areas of malaria, FP, HIV, diarrhea, pneumonia, and sanitation. Headquartered in Washington, DC, PSI is supported by 8,000 staff in more than 50 countries, many of whom work for fully independent local Network Members.

PSI’s mission is influenced by a variety of factors, not least the health needs and realities of consumers and health markets, as well as by measuring impact. A hallmark of its work is a commitment to the principle that health services and products are most effective when they are accompanied by robust communications and distribution efforts that help ensure wide acceptance and correct use. SIFPO2 was critical to scaling and institutionalizing initial gains under SIFPO1 in building PSI’s capacity in high-quality FP service delivery from a historical, nearly exclusive emphasis on social marketing of FP products. In 2017, PSI’s total annual revenue was $600 million.

Figure 1 (next page) shows cumulative SIFPO2 obligated core funds for each IP by Result Area. Given the differing profiles of the three organizations and that PSI and MSI had already received funding under SIFPO1, the overall obligated core funding patterns across the IPs differ, though this is partly due to inconsistencies in how each one assigned activities across the Sub-Result areas. During SIFPO1, it was noted that, for MSI, starting up USAID compliance systems from scratch was rather time-consuming, administratively “heavy,” and somewhat costly. For SIFPO2, both PSI and MSI were already compliant and had incorporated the Agency’s reporting systems into their global and local structures. However,
IPPF had to initiate these complex systems because it had never had USAID funding at the Federation level. This may explain why, unlike PSI and MSI, it had to invest in project management, which may have contributed to its relatively slow start-up. (See Section IV for further discussion.)

Figure 1. SIFPO2 Obligated Core Funds (Years 1–3)

IPPF and PSI invested similar amounts (37 percent) in Result 1.1 (global organizational systems), more than twice what MSI invested in this result area (18 percent). Much of MSI's systems-level work was initiated under SIFPO1, while a key focus on SIFPO2 was scale-up and further embedding at country level. In contrast, MSI invested half its SIFPO2 budget in Result 1.2 (innovations, tools, and approaches), compared with 15 percent for IPPF and 24 percent for PSI. This is due to the substantial number of innovations and tools that were developed and disseminated, many of which were to enhance organizational systems. Conversely, PSI spent almost three times as much as MSI (20 percent versus 7 percent) on Result 2.1 and four times as much as IPPF (5 percent). This may reflect their sub-award with partners such as Results for Development (R4D), as well as their ambition to invest further on domestic health financing and sustainability. IPPF invested considerably more (22 percent) in Result 2.2 (building capacity of local partners) than the other two organizations. For IPPF, this reflects the specific country project funds (for five focal countries).

Under Result Area 2.3 (pursuing innovative partnerships), IPPF and MSI spent similar amounts (19 percent and 17 percent, respectively). PSI spent very little (4 percent), as they categorized activities that could be viewed as addressing innovative partnerships in other Result Areas. For example, their work with R4D often focused on public-private partnerships (PPPs) and integration, but that was generally coded under Result Area 2.1. Similarly, PSI’s work on Health Network Quality Improvement Systems (HNQIS) could have been coded in Result Area 2.3 but was mostly organized under Result Area 1.1. As the project continued, PSI did invest more SIFPO2 core funding in Result Area 2.3 by focusing on communities of practice for the long-acting reversible contraceptives (LARC) and permanent methods (PM), as well as activities focused on the Total Market Approach (TMA).
III. EVALUATION METHODS AND LIMITATIONS

The evaluation used both quantitative and qualitative methods to triangulate evidence for greater validity. Each evaluator brought a complementary skill set to the evaluation. The Team Leader, Sarah Castle, conducted the SIFPO1 midterm evaluations for MSI and PSI. She has a background in demography, epidemiology, and program evaluation, and focused on the evaluation process, developing the evaluation’s tools, and carrying out structured analysis. Gabrielle Appleford is an FP expert and has specific subject experience in health financing, FP community and health systems strengthening, and private sector engagement. Pellavi Sharma and Erika Houghtaling, both USAID program analysts with experience in similar evaluations, assisted the evaluation team. They helped with the research design, note-taking, and collation of findings. GH Pro assisted with coordinating the administrative aspects of the evaluation, including managing the timeline. They also managed the distribution of the online survey questionnaires.

EVALUATION METHODS

The evaluators used multiple methods to source data:

1. **Review of key documentation:** This included SIFPO2 project documents, including project award documents, semi-annual and annual reports, work plans, project management tools, and published articles. The team also reviewed USAID policy and strategy documents and relevant documents prepared by SIFPO2 project partners. The Agency asked each partner to do a self-assessment of their achievements and challenges pertaining to SIFPO2. These proved very helpful in framing the subsequent inquiry.

2. **Development of work plan and research instruments:** The evaluation team developed a work plan and submitted it to USAID for approval. The team also developed research instruments for use with USAID staff and staff in IPPF, MSI, and PSI head offices, as well as those in the field. A checklist was developed for observations during field visits in Uganda and Malawi.

3. **Key informant interviews:** Informants included USAID staff in Washington, DC, including the SIFPO agreement officer representative (AOR) for MSI, the AOR for PSI and IPPF, and SIFPO2 senior technical advisors. The PRH office director and the senior gender advisor were interviewed by telephone. Staff from the Malawi Mission were interviewed in-country. Representatives from IPPF, MSI, and PSI were interviewed at their head offices, both individually and in groups (sometimes with key overseas staff phoning in). These included the SIFPO2 managers and staff responsible for FP service quality, FP clinical standards, social franchising, client information systems, monitoring and evaluation (M&E), youth, and gender. Many of these exchanges were accompanied by PowerPoint presentations that were subsequently included as project documentation. Given the federated nature of IPPF, additional interviews were carried out by telephone with staff their Africa Regional Office (ARO). In Washington, DC, a face-to-face interview was carried out with PSI’s partner R4D.

4. **Online surveys:** Two sets of online survey questionnaires were administered to IP country offices, as well as their institutional partners under SIFPO2. The country offices chosen were those that had received SIFPO2-funded systems, tools, and innovations, as well as those that had SIFPO2 funding for specific projects, such as the development of IPPF’s vasectomy tool kit in Togo. Questions to the country offices and partners addressed outputs developed under SIFPO2 and their methods of rollout, and explored the challenges and benefits of SIFPO2.
funding, including the partnerships it aimed to create and strengthen. Unfortunately, there were some technical difficulties around the completion and submission of the country office questionnaires by recipients in francophone countries and one partner, University of California at San Diego. The cause of this was not clear, but this resulted in fewer completed questionnaires for MSI (Table 1). The likely biases associated with this are addressed in the analyses.

Table 1. Number of Online Questionnaires Sent and Completed by IP

<table>
<thead>
<tr>
<th>Implementing Partner</th>
<th>Country Office/MA Response Rate</th>
<th>SIFPO Partner HQ Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPPF</td>
<td>8/11 (73%)</td>
<td>1/2 (50%)</td>
</tr>
<tr>
<td>MSI</td>
<td>7/16 (44%)</td>
<td>2/2 (100%)</td>
</tr>
<tr>
<td>PSI</td>
<td>13/13 (100%)</td>
<td>2/3 (67%)</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td><strong>28/40 (70%)</strong></td>
<td><strong>5/7 (71%)</strong></td>
</tr>
</tbody>
</table>

Field visits to Uganda and Malawi: The purpose of these visits was to interview field staff and to observe the implementation of SIFPO2 initiatives. The USAID AOR team selected these countries because all three SIFPO2 partners are (or were) implementing PRH core-funded investments. Annex II shows the characteristics of each IP country program, including an overview of the FP services each provided in 2017. This gives a sense of the breadth and depth of each IP’s programming.

The field visits were oriented around understanding system-level aspects of the country programs, which reflected core investments made at headquarters. The team spent approximately one week in each country and generally talked to head office staff responsible for FP service delivery. Limited field visits (about two per IP per country) enabled the observation of FP systems such as data management, QA, and supportive supervision in facility settings and during outreach. In each country, additional interviews took place with representatives from the MOH.

For all interviews, the team used established interview guides and took written notes during the exchanges. Notes were usually typed within 48 hours of each interview using a template designed for this purpose. Evaluation team members shared their interview notes with each other as soon as possible via Google Drive. If there was a need to follow up on points raised during an interview, this was done via email with the individual concerned.

Data Analysis

The team used a parallel combination approach for data analysis, whereby each data collection method was carried out in its entirety and analyzed separately. The results were then triangulated, and the results from different methods were compared, contrasted, and validated.

Ethical Considerations and Human Subject Protection

Each key informant was informed of the confidentiality of the interview and, where appropriate, provided oral consent prior to beginning the interview. Vulnerable populations were not interviewed for this evaluation.

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1 It should be noted that the visits explored the rollout and use of systems, tools, and innovations. The evaluators did not focus on, for example, clinical aspects of service quality, client satisfaction, or the behavioral and socio-cultural aspects of provision.
LIMITATIONS

There were several limitations to the evaluation. First, time in Uganda and Malawi was short, given there were three IPs to assess. In each country, the evaluators had only 1.5 days per IP to talk to head office staff and visit facilities and outreach. In both countries, IPPF’s affiliates had field projects that were located far from the capital cities. In Uganda, we were unfortunately unable to visit the facilities and activities of Reproductive Health Uganda (RHU), an IPPF affiliate, as the distance was too great. Second, the IPs chose the sites we visited, which may have introduced some bias. Although we preferred that IP staff were not present during interviews, especially with ministry partners or local providers, in some cases, they were, which may have induced “desired” responses. Last, as described, the online survey exercise had some missed submissions from francophone countries, which may have resulted in biases regarding the kinds of respondents who were able to return questionnaires.
IV. FINDINGS

USAID/WASHINGTON

In general, USAID was satisfied with the way all three IPs had implemented SIFPO2. Common achievements included the decentralized systems and outreach, which enabled the delivery of services to the field, and, in particular, to the rural poor. South-to-South mentoring for systems rollout was also highlighted as a common accomplishment. In addition, across SIFPO2, pilots of new methods, such as subcutaneously administered depot medroxyprogesterone acetate (DMPA-SC), were reported to have increased uptake of all methods, reflecting appropriate systems of voluntary choice.

MSI’s work on contraceptive security, value for money, and FP clinical quality was underscored as being of high quality. USAID suggested that MSI’s services had possibly led to increased modern contraceptive prevalence rate (mCPR) in some countries. Using mapping and geospatial systems to carefully target outreach to the poorest communities with high unmet need2 was seen as a good use of resources.

IPPF was praised for its work on community-based approaches and grassroots activism and advocacy. In addition, it was felt that other agencies could learn from IPPF and further strengthen their regional approaches. However, it was also noted that in-country spending via the MAs was minimal in the early stages of implementation, and a source of some frustration. The slow start-up was also problematic but thought to be related to the time needed to put systems in place for USAID compliance, the time needed to ground a first-ever USAID core grant to IPPF via four regional office sites, and high staff turnover. The MAs’ quasi-governmental status in many settings was seen as a distinct advantage for FP service delivery and advocacy. However, it was felt (and borne out by the evaluators’ field visits) that the rights-based service delivery approach as piloted was difficult for the MAs and government stakeholders to understand and operationalize in the field.

It was suggested that PSI’s approach to delivering FP via other services (e.g., MCH and HIV) was likely to be cost-effective. Their emphasis on digital health and technological innovation for program reporting and QA is ground-breaking, although subject to some limitations associated with capacity and connectivity in the field.

SIFPO2 has left an evidence-based legacy of its results and approaches. The IPs’ contribution to the documenting of High-Impact Practices on, for example, outreach, vouchers, and social franchising, was seen as important, as was a joint article written on the latter.3 Their participation in the Technical Working Groups (TWGs) was described as “indispensable.” Global webinars were seen to have an effect at the country level by showcasing experience and helping to motivate local staff and partners.

USAID noted that there was some competition between the three IPs at the country level, which did not facilitate high-level or in-country collaboration or sharing; this observation was borne out by the evaluators’ field visits and requires attention. That said, USAID praised the three IPs for their collaboration on global areas such as Sayana Press, social franchising, and District Health Information Software 2 (DHIS-2).

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2 Unmet need for FP is defined as the percentage of women of reproductive age, either married or in a union, who have an unmet need for FP. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception.


SIFPO2 PARTNERS

SIFPO2 partners chose to engage in formal partnerships, in the form of sub-awards, to broaden their expertise and ability to meet the objectives of the project. The choice of partners was based on perceived needs to address gaps in systems and tools, as well as to strengthen capacity.

IPPF

The Population Council: IPPF’s collaboration with The Population Council included supporting the Addressing Reproductive Coercion in Health Settings (ARCHES) project on reproductive coercion4 in Kenya, evaluating the rights-based approach (RBA) FP service delivery model and a retrospective evaluation of DMPA-SC in Uganda, and an evaluation of the Kenya Girls, Reproductive Health, Empowerment, Access, and Transformation (GREAT) project. This proved to be rather costly and did not build the capacity of the Uganda MA, which was not the intent of the collaboration. Regarding the ARCHES project, The Population Council suggested the “country partner had embedded the intervention tools and materials, which will become institutionalized within the Ministry of Health.” The ARCHES project has received follow-on funding as a result of promising results achieved under SIFPO2, with a view to roll out this model within Kenyan public sector facilities and in new IPPF MAs.

MSI

FHI360: FHI360 implemented two studies: youth and FP use in the Sahel and LARC use and discontinuation in Senegal. FHI360 further provided TA on M&E of MSI Nigeria’s pilot rollout of the levonorgestrel-releasing intrauterine system (LNG-IUS) and technical leadership, coordination, and assistance with documentation of the introduction of the method. However, again, the studies and TA were considered expensive by MSI and the gains from the partnership were perhaps not cost-effective.

EngenderHealth: EngenderHealth provided TA toward reviewing the USAID/United Nations Population Fund/World Health Organization (WHO) PM Training Resource Package and co-hosting a regional forum on voluntary PMs with MSI. In addition, the EngenderHealth Gender Advisor visited London to provide TA on gender and recommended the establishment of a gender working group, which MSI started after the gender training. The five-day training was shortened to one day and rolled out in some country programs. However, although MSI has a gender strategy, EngenderHealth could not help them operationalize it, indicating again that there seemed to be a lack of applied support on a practical level by some of the institutional partners.

PSI

Stanford Program for International Reproductive Education and Services (SPIRES): Dr. Paul Blumenthal, M.D., OB/GYN, MPH, leads SPIRES at Stanford University and is responsible for overseeing PSI’s FP QA activities as they relate to long-acting and permanent contraceptive method (LAPM) service provision. He is the creator of PSI’s dedicated postpartum intrauterine device (PPIUD) inserter. Under SIFPO2, this has been piloted in Mali and Haiti and found to be highly acceptable by providers and clients. Dr. Blumenthal acts as a resource to support PSI’s decentralized QA staff while providing remote advice on medical emergencies and adverse event management. PSI acknowledged that adverse event reporting was low, although Dr. Blumenthal provided context for this by adding that the adverse event procedure was first introduced under SIFPO2, and the picture was varied: Some countries reported it was relatively low; others had longer-standing, higher-quality clinical programs; and still

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4 Reproductive and sexual coercion involves behavior intended to maintain power and control in a relationship related to RH by someone who is, was, or wishes to be involved in an intimate relationship with an adult or adolescent. This behavior includes explicit attempts to impregnate a partner against her will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods. Definition accessed from: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-and-Sexual-Coercion.
others reported adverse events to a level expected for the relevant clinical procedure (e.g., inserting an IUD).

**International Center on Research for Women (ICRW):** In collaboration with ICRW, PSI conducted a literature review on couple communication about FP and completed related research with a specific focus on men married to adolescent girls in Zambia. ICRW also provided remote TA for participatory action research on gender-based violence in Haiti. In addition, they reviewed a study protocol for an assessment of youth-friendly pharmacies in Mozambique and developed slides on youth and voluntary FP in Asia for PSI’s youth-friendly health services training for Asian network members. Most recently, ICRW supported a literature review on cervical cancer programming, which PSI considered a “useful and practical approach.” However, PSI was hesitant to invest in further formative research given the service delivery orientation of SIFPO2. Instead, PSI turned to ICRW as a source of expert guidance for their own research and programs related to youth and gender. Concurrently, ICRW scaled back their level of involvement on SIFPO2, which coincided with the two key people from ICRW assigned to SIFPO2 leaving the organization.

**Results for Development:** R4D implemented a strategic planning process that enabled five PSI-affiliated organizations to think about options for social franchising, financial sustainability, and equity for financing. These fed into the PSI HQ strategy related to the integration of FP and universal health coverage (UHC). However, there were challenges in implementing the projects designed with R4D and PSI, both highlighting the slow pace of change with collaborating governments in terms of domestic financing for FP, particularly through PPPs. Importantly, R4D said that they, as an organization, had been positively influenced by the collaboration with PSI:

“As an organization that previously worked much more on the government-side of advancing UHC and FP, we now have a much better understanding of the private providers’ and aggregators’ perspectives. We have already started working through other projects on innovative ways to bring the two sides together for mutual benefit.”

**PharmAccess:** PharmAccess facilitated national capacity building around quality standards for PSI’s social franchises in Uganda. Part of this involved working on a licensing approach to create a market for quality assessments, although the terms and details of the licensing agreement have not been agreed upon. PharmAccess evolved its approach to the provision of remote support to the Ugandan Health Care Federation, which implements SafeCare with a subset of social franchisees.

Across sub-award relationships, there were some challenges with IP management of sub-awards due to limited staff and lack of experience managing such awards; these yielded undesirable results, such as less-than-ideal outputs/products and their timing. Testimonies pointed to the need to revisit the purpose, selection, and financing of sub-awards to improve cost-effectiveness and impact and to embed learning. (See Section V, “Recommendations.”) It should be noted that prime contractors choose sub-awardees at bidding time; USAID does not have control over their selection or any direct relationship with them.

**EVALUATION QUESTION 1a**

To what extent did PRH core resources strengthen the capacity of each recipient organization as a whole in family planning service delivery, including country level platforms?

Recipient organizations implemented a range of initiatives to strengthen voluntary FP service delivery, with evidence of impact as monitored through IP performance M&E data (Tables 2, 3, and 4, next page).
Table 2. Selected Indicators for IPPF

<table>
<thead>
<tr>
<th>Indicator</th>
<th>IPPF (2016)5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual couple-years of protection (CYPs)</td>
<td>7.3 million</td>
</tr>
<tr>
<td>CYPs from LAPM</td>
<td></td>
</tr>
<tr>
<td>Voluntary FP services delivered</td>
<td>46.8 million</td>
</tr>
<tr>
<td>New users or adopters of contraception</td>
<td>5.2 million (new users)</td>
</tr>
</tbody>
</table>

Table 3. Selected Indicators for MSI

<table>
<thead>
<tr>
<th>Indicator</th>
<th>MSI (2017)6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual CYPs</td>
<td>20.3 million</td>
</tr>
<tr>
<td>CYPs from LAPM</td>
<td>17.3 million (approx. 85%)</td>
</tr>
<tr>
<td>Voluntary FP services delivered</td>
<td>16 million</td>
</tr>
<tr>
<td>New users or adopters of contraception</td>
<td>51% (adopters, based on client exit interviews)</td>
</tr>
</tbody>
</table>

Table 4. Selected Indicators for PSI

<table>
<thead>
<tr>
<th>Indicator</th>
<th>PSI (2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual CYPs</td>
<td>20.88 million</td>
</tr>
<tr>
<td>CYPs from LAPM</td>
<td>8.3 million</td>
</tr>
<tr>
<td>Voluntary FP services delivered</td>
<td></td>
</tr>
<tr>
<td>New users or adopters of contraception</td>
<td>48% (adopters)</td>
</tr>
</tbody>
</table>

For MSI and PSI, these efforts built upon investments initiated under SIFPO1, although IPPF did not benefit from this foundation and “had to restructure their systems to be compliant” (IPPF country office interview). In all instances, a range of capacity strengthening efforts was carried out, but not all were sustained through the lifespan of SIFPO2.

Annex III provides an overview of capacity strengthening initiatives, outlining strengths, limitations, and effects on FP service delivery. Annex IV provides a more detailed analysis of organizational effort and investment financing. The three IPs used the funds to implement quite different activities, reflecting their individual organizational ethos. IPPF tended to develop tools and approaches in a project-based manner while, broadly speaking, MSI focused more on improving FP service delivery (access and quality). PSI had a more experimental approach, initiating a large number of projects but curtailing ones that proved not to be useful or cost-effective, or, in some cases, transitioned them to other financing sources (e.g., third generation Oral Contraceptive Pill introduction).

While the annexes cover the range of investments made under SIFPO2, the evaluation team has focused its attention on Sub-Result 1.1, “Global systems that strengthen FP and other health program performance improved, streamlined and disseminated.” Where possible, this has been evidenced with information from the field visits to Uganda and Malawi, as well as additional feedback provided through the online survey.

The starting point for organizational systems strengthening related to FP was based upon IP technical proposals, priorities, and feedback from PRH, as well as recommendations from the SIFPO1 evaluation for MSI and PSI. All three organizations grounded priorities in their respective Strategic Plans and used the annual work plan and reporting process as a means of aligning technical and operational focus between support offices and country programs. Each agency invested different proportions of SIFPO2 resources into organizational systems. Irrespective of agency, a major focus of organizational systems

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5 IPPF baseline and results are from 26 USAID priority FP countries.
6 Includes where SIFPO2 has directly funded service delivery through buy-ins and where SIFPO2 core funds have made an indirect impact in activities directly funded by other donors/funds.
strengthening related to FP clinical quality and data management and analysis to improve service delivery.\(^7\)

**IPPF**

The bulk of SIFPO2 investment was focused on FP systems strengthening, with 38 activities in total over the life of the project. IPPF also invested in tools, including ones to translate data between a Client Management Information System (CMIS) and DHIS 2. It had 19 activities focused on sustainability—15 focused on service quality, 14 focused on service reach, and 3 focused on partnerships.

Systems development has largely been managed with internal human resources with deployment supported through regional office TA and an MA champions approach, referred to as MA2MA (Evaluation Question 3). This included work such as assessing their DHIS2 pilots in order to make key recommendations for Health Management Information Systems (HMIS) that would be rolled out across the Federation. “SIFPO2 enabled the creation of a local platform for DHIS2 within ABBEF [Burkinabé Association for Family Welfare] and this contributed to a significant improvement in data quality. It allowed us to train providers in the use of DHIS2 and how these data can be used for decision-making.” (ABBEF, IPPF MA, Burkina Faso.)

**FP Quality assurance system:** SIFPO2 supported the development of a uniform framework for FP QA, as well as updates to medical and FP service delivery guidelines—“the IPPF bible for [FP] service providers”—which had not been updated since 2004. Through the MA2MA model, the QA system has been introduced in 21 of 38 MAs in sub-Saharan Africa. Findings from QA assessments need to be addressed in MA business plans, and additional funds were allocated from core non-USAID funds to enable implementation of these plans; however, it was noted that there were some challenges with this in both Malawi and Uganda due to funding shortages.\(^8\) It was also observed that the system required further automation and operationalization of terms used and development of user guidelines.\(^9\) It does not appear to be very sensitive as it uses a yes-no binary scale and does not address other aspects of QA, such as adverse events and medical emergencies. Despite some limitations, it is seen as an important initiative, one which gave ARO the “moral authority” to push MAs to address quality of care (QoC).

**Data management system:** In selected MAs,\(^10\) IPPF introduced a CMIS and DHIS2 in both electronic and manual format. This is reported to have improved the once-a-year MA reporting into DHIS2, which generates IPPF global service statistics, and also enabled more regular aggregation and analysis of data on a quarterly/monthly basis. However, from site visits to Malawi and Uganda, it was unclear how the system has impacted FP performance due to limited data and trend analysis. There were also some system challenges, which the local teams seemed disempowered to address, as they waited on guidance from the ARO and the regional champions. Despite challenges, improved data management has allowed MAs to focus less on collection and more on analysis, and has created increased demand for this system.

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\(^7\) Other systems strengthening included anti-fraud and bribery (MSI), FP compliance systems (all IPs), supply chain management (IPPF), and research (MSI and PSI). These are described in Annex III.

\(^8\) In Malawi, action plans dated from 2016 and 2017 (two sites, respectively) with actions pending; plans focused on structural quality (including some light refurbishment and equipment).

\(^9\) IPPF noted this as a critical gap that was initially overlooked. There are plans to address this gap and develop user-friendly job aids for service providers.

\(^10\) HMIS strengthening was done in Benin, Burkina Faso, Central African Republic, Cote d’Ivoire, Liberia, Malawi, Nigeria, Senegal, Togo, and Uganda.
in other MAs. One IPPF ARO respondent noted that “[ARO] involved the end-user and increased ownership … this had never been done before SIFPO2.”

**MSI**

MSI had fewer capacity strengthening initiatives than IPPF and PSI. This was deliberate, based upon learning from SIFPO1. In total, MSI had around 40 activities over the three years of implementation, most of which were implemented throughout the lifespan of SIFPO2. Just over half of these core-funded activities focused on system improvements and dissemination. The majority of MSI’s core-funded FP activities impacted affected service quality and reach; only a few focused on sustainability and partnership. Despite not being classified as such, MSI considered investment in quality and reach of services, in addition to systems strengthening, as facilitating its sustainability beyond the duration of SIFPO2. An example of this sustainability was the development of “One MSI” IT system to better connect the support office and country programs.

**FP service delivery success models (SuMos):** Developed by MSI HQ, with input from country staff, SuMos are the main organizational system for FP service delivery and show what “good looks like” for country programs. They employ clear rules (i.e., standards) and recommendations and prioritize evidence gaps for further research or testing. Considered a labor-intensive and group process, SuMos were disseminated globally and appear to be highly accepted and utilized by the Malawi and Uganda teams. There is evidence that the outreach SuMo and fleet management tool have guided systems strengthening, such as reduced client waiting times, improved scheduling, efficiency, and responsiveness to demand. They have also prompted some local innovation, including an additional application developed in Uganda that allows deeper performance analysis and identification of sites with high numbers of likely new users.

**FP clinical quality system:** SIFPO2 supported the Medical Development Team with a number of initiatives, including FP clinical standards for infection prevention, medical emergencies management, counseling and consent, adverse events reporting, an individualized competency assessment system for core services, and the internal and external Quality Technical Assistance (QTA) system. This includes an International Clinical Governance Committee of the MSI Board, which meets every four months to review QTA findings, all clinical activities and data related to quality, including data reported by country programs, such as internal audit (internal QTA) coverage, clinical- and product-related incident reporting, and Medical Advisory Team meeting minutes for the four-month period and year-to-date. This has resulted in significant improvement to adverse event reporting, savings through targeted training by competency level, and a more “sensitized” QTA system, which has resulted in lower QTA scores in Malawi. The Malawi Clinical Director viewed a lower QTA score positively as the team knew where to focus quality improvement (QI) efforts. Given improved rigor of the system, MSI has made significant decisions based around prioritizing specific channels. For example, outreach was strengthened while funding for social franchises came to an end, leading to their closure.

**Data management system:** MSI uses the Client Information Center (CLIC) for the service delivery channels it manages and Organizational Register and Informatics Online (ORION), its configuration of

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11 For example, the Kenya MA was initially reluctant to be part of this initiative, but it has expressed interest, as have the other MAs in the ARO region.

12 The evaluation focused on the outreach SuMo, even though SuMos were also developed for social franchising, MS Ladies, centers, youth, and public sector support. Some had gone through iterations/updates under SIFPO2.
DHIS2,\textsuperscript{13} for social franchising and public sector support. CLIC was initiated under SIFPO1 and has been further embedded and scaled up with SIFPO2 support. While there have been some challenges with systems embedding, both systems have catalyzed a “data culture” at MSI. Pre-ORION, this was limited to no visibility on contraceptive method mix by facility or region. Now with ORION, MSI can go down to the franchisee level. Lessons also led to the development of “embedding plans,” which are now a standard across all large-scale MSI initiatives.

\textbf{PSI}

PSI invested core funds heavily into systems (41 activities), approaches (36 activities), and dissemination (26 activities), with fewer activities focused on tools and innovations (seven and eight activities, respectively). In terms of systems work, PSI used SIFPO2 core funds to provide TA, conduct QA audits, scale up regional QA, and scale up the HNQIS to their SIFPO2 countries. HNQIS is now reportedly used by more than 450 QA officers in 22 countries and has been the tool for 18,000 assessments in 8,000 outlets. PSI also focused core funds on approaches such as co-designing the Equity Tool and subsequent research to assess the wealth profile of clients, as well as revising tools for couples counseling on contraception. The Equity Tool is now reportedly available for use in 40 countries by a wide range of organizations across a broad spectrum of health areas. The majority of PSI’s core FP activities impacted contraceptive method choice, service quality, service reach, sustainability, and partnerships. An example of PSI’s use of SIFPO2 core funds to expand FP service reach is providing ongoing TA to its activities in the Democratic Republic of Congo on the rollout of DMPA-SC, including using research on the perceptions of injectable contraception to develop a market introduction plan. Their experiences led to SIFPO2 TA to other countries to support them in the introduction of DMPA-SC (e.g., PSI Mozambique and Society for Family Health Zambia).

\textbf{Clinical quality system for FP:} PSI developed central capacity for QA, including minimum standards, youth-friendly FP health services, an internal audit orientation guide in multiple languages, standard checklists for PMs, and informed choice.\textsuperscript{14} This includes a QA scorecard, considered as both an evaluative and action planning tool, which then becomes a “roadmap” to QI. According to PSI, enhanced regional leadership capacity for QA audits has facilitated the QA rollout and ongoing QI support.

QA also included the introduction of continuous medical education modules, delivered through video and integrated with HNQIS. While “live versions” of standards and tools are on SharePoint, there have been some challenges with rolling these out as, according to PSI, there are “greater standards but some resistance.” Additionally, adverse event reporting is still centrally managed (via partnership with Dr. Paul Blumenthal at SPIRES).\textsuperscript{15} In response, PSI has developed a course on “adverse events versus complications.” SafeCare standards were also integrated into PSI’s FP clinical quality system. Although this is considered a more structural approach to quality at the facility level, benchmarked to international standards, it is also time- and resource-intensive, which seems to cause

\textsuperscript{13} ORION is an open-source dashboard app that works off of DHIS2.

\textsuperscript{14} PM and informed choice checklists were developed with support of MSI.

\textsuperscript{15} PSI clarified on review of the report that all adverse events that are reported to PSI/Washington are reviewed by each QA Regional Lead. In addition, QA Regional Leads participate in a quarterly “Adverse Event Review Board,” where reported events are selected for a root cause analysis and discussion in order to build PSI national staff’s capacity and leadership in the management of such events. Before SIFPO2, there was no process whereby national QA managers received capacity building in adverse event management. This additional information was not presented at the time of the evaluation, despite probing adverse event management.
providers in Uganda to drop out. According to the local partner, Uganda HealthCare Federation, 47 providers were assessed in in Year 1, but only eight were being assessed in 2018.16

Data management system: PSI views systems strengthening built upon DHIS2 and HNQIS as “innovations, tools, and systems all in one.” In Niger, where SIFPO2 core funds support an FP mobile outreach service model that combines public sector capacity building with LARC and DMPA-SC introduction and service provision at public primary care centers, PSI’s country office noted, “The HNQIS platform is one of the best quality assurance developments supported by SIFPO2. It increases the quality of care and standardizes the evaluation of quality.” This initiative included the development of a data to action [D2A] framework and the addition of an interpretations section and tagging feature in HNQIS.17

Internally, PSI is building a movement on data use as part of a long-term commitment to “Sara,” the archetype client it uses to ensure their work is client-focused. PSI considers its “Connecting with Sara” app to be the “go-to” app for interpersonal communications (IPC) support, enabling providers to track and engage with clients through their mobile phones. Using phone calls, text messages, and social media, PSI can use the app to link her to care, provide her with relevant health information, and follow her through the continuum of care. PSI/Tanzania described the way the app was piloted there and rolled out to other countries as “very effective,” giving “real time data on client referrals and allowing for follow-up on client satisfaction.” However, PSI in Mozambique noted that,

“Recently, we discussed with the SIFPO2 team the need to complete the technology ecosystem. HNQIS is a tool for supervisors and for providing feedback. [Connecting with Sara] is a tool for promoters. However, we lack a linkage for communicating with providers. An ‘ecosystem’ of solutions would connect them, and we can create something greater than the individual parts.”

Externally, PSI is a global leader in DHIS2 and considers this an investment in a public good, available to the wider CoP. Other improvements to data management included the introduction of a client-based records system, with Uganda considered a “center of excellence” in this regard. However, in both Malawi and Uganda, it was observed that staff and franchise providers had difficulty with querying and interpreting the data, that some providers were not conversant with the systems, and that these may be more suitable to environments with more stable electricity and internet. PSI is aware of these issues and is addressing them.

Partnership

The three IPs have contributed evidence and learning, informed through SIFPO2 investments, with the broader FP CoP. This has included contributions to the High-Impact Practice briefs, such as social franchising, outreach, and vouchers. They also collaborated on a social franchising paper for Global Health: Science and Practice.18 More recently, IPPF published on its Net Promoter Score methodology.19 Each IP has also made substantial contributions in the form of papers, oral presentations, panels, and posters at conferences such as the International Conference on Family Planning and Women Deliver. IPs

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16 As clarified by PSI, while it is true that some facilities did not perform well enough in their QI plans to warrant a second assessment before the close of SIFPO2, 25 of the original 47 had a second assessment in 2017, and a further eight have had a second assessment in 2018, bringing the total to 33.

17 HNQIS is an app that overlays on to the DHIS2 and allows for visualization and interpretation of data.


led or participated in TWGs on diverse topics, such as Implementing Best Practices Consortium; the High-Impact Practice Technical Advisory Group; gender; social and behavior change communication; contraceptive methods (e.g., DMPA-SC, emergency contraceptive pills, LNG IUS, vasectomy); TMA; and the LARC PM CoP. One IP noted that TWGs were considered “useful for prompting USAID’s thinking; however, forums are ‘very U.S.-focused’ and are better when done face-to-face,” while another indicated that “SIFPO2 has enabled us to become more outward facing as an organization.” The social franchising metrics TWG, for example, was instrumental in defining metrics for the social CoP and advancing understanding of equity.20

EVALUATION QUESTION 1b

What evidence exists to suggest that these improvements will be sustained?

The evaluation team has considered three dimensions of sustainability in line with those used in the USAID APS and reiterated during the USAID in-brief.

- **Programmatic sustainability:** The likelihood that projects and initiatives initially supported by SIFPO2 will continue in the absence of USAID/PRH support
- **Organizational Sustainability:** The extent to which SIFPO2-supported work increased organizational capacity to continue operating and delivering high-quality FP services beyond the life of the project
- **Financial sustainability:** The extent to which SIFPO2-supported work will ensure a steady financial flow, including leverage of domestic financing, and will generate revenue for maintaining and continuing core-funded work

The interviews and field visits revealed the following methods and strategies for sustainability of the SIFPO2-generated improvements:

**IPPF**

- **Local ownership:** IPPF’s decentralized structure comprises MAs that have local Boards embedded in the community. This means that approaches to FP service delivery, such as RBA, are implanted at a grassroots level, enhancing ownership and acceptance.

- **Strong partnerships with government:** In West Africa, many MAs have public statute status; they get some core funding from the government and carry out joint initiatives. For example, *Association Togolaise pour le Bien-Etre Familial* (ATBEF)/Togo is currently the only provider of voluntary PMs in Togo, but through the work supported by SIFPO2, ATBEF/Togo worked with the Togolese MOH to produce a guide for training public sector service providers to provide safe voluntary vasectomies.

- **Additional donor support:** Reproductive coercion is a barrier to effective use of voluntary FP among Family Health Options Kenya clients and their partners, and the MA plans to roll out the ARCHES model across all clinics in 2018/19 with tentative follow-on funding from the Bill & Melinda Gates Foundation. IPPF noted that SIFPO2 had increased the absorptive capacity to receive additional donor funds.

- **South-to-South support and mentoring:** With support from SIFPO2, IPPF’s ARO established a network of QoC champions. Via this peer-support approach, ARO has been able to more rapidly introduce quality tools across the region and establish a sustainable network of individuals with technical expertise in QoC that can be called on to provide advice and support. The IPPF affiliate in Kenya noted that “Following the training of Quality of Care champions, QoC assessments were also conducted in

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facilities that did not have USAID funds. This was made possible through mentorship and peer-to-peer support among health care providers."

**MSI**

**Implementation of financing mechanisms that improve sustainability of FP services:** MSI provides TA to country programs on health financing seeking to utilize domestic financing opportunities. They have also shared evidence on their FP vouchers through the development of a global voucher Standard Operating Procedures Manual. MSI presented at the USAID-funded FP health financing meeting in Accra, Ghana, in January 2018, and helped develop the agenda.

**Strengthening of local affiliate technical and organizational capacity to provide services and to contribute to strengthening the broader health system:** SIFPO2 has also enabled MSI to invest in broader capacity strengthening initiatives. Building on the “business-to-business” peer support approach developed during SIFPO1, MSI has also continued to train and deploy peer champions from country programs to provide TA, including for fleet management and clinical QA/training.

**Strengthening FP mobile outreach to increase efficiency and equity:** Mobile outreach for FP stimulates demand in a low-cost way and is MSI’s largest channel for reaching the poor. SIFPO2 has helped MSI demonstrate that this is a cost-effective approach. USAID leadership in this area has encouraged other donors to invest in outreach. MSI has been able to deepen their understanding of the trade-offs between efficiency and equity and to strategize on how to position the channel to maximize both. This has seen MSI experiment with “lighter” outreach models\(^{21}\) (as observed in Malawi) and spawned innovations, such as fleet management and the poverty mapping tool, to improve efficiency—and team safety—and target areas with high poverty densities.

**Creating meaningful partnerships with country-level governments:** SIFPO2 has enabled MSI to work with governments to develop a public sector strengthening (PSS) “channel” incorporating minimum standards and criteria for MSI involvement around FP clinical quality, logistics, awareness-raising, data/reporting, and vision/sustainability. A total of 14 MSI country programs are now providing this formalized PSS. In addition, MSI, with SIFPO2 and other donor support, is helping countries develop financing arrangements with local- and country-level government for contracting services and/or technical support from MSI country programs.

**Creating innovative partnerships to strengthen FP health service delivery networks:** MSI has used SIFPO2 funding to explore opportunities for integration of non-FP services into their FP service delivery or mobile outreach. It has enabled the documentation of findings from their MCH/FP, HIV/FP, and cervical cancer screening and preventative therapy/FP programming. These are helping MSI to identify how integration can lead to greater FP reach, which trade-offs and programming adaptations are required, and what the implications are for sustainability.

**PSI**

**Creating catalytic movements across the organization:** PSI seeks to capture and “cross-fertilize innovation from different health areas within their organization. For example, the HNQIS were originally developed from QA models in malaria; they were expanded for use in FP/RH, then to other health areas, and are now being expanded to the public sector. As shown above, SIFPO2-funded pilots or seed funding have led to the adoption of tools and approaches throughout PSI and beyond.

**Social franchising:** As the model matures, it is hypothesized that the costs a social franchising donor incurs for quality FP could be reduced and borne by other stakeholders, including the franchisee and consumers. The Tunza social franchise value proposition is being strengthened and viewed as a long-term

\(^{21}\) MSI “light” outreach teams are smaller than other teams and do not include physicians.
pilot, beyond SIFPO2. PSI’s and R4D’s work in health financing in five countries provided examples of how domestic financing agencies will respond to PPPs in support of FP via social franchising. In Nigeria, this has led to Society for Family Health having emerging partnerships with state-level government focused on primary health care; in Uganda and Cambodia, specific examples of PPP were discussed with national funding bodies as a result of this partnership, and these may yet bear fruit. Like MSI, PSI hosted and represented several financing sessions at the 2018 Accra Financing conference, which would not have been possible five years ago or without SIFPO2’s support.

**Health financing:** The exploratory health financing/domestic resource mobilization work of PSI and R4D in five countries provided examples of how domestic financing agencies could respond to the prospect of PPPs in support of FP via social franchising, knowledge, and experience that strengthens PSI and other organizations. In Nigeria, PSI reported that this work has led to Society for Family Health having emerging partnerships with state-level government focused on primary health care. Like MSI, PSI hosted and represented several financing sessions at the 2018 Accra Financing conference. SIFPO2 has allowed PSI to bring new and important commercial and market-oriented perspectives to the health financing arena.

**Cost recovery:** PSI has also invested SIFPO2 funds in enhancing their cost recovery analyses and cost accounting. This has resulted in the emergence of a global social enterprise portfolio within PSI, including the creation of the Tunza social enterprise network. This emerging culture and practice also assisted the West and Central Africa region to consolidate condom sales to assist with cost recovery.

**SIFPO2 core objectives incorporated into Strategic Plan:** It should be noted that many objectives that SIFPO2 had for PSI (e.g., around shaping markets, sustainability, youth, and equity) are now central pillars of the PSI Strategic Plan 2018–2020 and will thus inform the organization’s focus in the coming years.

**EVALUATION QUESTION 2**

**What are areas in need of improvement or strengthening in FP/RH service delivery at the country level or globally, and how can a central office or global project support these improvements?**

The areas most in need of improvement or strengthening that emerged from the SIFPO2 evaluation cut across geographies and agencies and have significant implications for high-quality FP programming, client access and choice, and the achievement of FP2020 commitments.

**Collaboration:** Although all IPs participate in national advocacy (e.g., through TWGs), they do not necessarily work as one FP community. Greater in-country collaboration is to be encouraged, as is the sharing of tools and approaches. In the future, such collaboration could be strengthened with the support of IPs’ central offices. At a central office level, there is more evidence of collaboration, which should be encouraged and strengthened. A successful example of this is collaboration among IPs on LNG-IUS and DMPA-SC pilots and sharing of MSI clinical resources with the wider FP community, including IPPF. Task-sharing pilots have also benefitted from greater cross-agency collaboration, reducing duplication and improving the evidence base for this important initiative. Where possible, USAID Mission staff need to encourage greater in-country collaboration. This cannot be done at the central level, but only where the USAID Mission funds all partners in a national setting.

**Commodity security:** In many of the contexts in which IPs operate, commodity security is fragile, affected by limitations in domestic financing, a contraction of donor resources dedicated to FP commodities,22 growing populations of users of reproductive age, and global commodity demand outstripping supply, as may be the case with implants. The introduction of new methods, such as DMPA-

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SC, is welcome, but these methods will also be challenged by the same resource constraints. This leaves mCPR vulnerable in many country contexts, where progress may stagnate or be reversed if not collectively addressed by national governments and the wider FP community. In a context of informed choice, ensuring a wide method mix, available to all women and couples, and delivered through partners in a complementary (not competitive) way is required. IPs have supported this through contribution of commodities, including the provision of under-supplied methods, such as PMs and intrauterine contraceptive devices, allowing a more robust method mix in selected contexts.

Health financing: In a similar vein, health financing remains fragmented within countries due to limited resources and poor coordination, at times exacerbated by decentralization and funding “competition” among health areas. In an era of increasing emphasis on UHC, being on plan and in the package is important for FP and the private sector, and has implications for sustainable FP programs, with the risk that poor resourcing or ineffective inclusion of FP in UHC schemes is passed on to clients, in the form of out-of-pocket expenditure.

PSI has responded to this challenge through engagement of R4D in select health markets and allowing for a “meeting in the middle” between service delivery and health financing experts. PSI is also promoting a TMA as part of its overall Strategic Plan, working with other partners and MOHs to ensure that subsidy is directed to those that need it most.

For MSI, SIFPO2 builds upon catalytic work done under SIFPO1, including health financing and voucher tools and assessments. Under SIFPO2, analysis of 20 MSI FP financing assessments informed the “4Ps” paper, which has been shared widely within the FP CoP and influenced other agency strategies, such as the Bill & Melinda Gates Foundation. In Uganda, the MOH and World Bank drew on MSI’s considerable experience and tools under the RHU Voucher Program to increase access to antenatal care, skilled delivery, and post-natal care among poor women living in rural and disadvantaged areas.

In addition, the leveraging of domestic financing has also contributed to sustainability. For example, in Kenya, MSI and PSI social franchises brokered franchisee accreditation into the National Hospital Insurance Fund, while MSI country programs as diverse as India and Papua New Guinea have been able to secure government contracts.

This work, while commendable, remains unfinished as access to domestic financing for FP and the inclusion of the private sector through strategic purchasing remains nascent in many contexts, particularly sub-Saharan Africa. A senior staff member at MSI noted,

“SIFPO2 has enabled us to become more outward-facing as an organization and a better integrated organization. MSI has a good understanding of what it costs to deliver good-quality services and can work with governments and other stakeholders on this. We intend to continue to build capacity across the organization and to continue to build and maintain relationships [with regard to financing].”

Information and communication technologies (ICT). Harnessing ICT needs to consider the context in which technologies are introduced, in terms of the end-user and the operating environment (e.g., the stability of electricity and internet). MSI noted with its data management systems that implementation relies on country structure and staffing: “Without support for the end-user, including

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24 Appleford, G. and E. Owino, 2017, National Hospital Insurance Fund tariffs—what are the effects on Amua franchisee businesses? MSI, London, UK. This will be presented at the 2018 International Conference on Family Planning.
25 A case study was prepared on the Papua New Guinea experience with contracting under SIFPO1 and presented at the 2016 International Conference on Family Planning.
basic IT [information technology] support, it’s hard to implement.” IPPF’s self-assessment also noted that better evaluations of ICT solutions are needed for m-Health solutions for youth and data management systems for MAs. Field observations also noted that PSI staff, likely the most tech-invested of the three IPs, had difficulty utilizing their ICT-driven platforms due to tablet and connectivity issues. Although ICT remains a critical tool for organizational systems strengthening, it needs to be fit for context and requires end-user support.

**Gender:** IPPF’s gender advisor noted that “support from SIFPO2 changed thinking on gender and allowed IPPF to connect to other platforms, including USAID. The USAID APS was very clear on gender—it was not an ‘afterthought.’” All IPs have participated in the gender TWG and sought to promote male involvement. This has included a vasectomy toolkit (IPPF in Togo), a vasectomy pilot (MSI in Malawi and Ethiopia), and work with young men/husbands (PSI in Niger and Cote d’Ivoire). For IPPF, recognized as a leader in gender and rights-based approaches, there was a strong interest in integrating gender through SIFPO2, which included the development of organizational policies and tools on gender mainstreaming and sexual and gender-based programming in Kenya and Malawi.

However, gender remains “unfinished business” for each IP. IPPF interviewees recognized that integrating gender-transformative approaches to service delivery required investment and support across the Federation. For example, IPPF’s MA in Liberia has been engaging with male gatekeepers and sees this as a way of furthering uptake of contraception among adolescents and dispelling myths and rumors: “We are increasing awareness and sensitization with religious and traditional leaders, parents, grandparents, guardians, [and] teachers regarding the benefits of family planning to adolescents and in order to dispel myths and rumors.” For MSI, gender was introduced under SIFPO1, and further embedded under SIFPO2 and has catalyzed additional sources of funding. PSI also recognized that gender was an area that required additional strengthening, with a staff member in Benin saying, “Gender could be intensified, and countries may need more support on this.” All IPs need innovation and a stronger commitment to gender that can be operationalized, not just theorized, at a country level and backed with sufficient resources and follow-up both within IPs and the communities within which they work.

**Equity:** Just as SIFPO has catalyzed IPs’ systems of integration of youth and adolescents, similar attention is needed to address other marginalized groups, such as the extremely poor, including those who live in hard-to-reach areas or fragile states. As an MSI respondent noted, SIFPO2 “could have pushed MSI further to drive a focus on reaching the poor” in the same way that the organization was inspired to address youth and adolescents. MSI introduced poverty mapping to target service delivery, notably in the Sahel, and has seen steady improvement in reaching those living under $1.25 day in most of its country programs, captured using the poverty and equity tool developed under SIFPO1. IPPF also captures poverty data (using a Poverty Scorecard methodology) and has developed a humanitarian strategy to guide its work in fragile states. PSI has invested in the “Connecting with Sara” app to deepen IPC reach, the quality of IPC-client interaction, and referral completion, and employs use/need analysis to understand FP markets “to show what universal coverage could look like and link to [the] FP2020 pledge.” More cross-learning among FP organizations and reporting on equity measures is needed.26 As an MSI respondent indicated, “[I]f you’re not serving the poor, you’re not serving the market.” PSI has focused on use-need analysis and the equity tool, through the social franchising metrics TWG and work with Metrics for Management. While greater attention to vulnerable groups such as the poor is recommended, it is understood that this may require additional resources and subsidy and can be at odds with objectives of working toward greater financial sustainability.

**Standard definitions:** Evidence suggests that consistent use of appropriate metrics is essential to advance the field. “Using the right metrics ensures that program growth translates into additional impact, gives credit for ensuring current family planning clients have continued access to services, and

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26 The social franchising metrics TWG has been addressing this and supported the development of the Equity Tool.
links programmatic increases in contraceptive use with expanded national coverage, not just attracting clients from other providers.”27 As each IP worked with a different performance monitoring plan, guided by the APS, there was significant variability in the interpretation of key terms and a lack of standardization for very basic indicators, such as FP new users and adopters.28 Annex V illuminates the variability of definitions the three IPs provided to the evaluation team and indicates a need for standardization. Effort has been made to address this, including a 2018 meeting with IPs and the MEASURE Evaluation to agree on tracking new users. MSI has adjusted their metrics; PSI and IPPF are working toward this, and have started to collect data by age and use standard age bands, for example.

**EVALUATION QUESTION 3**

*What processes and/or models were used to transfer capacity to the field (E.G., local affiliates, MOH or other partners) and if there were differences, what were the strengths/ weaknesses of each?*

The “null hypothesis” of SIFPO2 was that by strengthening centralized systems, tools, and approaches, significant outcomes will be achieved at country level due to capacity transfer. Organizational ethos varied in terms of how this was approached and invested in.

**IPPF**

**Regional TA:** IPPF has a decentralized structure with strong regional offices in Asia, Africa, and Latin America and Caribbean. Technical advisors in these offices, together with the central office, were mobilized to develop systems, tools, and approaches, and support their introduction in selected MAs. A key model was using regional workshops and trainings, held in country MAs or at the regional office.

**Champion model:** MAs in which new systems, tools, and approaches were introduced, and where capacity was deemed strong, were used to mentor weaker MAs, creating a strong South-to-South model. Within MAs, champions were also formalized around specific systems, tools, and approaches. These individuals were instrumental in socializing team members to new initiatives and championing their integration.

**Projects:** In several MAs, projects were also conducted with SIFPO2 support. This included the RBA project in three districts of Uganda and the youth-focused project in one district of Malawi. Projects were used to either build up presence (Malawi) or for the purposes of demonstration (Uganda). These were often done in partnership with technical experts, allowing MAs to “access expertise and build capacity in areas beyond their core skill-set.”29

**Public sector engagement:** In several contexts, MAs partnered with public facilities, trained government staff, and mobilized public sector community health workers, including within the projects described above. Some of this work has been evaluated and found to have improved client experience and quality of care.30

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27 Ibid.
29 IPPF’s self-assessment mentions research agencies such as The Population Council; social and behavior change communication specialists such as the John Hopkins for Communication’s Programs), gender specialists (at the University of California San Diego), and supply chain management experts (John Snow, Inc.).
30 Population Council’s Evidence Project found that the Rights-Based Family Planning project had a marked improvement in clients’ experience of privacy and confidentiality; provider counselling and reduced provider bias; reported improvements in the number of methods routinely provided and clients; and improved client satisfaction.
**MSI**

**SuMos:** SuMos were both a system (addressed under Evaluation Question 1) and models for capacity transfer under SIFPO2. Adopted from the commercial sector and introduced through MSI’s senior leadership at headquarters, SuMos allowed for consolidation of different strands of innovation and for systems strengthening to be “housed” under one model (some of which was initiated under SIFPO1). This facilitated lateral consolidation among teams in the support office and eased capacity transfer to country teams as this came in one source document, which was used as a template at the country level to refine and better orient service channels and ways to reach groups such as adolescents. For example, as the MSI country office in Sierra Leone said, “the Outreach SuMo developed by the Global MSI partnership led to our outreach program evolving to reach clients better and more effectively.”

**Co-creation and feedback:** SuMos evolved to a model of co-creation to tap local knowledge with an understanding that “the answer to all of the challenges is in the room.” The process of developing and updating the SuMos has given country teams the space to contribute their expertise and experience. Teams have participated in regional workshops to provide input into SuMo development and periodic updates, funded with SIFPO2 support. Bimonthly webinars are also held for service delivery channel leads to report on progress with embedding SuMos and channel performance (specific indicators are reported on). Channel and other champions have been introduced to recognize strong performance. Other teams (e.g., research, M&E) use webinars to jointly interpret data.

**Public sector strengthening:** PSS was a new channel, developed with support of SIFPO2. This helped to provide SuMo “guardrails,” including accompanying rules and recommendations, to what had previously been ad hoc and loosely defined capacity transfer to MOHs. In the two countries visited, this included a nested provider model, competency-based training and mentorship, and certification on LARCs.

**PSI**

**Institutionalized/systematic training:** This included a range of FP related practical in-service trainings combined with supportive supervision and monitoring from headquarters or regional staff. It also included peer support from one country program to another. This was done for QA where there was a training-of-trainers approach to TA as countries shadowed a lead auditor.

**Regional movements:** Regional FP meetings were used for QA, the TMA, data-for-action, and youth. These are described in PSI’s 2018 Self-Assessment Report as “part training, part creating a movement for that area of work.” PSI considers that several movements have been created as part of SIFPO2. QA also benefitted from the development of regional resource people, in order to provide QA closer to platforms.

**Other processes:** These included in-country and remote TA, study tours, online forums, help desks, SharePoint sites, the PSI University, e-learning courses, and other learning opportunities. PSI, in its 2018 Self-Assessment Report, also identified “spontaneous transfer,” a process engendered through “listening closely and fostering collaboration.” This has included the grafting of innovation in one health area on to another, as happened with what ultimately became HNQIS. In addition, PSI’s self-assessment report noted that “[t]he Equity tool was born from a corridor conversation in PSI, that came out of a difficulty faced by country teams’ relatively low levels of measurement of equity within their programs.”

At other times, decisions on where to focus capacity transfer, and related core resources, were guided by funding gaps or country-led projects with SIFPO2 used for wider buy-in.

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31 Three SuMos were developed in 2016 (outreach, social franchising, and MS Ladies); three were updated in 2017 (channel SuMos); a youth SuMo was created in 2017; and a PSS SuMo was created in 2018, after SIFPO2 funding ceased.
Models and processes differed across IPs, reflecting organizational ethos and structures
IPPF is very large, operating in more than 150 countries, which presents challenges when rolling out systems, processes, and approaches. Its decentralized structure created layers of support for models and processes for transferring capacity. As a result, this has arguably been slower to filter down to MAs, with only a subset benefitting to date. “Sub-awards to MAs were slow to spend, more of a dribble,” as one USAID respondent said. However, this is by design, as IPPF uses a “bottom-up” approach and only engages MAs if there is demonstrable commitment. Where systems have been introduced, there have been funding constraints regarding ensuring sustained support. For example, although RHU is a QA systems champion, only six of its 18 clinics have been assessed for quality in 2018, with the remainder pending other donor support. The project approach has allowed MAs to test comprehensive models (e.g., for RBA and youth), working closely with subnational and community stakeholders. However, the resource intensiveness of projects has also created some challenges for scaling these, both within host MAs and more broadly. In total, five MAs—Kenya, Uganda, Malawi, Togo, and Cote d’Ivoire—benefitted from more intensive support and were used to “incubate ideas,” while others benefitted through TA and the champion model.

MSI’s SuMos introduced rules and recommendations as a means of strengthening FP service delivery channels across all its 32 country programs, allowing for a more uniform application of SIFPO2 support focused upon “embedding.” A SIFPO2 self-assessment noted that “MSI [initiated] step change, building on SIFPO1, [with] the main emphasis on ‘embed and scale,’” and a SIFPO2 Director said, “There were challenges and hiccups, it’s not been easy … MSI brought in a cadre to sit in the operations team, solely focused on systems embedding.” This has also allowed MSI to strengthen nascent programming in contexts such as the Sahel in a more effective and efficient manner (and more recently in the Democratic Republic of the Congo). The MSI office in Mali noted that the leadership processes empowered staff to commit to change:

“The leadership processes identified the vision to ensure we were all aligned. MSI Mali was growing and had mushroomed out. This gave the opportunity to go through with organizational change with people more committed to the process of change. Change is not a natural habit for some people but this helped a lot.”

Team members who visited in Malawi and Uganda were very positive about the SuMo process and the benefits to FP service delivery, reporting that they felt empowered to make adaptations. Similarly, a more rigorous clinical competency model was viewed as empowering to providers, who liked the individualized approach and tailored mentorship. The PSS model was introduced as a strategy for addressing sustainability and what was previously more ad hoc capacity building support. The less effective capacity transfer processes were those that were too organic and driven by individuals within countries/regions. For example, an MSI self-assessment report noted that the “Nine Conversations Leadership Program” training evaluation found that benefits could have been better sustained with greater global oversight and buy-in.

PSI did not employ a “one size fits all” approach to most of their processes and/or models, a notable exception being clinical and data management capacity building, which was done in a systematic manner. PSI’s 2018 Self-Assessment Report described their approach as a “pull effect from the field.” As PSI’s model and processes relied upon “pull” from country teams, there is less evidence of uniform application of SIFPO2 support. In total, 36 countries were involved in FP service delivery under SIFPO2, mainly through social franchising, with a big focus on central capacity and the value proposition to providers.
V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

SIFPO2 was catalytic for all three organizations. IPPF had never received dedicated funding for FP systems strengthening, noting, “SIFPO2 is unique. IPPF never had financial support for the organization before [and] may never have it again.” For MSI, the organization “grew more in the past five years with SIFPO2 funding than it did in the combined 15 years prior.” And, as PSI stated in its July 2018 self-assessment report, “Without SIFPO2, PSI would almost certainly not have been able to create an organized, systematic, and effective movement around … youth, increasing access to quality and voluntary LARCs and improved use of data in FP service delivery.” The organization expressed their gratitude for having been included in the SIFPO mechanism, saying it enabled them to deliver on strategic priorities in a step-wise, not incremental, way. In some instances, these have transcended respective organizations and positively impacted the wider FP CoP at national and global levels. The challenge function, provided by highly experienced AORs and technical advisors and based on a foundation of mutual respect and trust, was important to this.

While the process was catalytic, organizations were humbled by the challenge of supporting FP2020 commitments and sustaining mCPR gains in countries. These remain fragile due to commodity insecurity, with demand for implants, for example, predicted by some respondents to outstrip future supply. In a context of informed choice, ensuring a wide method mix, available to all women and couples, and delivered through partners in a complementary, not competitive, manner, is required. This extends to Mission buy-ins, which provided significant sources of financing but were not always aligned with organizational priorities. As one MSI respondent said, there remains a “need to figure out how to get more out of buy-ins,” and Missions could also “help move policy dialogue [on FP between partners], enabling the integration of country programs so they are not ‘standalone.’”

More could have been done with SIFPO2 investment in reaching vulnerable and underserved groups (e.g., the poorest, those in hard-to-reach or conflict-affected areas, adolescents, and youth) and “unfinished business” remains to which all three IPs are committed and toward which MSI has made progress. This includes continued FP work on reaching adolescents and youth. It extends to greater male involvement and reaching the poor and other marginalized populations, including those in conflict-affected and fragile states. In short, future investments should facilitate systems strengthening as well as innovations, partnerships, and models that enable IPs to reach the unreached with voluntary FP. It is recognized that this may conflict with or challenge mandates to be more financially sustainable, as vulnerable groups require additional effort and attention.

RECOMMENDATIONS

Recommendations have been formulated in the spirit of unfinished business, reflective of QI as a journey and not a destination. These are based upon an appreciation of the talented teams and work done by USAID and the three IPs.

Maintain

Continue the SIFPO mechanism: USAID’s leadership in FP and systems strengthening should continue. This has allowed for step-wise, not incremental, investment in FP research and development, supported by an appetite for “failing fast to learn quicker.” Without this form of FP funding, the tremendous systems improvements supported by SIFPO2, some of which started under SIFPO1, would not have been possible. In a context of value for money, other donors may be more constrained to
invest in large-scale FP systems strengthening and the evidence base, which require longer horizons and may not immediately translate into impact.

**Youth and adolescents:** There is a need to sustain efforts to reach youth and adolescents with high-quality FP information and services, initiated under SIFPO1 (for MSI and PSI) and further mainstreamed under SIFPO2. While there is evidence of integration of these groups, this is not adequately reflected in all contexts or service delivery channels, even those deemed “youth-friendly,” suggesting there is more work to do to address demand for FP, as well as communal and provider attitudes towards FP for youth and adolescents. There is also an opportunity to link the work of service delivery organizations with broader youth-related initiatives, such as the demographic dividend.

**Dissemination:** IPs should be encouraged to continue to disseminate learning and evidence, both the good and bad (we learn as much from failures as successes), in the spirit of building stronger FP service delivery platforms, national FP programs, and a global CoP. Learning and evidence, as well as accompanying systems, tools, and approaches, should be open source inasmuch as possible to create global goods.

**Clinical quality for FP:** The evaluators respect organizational differences in QA as an FP service delivery investment, but believe there should be minimum standards that transcend organizations. These should include realistic thresholds for quality, recognizing that third-party providers (e.g., social franchisees and the public sector) will have different constraints and incentives for quality than channels directly managed by IPs. Recognition of this would allow teams to set more realistic benchmarks and work toward quality as a continuous process. Finally, PSI and IPPF may wish to learn from MSI’s FP clinical quality system, which may be considered best practice, particularly reporting of adverse events, emergency management, and provider assessment.

**Capacity transfer:** There is room to improve on organizational models and processes for capacity transfer. While there may be different agency conceptual differences in how this is done (e.g., pushed or pulled), creating an environment in which country teams are empowered through capacity transfer is important. This extends to technologies, which need to be fit-for-purpose and, in some contexts, may necessitate the need for models that are less dependent on technology.

**Change**

**Clarity of terms:** The evaluation team recommends the use of standard FP indicators, such as consistent user definitions to reduce misunderstanding and present impact in a uniform manner. In this regard, Dasgupta et al have proposed adopting the term “additional users” and dropping “new user” and “acceptor,” given that the latter has multiple definitions (or a standard definition be applied). It is also recommended that effort be made to “demystify” conceptual differences in approaches, such as rights-based and client-centered FP. This may further the potential for misunderstanding and place IP ethos and principles in competition.

**Local ownership:** There is a need for greater country-level ownership of FP programs, which a SIFPO mechanism can foster. This necessitates that IPs’ services complement and do not replace those ably provided through government (i.e., operationalizing “ability” is needed at country level). This should also seek to transition from IP reliance on donor funding to shared investment through increased domestic financing. This, like quality, is recognized as a journey, but one that does need to start, and, in a few instances, has already borne fruit. This is particularly necessary in markets where donors are exiting but need still exists for IP services in terms of quality, access, and capacity transfer.

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**Equity:** Alongside sustained attention to youth and adolescents, IPs are challenged to reach other marginalized groups, particularly the extremely poor, including those living in remote areas and those in fragile states. Across IPs and service channels, this would require that systems are robust and can adapt to challenging contexts while ensuring that standards of quality and choice are maintained. MSI has demonstrated that it is possible to calibrate systems to reach remote and poor populations in the Sahel, for example, through outreach and poverty mapping (as part of a demonstration pilot under SIFPO2). For all IPs, this would be a true test of SIFPO systems investments and make a significant contribution to FP2020 and the Sustainable Development Goals.

**Gender:** Gender is a “systems issue” and intersects with other social stratifiers to create different experiences of vulnerability. It is also very much linked with equity.33 While this was recognized in the APS, IPs have not been able to progress gender to this level of understanding or implementation, with activities remaining more at an interpersonal or organizational level. Greater capacity to use gender analysis and integrate gender is recommended and can inform strengthening male involvement. As WHO noted, “If gender equitable health systems are to be achieved, male gatekeepers or decision-makers who influence the contexts in which poor women live and work need to be involved, alongside women who have to be able to make autonomous choices about their health.”34

**Sustainability:** For IPs to transition from a SIFPO mechanism, greater operationalization of sustainability is required, one that seeks to validate whether this has been achieved. To date, IPs have addressed efficiency; however, this could be considered alongside effectiveness, including cost-effectiveness. At the moment, because cost-effectiveness analysis is not conducted as part of assessing the systems, tools, approaches, and innovations, it is difficult to determine the strengths and limitations of these to determine if an IP is making a “smart investment” in FP with SIFPO2 resources. There are, however, indications that mobile outreach is effective and that MSI and PSI have lower costs and NICRAs than other routine USAID partners.

**Sub-awardees:** Overall, the IPs did not have particularly successful partnerships with sub-awardees. The IPs found some of their sub-awardees expensive, inflexible (e.g., not able to meet their specific technical need), or simply ineffective. Instead, IPs had more success with consultants or contractors brought in to address discrete TA needs. Therefore, the evaluation team recommends that the sub-award partnership model is be examined to inform clarity on the purpose (gap being addressed) and the role of partners, as well as temporal involvement in SIFPO2. These forms of partnership are put together by the prime contractor, and not required by USAID. They are initiated to present a strong and compelling team and address specific technical areas that an IP may be unable to address on its own or to add credibility to jointly undertaken activities.

**Eliminate**

**Project approaches:** It is recommended to reduce reliance on pilots or projects that may concentrate SIFPO2 investment and run counter to FP systems strengthening (unless this is built into the purpose of the pilot or project). This is especially the case for pilots that run beyond the timeframe of SIFPO2, where there is no evidence of systems-level or FP service delivery impact. If this is to continue, extended pilots should have clear milestones and performance criteria and be able to show how they are improving FP service delivery, given the focus of the SIFPO2 investment.

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ANNEX I. SCOPE OF WORK

Assignment #: 563 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 04-05-18
Last update: 08-06-2018
AMENDMENT #1

I. TITLE: SUPPORT FOR INTERNATIONAL FAMILY PLANNING ORGANIZATIONS (SIFPO) II PROJECT EVALUATION

II. Requester / Client
☑ USAID/Washington
Office/Division: GH/PRH/SDI

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☐ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☐ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☐ 3.1.6 MCH
☑ 3.1.7 FP/RH
☐ 3.1.8 WSSH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period
Expected Start Date (on or about): May 16, 2018
Anticipated End Date (on or about): November 30, 2018

VI. Location(s) of Assignment: (Indicate where work will be performed)

The Support for International Family Planning Organizations II (SIFPO2) APS awarded three projects to different primes - MSI is located in London, PSI is located in Washington DC and IPPF is located in London. In addition to visiting partners in these two locations, it is expected that the evaluators will visit one or two countries: Malawi and Uganda. These countries were selected because all three SIFPO2 partners are (or were) implementing PRH core-funded investments there. USAID is most interested in understanding the effect of outcomes of the USG’s global FP investments in these organizations since the inception of the SIFPO2 projects (this evaluation will not consider the original SIFPO1 projects), rather than the individual PRH-funded activities or non-PRH funded activities, although that would also be informative.

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 encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or...
cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation), how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making.

☐ Impact Evaluation (Check timing(s) of data collection)

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFA-funded, check the box for type of evaluation

☐ Process Evaluation (Check timing of data collection)

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ Impact Evaluation (Check timing(s) of data collection)

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and
outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. Background

If an evaluation, Project/Program being evaluated:

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<td>Award/Contract Dates:</td>
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<td>Implementing Organization(s):</td>
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<tr>
<td>Project/Activity AOR/COR:</td>
<td>Marguerite Farrell</td>
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<th>Project/Activity Title:</th>
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<td>Implementing Organization(s):</td>
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<td>Project/Activity AOR/COR:</td>
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<td>Award/Contract Number:</td>
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<td>Implementing Organization(s):</td>
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<td>Project/Activity AOR/COR:</td>
<td>Elaine Menotti</td>
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Background of project/program/intervention (Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis)

Program Overview

Support for International Family Planning Organizations II Project

The SIFPO2 Projects are central mechanisms managed by Office of Population and Reproductive Health (PRH) to increase access to and use of high quality, affordable family planning (FP) and other health information, products and services globally by strengthening international FP organizations with a global reach and network of FP clinics and other health platforms. In April-May 2014, GH/PRH/SDI (Bureau for Global Health/Office of Population and Reproductive Health/Service Delivery Improvement) awarded three SIFPO2 projects, which are 5-year Cooperative Agreements to:

1. MSI, with partners FHI360, EngenderHealth and Grameen Foundation
2. PSI, with partners the Stanford Program for International Reproductive Education and Services, Results for Development, The International Center for Research on Women () and PharmAccess
3. IPPF, with partners Population Council and Member Associations

SIFPO2 works to achieve health-related impact in FP, maternal/child health, HIV/AIDS and infectious disease. The SIFPO2 projects are a continuation of previous USAID Global Health investments in private sector FP service delivery and build on lessons learned under previous activities, including the SIFPO1 awards to MSI and PSI (2010-2015). Midterm evaluations conducted in 2013 deemed SIFPO1 projects successful so design efforts began for a set of follow-on projects that would continue to support global FP networks, primarily for FP but capable of receiving all types of funding in support of a range of activities. The SIFPO2 projects were awarded through an APS process.
There has been great demand for SIFPO2 in the field. In addition to core support, more than 18 Missions and HQ operating units have bought into SIFPO2. The types of funding received by SIFPO2 include FP, Ebola, MCH, HIV/AIDS, Malaria, Water/Sanitation and Hygiene, and Zika. However, this evaluation will look specifically at PRH core-funded outcomes, since each project received different levels of field support buy-in and different types of funding.

In 2017, two of the three SIFPO2 projects communicated to USAID that they would not accept new funding due to inability to sign on to the Protecting Life Through Global Health Assistance provision. Those two projects, SIFPO2/IPPF and SIFPO2/MSI, are now in closeout.

The three projects are housed and managed in the Service Delivery Improvement Division of the Office of Population and Reproductive Health, the management teams include Agreement Officer Representatives, AORs (Marguerite Farrell & Elaine Menotti), Technical Advisor (Kimberly Cole) and Program Assistant (TBD)

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

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Access to and use of high quality, affordable family planning and other health information, products and services increased globally.</th>
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<tr>
<td>Strategic Objective:</td>
<td>International family planning organizations with a global reach and network of FP clinics and other health platforms strengthened</td>
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<tr>
<td>Result 1:</td>
<td>Organizational capacity strengthened to deliver high quality family planning and other health services to target groups</td>
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<tr>
<td>Sub Result 1:</td>
<td>Global systems that strengthen FP and other health program performance improved, streamlined and disseminated</td>
</tr>
<tr>
<td>Sub Result 2:</td>
<td>Innovations, tools and approaches for delivering FP services to target groups tested, implemented, and disseminated</td>
</tr>
<tr>
<td>Result 2:</td>
<td>Sustainability of country level FP and other health programs increased</td>
</tr>
<tr>
<td>Sub Result 1:</td>
<td>Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged</td>
</tr>
<tr>
<td>Sub Result 2:</td>
<td>Capacity of local partners to provide high quality FP and other health services built</td>
</tr>
<tr>
<td>Sub-Result 3:</td>
<td>Innovative partnerships to strengthen health service delivery networks pursued</td>
</tr>
</tbody>
</table>

The Sub-Results that the Evaluators should focus on in particular are Sub-Results 1.1 and 2.2. Sub Result 1.1 supports the standardization and streamlining of quality assurance and other global systems and processes to support strong country level service delivery networks, and strong overall global FP and other health program performance. It was expected that each project would institutionalize and disseminate inputs into global organizational systems and processes to improve performance of country level platforms. Sub Result 2.2 aims to strengthen local NGO affiliate technical and overall organizational capacity, where appropriate, to provide services and contribute to strengthening the broader health system. In addition, this sub result encouraged local NGO affiliates to engage in meaningful partnerships with country level governments to complement or expand FP/RH and other service offerings and ensure high quality health service provision.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?
USAID Countries where SIFPO2 projects worked using core funds. The AOR team will provide the evaluators with “Core Funds by Country” Matrices to enable evaluators to pinpoint the exact countries where core investments were made and at what funding levels.

IX. Purpose, Audience & Application

A. Purpose: Why is this evaluation/assessment 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.

• To assess the SIFPO2 project’s performance to date across all three prime partners and to assess whether or not the core project’s activities are achieving or achieved the intended results as outlined in the agreement, including:
  o Identifying if there have been any technical gaps that have prevented achieving intended results of the project
  o Based on accomplishments toward results as well as the current/anticipated environment, identify potential technical future directions
  o To gather information that will result in useful recommendations for a potential future project(s).

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

The evaluation results will be used by the Service Delivery Improvement (SDI) Division and PRH leadership to inform future procurements for private sector family planning service delivery. Missions are a secondary audience; this evaluation will describe the role of PRH core investments in supporting country-level outcomes. Other donors investing in these organizations are also a potential audience.

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

This evaluation is timely as USAID is in the process of realigning foreign assistance and seeking opportunities to improve efficiencies, increase the number of partners and increase local capacity. The evaluation results will inform important future program decisions related to private sector clinical and community service delivery. And, since there will be one year remaining in the life of the SIFPO2/PSI project the results will inform Year 5 activities.

Evaluation/Analytic Questions & Matrix:

• Questions should be: a) aligned with the evaluation/assessment 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/assessment questions. USAID Evaluation Policy recommends 1 to 5 evaluation questions.

• State the method and/or data source and describe the data elements needed to answer the evaluation questions.
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Suggested methods for answering this question</th>
<th>Sampling Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To what extent did PRH core resources strengthen the capacity of each recipient organization as a whole in family planning service delivery, including country level platforms, by: • Improving organizational systems • Testing, implementing and disseminating innovations, tools and approaches • Improving sustainability • Improving service delivery • Strengthening partnerships What evidence exists to suggest that these improvements will be sustained?</td>
<td>Key informant interviews (KII) with USAID staff in Washington and in Missions including by phone for countries that won’t be visited; • SIFPO2 project staff in each organization’s headquarters; • Interview country-level PSI/MSI/IPPF office staff • Project documents listed in “Section XX: Other Reference Materials” • Annual PRH Core funding levels • SIFPO2 self-assessments Data collection and analysis methods: document review, KIIs, group interviews, field visits</td>
</tr>
<tr>
<td>2</td>
<td>What are areas in need of improvement or strengthening in FP/RH service delivery at the country level or globally, and how can a central office or global project support these improvements?</td>
<td>Same as above</td>
</tr>
<tr>
<td>3</td>
<td>What processes and/or models were used to transfer capacity to the field (e.g., local affiliates, MOH or other partners) and if there were differences, what were the strengths/ weaknesses of each?</td>
<td>Same as above, to include an analysis of LOE needed and methodologies used.</td>
</tr>
</tbody>
</table>

---

35 Excluding USAID staff time.

36 The Evaluators should define “sustainability and “capacity” in the same way that the APS describes the concepts, taking into account how each organization defines these terms in their PMP.
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Suggested methods for answering this question</th>
<th>Sampling Frame</th>
</tr>
</thead>
</table>
| 4 Recommendations for Future Programming:\[37\] What do you recommend be considered for future programming? Please identify:  
  - emerging themes and opportunities in private sector family planning service delivery  
  - aspects of the SIFPO program that could be maintained, changed, or eliminated for a future design | Same as 1-3 above | To be determined by the evaluation team based on availability, appropriateness, and coverage of information. |

**X. Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/assessment 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.

**General Comments related to Methods:**
As a performance evaluation, no counterfactuals have been established and therefore, the results will not address a cause and effect relationship through rigorous methods. However, the SIFPO2 Projects have tracked progress throughout various interventions. As much as possible, the influence of SIFPO2 over these changes will be explored in the context of other factors which may have contributed to such changes.

Once the evaluation team has developed the data collection tools (questionnaires, interview guides, etc.) based on the agreed upon evaluation questions and approaches, they will present them to GH Pro Technical Advisor and the AOR for review and approval prior to their application, in order to verify their appropriateness. All tools should include an informed consent statement. These tools will be used in all data collection situations, especially during country field visits, in order to ensure consistency and comparability of data.

**Field Visits:** The evaluation team is expected to travel to Malawi and Nigeria. The team and USAID will determine how best to cover visits to these two countries. The evaluation team is expected to interview project staff, other implementing organizations and donors, and partners, and review relevant service delivery data (e.g. service statistics, exit interviews, DHIS2 data, quality assurance and supervision data, etc)) in local platform HQs. Points of contact for each country will be identified by USAID and SIFPO2 s

- Document and Data Review (list of documents and data recommended for review)

\[37\] To be submitted in a separate memo to the AOR team
This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

SIFPO2 project documents, including but not limited to:
- Annual Program Statement (APS)
- Cooperative Agreement for the primes
- Annual work plans for all primes
- PMPs and indicator data for all primes
- Financial reports for all primes
- Annual management review reports/annual progress reports for all primes
- Annual results review reports for all primes
- Annual “Core Funds by Country” matrices
- Work plans for field funded activities, as applicable
- Resource materials/tools, research and technical documents developed under SIFPO2
- Past internal and external evaluation reports related to SIFPO2 (SIFPO1 mid-term evaluation, SIFPO1 End of Project Reports), as applicable
- Self-Assessments including a results matrix developed by each partner
- Review each Prime’s client exit interview methodology used for the project, and findings.

The AOR will work with the SIFPO2 Projects to provide the evaluation team with a package of briefing materials related to the SIFPO2 evaluation. This documentation will include all documents listed in the references section.

### Key Informant Interviews (list categories of key informants, and purpose of inquiry)

The evaluation team will conduct qualitative, in-depth interviews with key stakeholders and partners (the AOR team will compile a list of stakeholders and partners, but the evaluation team should add to this list as necessary). Key stakeholders include:

<table>
<thead>
<tr>
<th>Category</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AOR team</td>
<td>Overview of the projects and technical and operational perception of the projects. Discuss challenges and successes.</td>
</tr>
<tr>
<td>Other USAID/GH Staff</td>
<td>To understand the projects’ work involving research, communications, behavior change, FP-HIV integration, gender, youth, etc.</td>
</tr>
<tr>
<td>SIFPO2 HQ Prime Staff</td>
<td>Overview of the projects and understand how PRH investments benefitted their organizations and beneficiaries at HQ and country levels.</td>
</tr>
<tr>
<td>SIFPO2 country-level staff</td>
<td>Understand how PRH investments benefitted their organizations and beneficiaries at the country level.</td>
</tr>
<tr>
<td>SIFPO2 partner staff</td>
<td>Understand the contribution each partner made towards outcomes.</td>
</tr>
<tr>
<td>Country-level stakeholders in</td>
<td>To evaluate external perceptions of changes observed</td>
</tr>
<tr>
<td>countries visited</td>
<td></td>
</tr>
</tbody>
</table>

Whenever possible, the evaluation team should conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. SIFPO2 and USAID staff will give advance notice to several key informants, and then the evaluation team will follow-up to schedule the interviews in coordination with SIFPO2 and USAID staff.

### Focus Group Discussions (list categories of groups, and purpose of inquiry)
### Group Interviews
(list categories of groups, and purpose of inquiry)

Some of the key informant interviews can be clustered, as long as there are no power differentials, and all respondents feel comfortable in voicing their opinions within the group. (See list and description above under KII.)

### Client/Participant Satisfaction or Exit Interviews
(list who is to be interviewed, and purpose of inquiry)

### Survey
(designate content of the survey and target responders, and purpose of inquiry)

The Evaluation Team may consider a web-based survey among IP field staff and stakeholders, to get input beyond the key informant interviews from a wider array of respondents.

### Facility or Service Assessment/Survey
(list type of facility or service of interest, and purpose of inquiry)

### Observations
(list types of sites or activities to be observed, and purpose of inquiry)

| Field Visits | During country visits the Evaluation Team should visit clinics that had been (or are being) supported by the project, to conduct semi-structured observations. If possible, the Team should observe other project-supported channels: mobile outreach, community-based service delivery, etc. Work during these site visits will include key informant and group interviews. While interviewing stakeholders, it is essential that the evaluation team determine the extent to which the project achieved their targets to enhance service delivery (quality, clinical skills, use of data for improvement etc), and test new and/or innovative approaches to achieve private sector FP service delivery results. |

### Cost Analysis
(list costing factors of interest, and type of costing assessment, if known)

| TBD. | We are interested, broadly, in whether modest core FP/RH investments were leveraged to achieve greater program outcomes than if USAID had funded the activities in isolation. This will be discussed further during the in-brief with USAID. |

## XI. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB.** The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:
- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
• Statement that all information provided is confidential and information provided will not be connected to the individual
• Right to refuse to answer questions or participate in interview/discussion/survey
• Request consent prior to initiating data collection (i.e., interview/discussion/survey)

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

As the team reviews the documents available and interview lists, and develops the data collection tools, they will ensure that they will in fact have the data they need to adequately respond to the evaluation questions. Once all data is collected, several days will be spent on carefully compiling, reviewing and identifying key findings prior to making a presentation of preliminary findings to USAID.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program’s achievements against its objectives and/or targets.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XIII. 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 analytic activity. These include SIFPO2 proposals, annual work plans, M&E plans, quarterly progress reports, and routine reports of projects’ performance indicator data, as well as survey data reports (i.e., DHS and MICS). 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 (TPM)** – A four-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
- 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
- Assign drafting/writing responsibilities for the final report
**Briefing and Debriefing Meetings** – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include all Evaluation Team experts, but will be determined in consultation with the AOR team. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead 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 Lead, and review the initial schedule and review other management issues.

- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.

- **In-brief with projects** to review the evaluation plans and timeline, and for the projects to give an overview of their projects to the Evaluation Team. Prior to initiating interviews with the implementing partners (IPs), the in-brief with PSI will be held in Washington, DC, and the in-briefs with MSI and IPPF will be held in London.

- The Team Lead (TL) will brief USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

- **Final debriefs** between the Evaluation Team and USAID. There will be two debriefs: 1) USAID SIFPO2 Management Team debrief; and 2) USAID/PRH debrief. These will be held at the end of the evaluation to present preliminary findings to USAID. During these meetings a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, 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 debrief in the evaluation report. *(Note: preliminary findings are not final and as more data sources are developed and analyzed these findings may change.)* The specific timing of these debriefs will be reviewed during the USAID in-brief.

- **IPs and Stakeholders’ debrief webinar** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with PRH, and will not include any information that may be deemed procurement sensitive or not suitable by USAID.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during the TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing for the field.

**Evaluation/Analytic Report** – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro.
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.

6. Once Evaluation Report is approved, GH Pro will re-format it for 508-compliance and post it to the DEC.

Additional Deliverables:

1. Please provide additional observations on each partner, captured in 2-page overviews of each partner’s specific results/findings/challenges. Please submit these overviews as a separate internal memo to the AOR team.

2. Recommendations for Future Programming - Please submit this as a separate internal memo to the AOR team.

The Evaluation Report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information, captured in the “Additional Deliverables” documents, will be submitted to USAID separate from the Evaluation Report.

Data Submission – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

XIV. 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.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch briefing</td>
<td>May 21, 2018</td>
</tr>
<tr>
<td>In-brief with USAID</td>
<td>Week of June 4</td>
</tr>
<tr>
<td>Workplan and methodology review briefing</td>
<td>June 8, 2018</td>
</tr>
<tr>
<td>Workplan (must include questions, methods, timeline, data analysis plan, and instruments)</td>
<td>June 15, 2018</td>
</tr>
<tr>
<td>Interviews and data collection in Washington, DC with project Primes &amp; USAID</td>
<td>June 2018</td>
</tr>
<tr>
<td>Data collection in UK</td>
<td>June - July</td>
</tr>
<tr>
<td>Data collection in Uganda and Malawi</td>
<td>July 2 – July 14, 2018</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>Debrief with USAID SIFPO2 Management Team with Power Point presentation</td>
<td>July 31, 2018</td>
</tr>
<tr>
<td>Out-brief with USAID/PRH with Power Point presentation</td>
<td>September 7, 2018</td>
</tr>
<tr>
<td>Findings review webinar with IPs and stakeholders with Power Point presentation</td>
<td>September 11 – 14, 2018</td>
</tr>
<tr>
<td>Draft report</td>
<td>Submit to GH Pro: August 15, 2018</td>
</tr>
<tr>
<td></td>
<td>GH Pro submits to USAID: August 24, 2018</td>
</tr>
<tr>
<td>Final report</td>
<td>Submit to GH Pro: September 26, 2018</td>
</tr>
<tr>
<td></td>
<td>GH Pro submits to USAID: October 1, 2018</td>
</tr>
</tbody>
</table>
Deliverable / Product | Timelines & Deadlines (estimated)
--- | ---
☑ Raw data (cleaned datasets in CSV or XML with codesheet) | 
☑ Report Posted to the DEC | November 30, 2018
☐ Other (specify): | 

Estimated USAID review time
Average number of business days USAID will need to review the Report? _____ 15 _____ Business days

XV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)
Evaluation/Assessment 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/assessments 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 (COI), or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity:
- List desired qualifications for the team as a whole
- List the key staff needed for this analytic activity and their roles.
- Sample position descriptions are posted on USAID/GH Pro webpage
- Edit as needed GH Pro provided position descriptions

Overall Team requirements:
The evaluation team will consist of evaluators external to USAID. The evaluation team should have 2 members that have collective knowledge, experience, and context in evaluation methods, human resources for health (HRH), health system strengthening, and local context.

Key Staff 1 Title: Team Lead / Evaluation Expert
Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations. Additionally, s/he will provide quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training/orientation of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, 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.
Qualifications:
- Minimum of 10 years of experience in public health and health project/program evaluations
- Experience in private sector and NGO health services activities in developing countries, especially in FP/RH is desirable
- Expertise in supply and demand for FP services is desirable
- Demonstrated experience leading health sector project/program evaluation-analytics, utilizing both quantitative and qualitative methods
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Background in organizational development is desirable
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience in English
- Experience working in USAID/PRH priority countries is desirable
- Familiarity with USAID M&E policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 2
Title: FP/RH Expert
Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in FP/RH. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.
Qualifications:
- At least 8 years’ experience with FP/RH projects/programs; USAID project implementation experience, which include experience in private sector and NGO health services activities in developing countries, especially in FP/RH
- Expertise in supply and demand for FP services
- Familiarity with FP-HIV integration is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Familiarity with USAID FP/RH policies
Key Staff 3

Title: Program Analyst (USAID, not currently on the AOR team)

Roles and Responsibilities: Serve as a member of the Evaluation Team, participating in data collection, analysis and reporting and will support the Team with all logistics and administration to allow them to carry out this evaluation. To support the Team, s/he will need to efficiently liaise with SIFPO2 staff to finalize arrangements and help conduct KII’s. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist with note taking at interviews and meetings, as well as with translation of data collection tools and transcripts. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing offering guidance and sections of the report.

Qualifications:

- The Assistant must have a minimum of a diploma in a relevant field (International Relations, International Development, Public Health, Program Administration).
- She or he should have experience in organizing meetings.
- Background and at least 5 years’ experience in international development (family planning preferred)
- Experience in implementing and/or evaluating programs/projects (family planning)
- Experience in stakeholder engagement
- Experience in conducting USAID evaluations of health programs/activities
- Ability to work well on a team
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report writing experience
- Proficient in written and spoken English

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

Local Evaluation Logistics/Program Assistant (1 per country visited) may support the Evaluation Team for country site visits. S/He will support the Team with all logistics and administration to allow them to carry out this evaluation. S/H may also be asked to assist with data collection. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations, including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments, including assisting booking interviews. S/He will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist with note taking at interviews and meetings, as well as with translation of data collection tools and transcripts, as well as interpreting during some meetings that require use of local language.

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 assessment activity.

☐ Full member of the Evaluation Team (including planning, data collection, analysis and report development) – If yes, specify who: TBD. USAID/PRH will assign a Program Analyst (not currently on the SIFPO2 AOR team) to work on this evaluation.
Some Involvement anticipated – If yes, specify who: Kimberly Cole, Elaine Menotti & Maggie Farrell will make introductions, help plan visits to HQs and country(ies) and review evaluation work plan, tools and draft reports.

☐ No

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

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

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Team Lead / Evaluation Expert</th>
<th>FP/RH Expert</th>
<th>Local Evaluator / Logistics &amp; Admin</th>
<th>USAID Program Analyst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch Briefing</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>HTSOS Training</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk review</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel to/from DC</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-brief with PRH</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Team Planning Meeting</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplan and methodology review briefing with PRH</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Eval planning deliverables: 1) workplan with timeline, eval matrix, protocol (methods, sampling &amp; analytic plan); 2) data collection tools</td>
<td>1.5</td>
<td>1.5</td>
<td></td>
<td>1.5</td>
</tr>
<tr>
<td>In-brief with project (0.5 day per project)</td>
<td>1.5</td>
<td>1.5</td>
<td></td>
<td>1.5</td>
</tr>
<tr>
<td>Data Collection DQA Workshop (protocol orientation for all involved in data collection)</td>
<td>1</td>
<td>1</td>
<td>2.5</td>
<td>1</td>
</tr>
<tr>
<td>Prep / Logistics for Site Visits</td>
<td>1</td>
<td>1</td>
<td>2.5</td>
<td>1</td>
</tr>
<tr>
<td>Travel to/from countries (UK + 1-2 countries)</td>
<td>5</td>
<td>5</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>US/London/Nairobi Data Collection</td>
<td>9</td>
<td>6</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>In-brief with Mission</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Site Visits &amp; data collection (Uganda &amp; Malawi)</td>
<td>14</td>
<td>14</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Data analysis</td>
<td>6</td>
<td>6</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Travel to/from DC</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debrief with PRH with prep</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>IP &amp; Stakeholder debrief workshop with prep</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Draft report(s)</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>GH Pro Report QC Review &amp; Formatting</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission of draft report(s) to Mission</td>
<td>3</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>USAID Report Review</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revise report(s) per USAID comments</td>
<td>3</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Finalize and submit report to USAID</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>USAID approves report</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final copy editing and formatting</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>508 Compliance editing</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upload Eval Report to the DEC</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted

☐ Yes

☐ No
Travel anticipated: List international and local travel anticipated by what team members.

<table>
<thead>
<tr>
<th>US:</th>
<th>Washington, DC area for meetings &amp; data collection for one prime.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseas:</td>
<td>London for meetings and data collection for two primes. Travel to Malawi and Uganda as preferred locations of travel as per the reasoning stated above. Data collection at the African regional office of IPPF in Nairobi.</td>
</tr>
</tbody>
</table>

XVI. LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>☐ Tourist</td>
</tr>
<tr>
<td>Uganda</td>
<td>☐ Tourist</td>
</tr>
<tr>
<td></td>
<td>☐ Tourist</td>
</tr>
<tr>
<td></td>
<td>☐ Tourist</td>
</tr>
</tbody>
</table>

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant’s behalf.

GH Pro can obtain Facility Access (FA) and transfer existing Secret Security Clearance for our consultants, but please note these requests, processed through AMS at USAID/GH (Washington, DC), can take 4-6 months to be granted. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. FAs for non-US citizens or Green Card holders must be obtained through the RSO. If FA or Security Clearance is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If Electronic Country Clearance (eCC) is required prior to the consultant’s travel, the consultant is also required to complete the High Threat Security Overseas Seminar (HTSOS). HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week Foreign Affairs Counter Threat (FACT) course offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.
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 (FA)
Specify who will require Facility Access: ________________________________

☐ Electronic County Clearance (ECC) (International travelers only)
☐ High Threat Security Overseas Seminar (HTSOS) (required in most countries with ECC)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
Specify who will require workspace at GH Pro: _______ As needed, GH Pro can provide work and meeting space in DC

☐ Travel -other than posting (specify): _______ GH Pro will arrange travel for GH Pro consultants (non-USAID staff)

☐ Other (specify): ________________________________

Specify any country-specific security concerns and/or requirements

XVII. GH PRO ROLES AND RESPONSIBILITIES
GH Pro will coordinate and manage the evaluation/assessment 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/assessment 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, workplan, 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 website. If the report is internal, then copy editing/formatting for internal distribution.

XVIII. USAID ROLES AND RESPONSIBILITIES
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
</tbody>
</table>

**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 CV’s 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 items 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.

**XIX. ANALYTIC REPORT**

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

The Evaluation/Analytic Final Report must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report should not exceed **30 pages** (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

**USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):**

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people’s opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

**Reporting Guidelines:** The draft report should be a comprehensive analytical evidence-based evaluation/assessment 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 findings from the evaluation/assessment will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- **Abstract:** briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- **Executive Summary:** summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- **Table of Contents** (1 page)
- **Acronyms**
- **Evaluation/Analytic Purpose and Evaluation/Analytic Questions:** state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- **Project [or Program] Background:** describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- **Evaluation/Analytic Methods and Limitations:** data collection, sampling, data analysis and limitations (1-3 pages)
- **Findings (organized by Evaluation/Analytic Questions):** substantiate findings with evidence/data
- **Conclusions**
- **Recommendations**
- **Annexes**
  - Annex I: Evaluation/Analytic Statement of Work
  - Annex II: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
  - Annex III: Data Collection Instruments
  - Annex IV: Sources of Information
    - List of Persons Interviews
    - Bibliography of Documents Reviewed
    - Databases
    - [etc.]
  - Annex V: Statement of Differences (if applicable)
  - Annex VI: Disclosure of Any Conflicts of Interest
  - Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.
The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports.

The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XX. USAID CONTACTS

<table>
<thead>
<tr>
<th>Name:</th>
<th>Kimberly Cole</th>
<th>Elaine Menotti</th>
<th>Marguerite Farrell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Technical Advisor</td>
<td>Health Officer</td>
<td>Private Sector Health Team Leader</td>
</tr>
<tr>
<td>USAID Office/Mission:</td>
<td>PRH/SDI</td>
<td>PRH/SDI</td>
<td>PRH/SDI</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:kcole@usaid.gov">kcole@usaid.gov</a></td>
<td><a href="mailto:emenotti@usaid.gov">emenotti@usaid.gov</a></td>
<td><a href="mailto:mfarrell@usaid.gov">mfarrell@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>571-551-7005</td>
<td>571.551.7033</td>
<td>571-551-7011</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>202-664-0970</td>
<td>202.716.0174</td>
<td>202-531-4762</td>
</tr>
</tbody>
</table>

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

| Name: | Amani Selim |
| Title: | Evaluation Technical Advisor |
| USAID Office/Mission: | PRH/PEC |
| Email: | aselim@usaid.gov |
| Telephone: | 571-551-7528 |

XXI. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)
## ANNEX II. COUNTRY PROFILES OF PROGRAMS VISITED IN UGANDA AND MALAWI

<table>
<thead>
<tr>
<th></th>
<th>IPPF Malawi</th>
<th>IPPF Uganda</th>
<th>MSI Malawi</th>
<th>MSI Uganda</th>
<th>PSI Malawi</th>
<th>PSI Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration in country</strong></td>
<td>19 years (since 1999)</td>
<td>61 years (since 1957)</td>
<td>31 years (since 1987)</td>
<td>3 years (since 2015)</td>
<td>25 years (since 1993)*</td>
<td>10 years (since 2008)</td>
</tr>
<tr>
<td><strong>Social franchises</strong></td>
<td>No</td>
<td>Yes (22 clinics)</td>
<td>Yes (44 clinics)</td>
<td>Yes (210 clinics)**</td>
<td>Yes (56 clinics)</td>
<td>Yes (156 clinics)</td>
</tr>
<tr>
<td><strong>Outreach</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (31 teams)</td>
<td>Yes (35 teams)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Geographic coverage of FP services</strong></td>
<td>12 districts</td>
<td>All sub-regions</td>
<td>16 districts</td>
<td>All districts</td>
<td>Social marketing: nationwide Outreach: 12 districts CBD: 8 districts Social franchise: central and northern regions</td>
<td>60 districts in all 4 regions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</table>

SUPPORT FOR INTERNATIONAL FAMILY PLANNING ORGANIZATIONS (SIFPO) II PROJECT EVALUATION / 49
<table>
<thead>
<tr>
<th></th>
<th>IPPF Malawi</th>
<th>IPPF Uganda</th>
<th>MSI Malawi</th>
<th>MSI Uganda</th>
<th>PSI Malawi</th>
<th>PSI Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution to national FP uptake</td>
<td>Estimate/data not available</td>
<td>Estimate/data not available</td>
<td>Estimate/data not available</td>
<td>5% contribution to mCPR in Uganda</td>
<td>Estimate/data not available</td>
<td>Estimate/data not available</td>
</tr>
<tr>
<td>Market share of LAPM</td>
<td>0% (FPAM does not provide LAPM but LARCs)</td>
<td>Estimate/data not available</td>
<td>45%</td>
<td>Estimate/data not available</td>
<td>Estimate/data not available</td>
<td>9%</td>
</tr>
<tr>
<td>Client profiles</td>
<td>Youth: 57%</td>
<td>Young people: 46%</td>
<td>39% live on less than $1.25/day</td>
<td>28% live on less than $1.25/day 8% of clients are 15-19 years old 22% are 20-24 years old 48% are voluntary adopters 59% have not completed secondary education 7% of clients would have had to travel over 3 hours to access FP services (versus 3% of clients accessing BLM’s FP services)</td>
<td>Women of reproductive age 15-49, with a variety of programs designed to ensure FP availability for specific groups of women such as rural women or youth</td>
<td>Social franchising serves a broad range of clients but statistically will focus on WRA between 20-29 years with some ability to pay for services in the private sector clinics, with an increasing focus on Youth FP. Via the public sector work, PSI Uganda reaches a broader range of WRA</td>
</tr>
<tr>
<td></td>
<td>Adults: 43%</td>
<td>Adults: 54%</td>
<td>7% of clients are 15-19 years old 32% are 20-24 years old 26% are voluntary adopters 64% have not completed secondary education 12% of clients would have had to travel over 3 hours to access FP services (versus 3% of clients accessing BLM’s FP services)</td>
<td>7% of clients are 15-19 years old 22% are 20-24 years old 48% are voluntary adopters 59% have not completed secondary education 7% of clients would have had to travel over 3 hours to access FP services (versus 2% of clients accessing MSIU’s FP services)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*25 years as PSI in Malawi. Reproductive health programs delivered since 2008.
**MSI Malawi dropped social franchises in 2018. Results are from 2017.
## ANNEX III. OVERVIEW OF SYSTEMS, TOOLS, APPROACHES, AND INNOVATIONS BY AGENCY

### IPPF

<table>
<thead>
<tr>
<th>Organizational System</th>
<th>Strengths</th>
<th>Limitations</th>
<th>Impact on FP service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care (QoC) framework and tools</td>
<td>Addressed a gap as previously no uniform framework or tool. The medical and service delivery guidelines updated – “IPPF bible for service providers” (this had not been updated since 2004). QoC approach uses strong MAs and partners with weaker ones, reduces burden on the regional offices. Findings from QoC assessments linked with business plans. QoC self-assessment introduced in 58% of MAs by 2016/17.</td>
<td>Tool needs further automation, operationalization of terms used, development of user guidelines provided. The tool does not appear to be very sensitive (binary scale). Self-described as “loose system for quality assurance.” Some indication of funding limitations to fully implement QoC self-assessments in Uganda and Malawi (partially done in 2018).</td>
<td>Unclear how it has impacted FP performance due to limited data and trend analysis. Not clear on how adverse events are reported or managed. SIFPO2 used as seed funding for other proposals, e.g., on QoC. In Malawi, facility action plans date from 2016 and 2017 (two sites respectively) with some actions pending; plans focus on infrastructure not on clinical quality or client care.</td>
</tr>
<tr>
<td>Performance based sub-awards to MAs</td>
<td>Subawards for service delivery, funded by core support to region.</td>
<td>Used a performance-based fund formula, which is not well understood by MAs (as revealed through assessment). IPPF cycle and USAID cycle are not aligned.</td>
<td>Lengthy award process, delayed impact on service delivery implementation in MAs, described as “a trickle.” “IPPF has to have agreement with regional offices – slows things down. Country has to write proposal.”</td>
</tr>
<tr>
<td>Data management system (CMIS and DHIS2)</td>
<td>Uses electronic and manual CMIS and DHIS2. Global DHIS2 generates IPPF’s global service statistics.</td>
<td>Partially introduced in MAs. Malawi M&amp;E Manager disempowered to make system improvements as this needs to be sanctioned by the regional office and champion.</td>
<td>Unclear how system has impacted family planning performance due to limited data and trend analysis In Malawi site visits, providers “overwhelmed” with data collection</td>
</tr>
</tbody>
</table>

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38 CMIS in Liberia and Malawi. DHIS2 in Nigeria, Burkina Faso, Uganda, Togo, Cote d’Ivoire, India and Nepal (IPPF Self-Assessment Report).
<table>
<thead>
<tr>
<th><strong>Organizational System</strong></th>
<th><strong>Strengths</strong></th>
<th><strong>Limitations</strong></th>
<th><strong>Impact on FP service delivery</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply chain management (SCM)</td>
<td>Survey of four MAs with Crown Agents which showed gaps in MA stock, storage, warehousing (not covered under the evaluation) SARO has regional supply chain guidelines which were implemented by India and Nepal Mas. Training hub established in Kenya for Anglophone Mas.</td>
<td>Not clear level of outsourcing of SCM or if this has led to improved SCM.</td>
<td>Decision taken to outsource SCM.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Tools, innovations, and approaches</strong></th>
<th><strong>Strengths</strong></th>
<th><strong>Limitations</strong></th>
<th><strong>Impact of FP service delivery</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client survey tool – net promoter score</td>
<td>SIFPO2 helped test and refine instrument and developed a tool kit for MAs Balance between measuring and self-learning. Piloted in several MAs.</td>
<td>None noted.</td>
<td>Results used to address areas for improvement. Findings from using the net promoter score have been published (Aug 2018) in GHSP.</td>
</tr>
<tr>
<td>Social franchising approach and tools</td>
<td>Improve standardization of the approach in IPPF Have developed a franchise manual and tools; mapping also conducted Established an IPPF global working group – with innovation fund.</td>
<td>MIS captures “enabled services” so can’t say how many MAs have social franchises, “more about a progression of thinking.” Work on social franchise packages in progress.</td>
<td>Previously, social franchising in IPPF more “organic, less systemic” with blurring of the of definitions with HSS and partnership. IPPF now more in line with the standard (University of California San Francisco) definition of social franchising.</td>
</tr>
</tbody>
</table>

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39 India, Kenya, Nigeria, El Salvador, Guatemala, Dominican Republic, and Honduras.

40 Pakistan, Ethiopia, and Peru are examples of strong social franchising MAs. The manuals and tools were piloted in Togo and Cote d’Ivoire.
<table>
<thead>
<tr>
<th>Organizational System</th>
<th>Strengths</th>
<th>Limitations</th>
<th>Impact on FP service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasectomy curriculum (Togo)</td>
<td>Developed national vasectomy curriculum, which was adopted by the MOH.</td>
<td></td>
<td>Not clear if this has driven an increase in the number and quality of vasectomies in Togo.</td>
</tr>
<tr>
<td>Research – ARCHES reproductive coercion pilot (Kenya)</td>
<td>Study conducted with Population Council, University of California San Diego, and MA.</td>
<td></td>
<td>Additional funding identified to continue the pilot. Funding identified to address SGBV within African Mas.</td>
</tr>
<tr>
<td>Rights-based approach (RBA) project in Uganda</td>
<td>Local MA developed RBA policy.</td>
<td>Heavy “project-based” model. Introduced RBA in the public sector but was notably “complex, expensive and violation had to be addressed.”</td>
<td>Limited funding for service delivery, heavy investment in measurement. Limited scale-up (in Uganda the project ended); it has been introduced in Seychelles but not clear if has been introduced in other contexts. MA has advocated for RBA with Uganda MOH but this has not been taken up to date, despite being in national FP CIP.</td>
</tr>
<tr>
<td>Liwonde Youth Life Centre in Malawi</td>
<td>Family Planning Association of Malawi works with 61 youth clubs to mobilize people. Trained over 80 peer educators. Established Watch Groups to mobilize community for SRH services.</td>
<td>Few resources for outreach, mainly short-term methods, supported by one staff (and sometimes a Health Surveillance Agent provides complementary services). No MOH supervision as no support for this.</td>
<td></td>
</tr>
<tr>
<td>Gender mainstreaming</td>
<td>IPPF had a pre-existing gender policy, but was not implemented. Gender equality strategy launched in 2017. Conducted a gender training and audit of central office and piloted in ARO. Gender tool kit developed that incorporates WHO sexual and</td>
<td>Limited resources to implement gender policy and tool kit. Audit revealed that there was no gender strategy, no clear implementation plans, no theory of change Only three gender focal points across the entire IPPF federation. There is an existing 2010 strategy</td>
<td>“Support from SIFPO2 changed thinking on gender” and allowed IPPF to connect to other platforms, including USAID. Gender tool kit piloted in Malawi but team could not speak of any tangible results and struggled to define gender equality.</td>
</tr>
<tr>
<td>Organizational System</td>
<td>Strengths</td>
<td>Limitations</td>
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| **Sayana Press (SP) Study** | gender-based violence guidelines and female genital mutilation.           | for men and boys which SIFPO2 “brought back to life.”                                                                                                                                                    | Study showed increased uptake of all methods, including SP.  
|                       |                                                                            |                                                                                                                                                                                                             | SP integrated into the method mix of all Reproductive Health Units service delivery points. |
|                       |                                                                            | Not currently in government supply pipeline, therefore IPPF set up parallel supply.                                                                                                                                     | No data on scale but data from pilot. High potential particularly among youth.               |
|                       |                                                                            | Limited scale of the pilot.                                                                                                                                                                                   |                                                                                               |
|                       |                                                                            | Study showed increased uptake of all methods, including SP.  
|                       |                                                                            | SP integrated into the method mix of all Reproductive Health Units service delivery points.                                                                                                                   |                                                                                               |
|                       |                                                                            | No data on scale but data from pilot. High potential particularly among youth.                                                                                                                                  |                                                                                               |
| **MSI**               |                                                                            |                                                                                                                                                    |                                                                                               |
| **Organizational System** | **Strengths**                                                             | **Limitations**                                                                                                                                                                                                 | **Impact on FP service delivery**                                                                 |
| **Service delivery SuMos (focused on outreach and public sector support for the evaluation)** | SuMos are the main organizational systems strengthening approach – act as a central repository for systems, tools, approaches, and evidence: shows what “good looks like” for country programs.  
|                       |                                                                            | Clear rules (standards) and recommendations based upon evidence generated through country teams.                                                                                                               | SuMo appears highly accepted/utilized in Malawi and Uganda; also used by technical and support staff when doing field visits. |
|                       |                                                                            | Evidence gaps are highlighted through the model and prioritized for further research or testing.                                                                                                               | Evidence that are used to guide systems strengthening, such as improved scheduling, efficiency, responsiveness to demand (e.g., alignment with immunization days in Uganda). |
|                       |                                                                            | “PSS and MS ladies were all over the place but with SIFPO2 support, MSI was able to develop standards, define significant involvement. This allowed for variation to respond to context but also standardization.” | Integration with health and community structures (e.g., Village Health Teams in Uganda, satisfied client testimonials were witnessed). |
|                       |                                                                            |                                                                                                                                                                                                             | Local innovation: additional application developed (in Uganda) that allows for deeper performance analysis. |

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41 Population Council, RHU, and IPPF have written an article about the pilot in GHSP.
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<td>Clinical quality system</td>
<td>Strengthened clinical standards for infection prevention, medical emergencies management, counselling and consent, Postpartum FP, Postpartum intrauterine device. Introduced individual competency assessment system for core services. Strengthened internal and external Quality Technical Assistance system. Strengthened adverse events reporting system. Strengthened governance - Clinical sub-committee meets every four months to review QTA findings for 4-month period, all clinical quality related activities and data (QTAs, major clinical incidents, and quality enforcement notices, clinical risk profiling and clinical quality scorecard), including data reported by country programmes, such as internal audit (internal QTA) coverage, clinical and product-related incident reporting, and Medical Advisory Team (MAT) meeting minutes. % model sites = site consistency % model areas = service consistency.</td>
<td>Challenge with adverse events in the public sector as some MOHs do not want these reported, e.g., Tanzania. MSI guidelines have been shared with WHO, IPPF, Engender Health, MSF, and national MOHs. Adverse event reporting significantly improved (system logs issues immediately during office hours); Rise in reporting attributed to a no blame culture and a culture of learning Cost savings through targeted training by competency level. QTA system more “sensitized” – cannot hide behind averages as all areas have a separate score. After QTA there is an action plan drafted by the country program and finalized by the Global Medical Director (GMD) and Regional Medical Advisor (RMA); the country team has 90 days to implement or gets flagged as “red” for accountability and leadership. Social franchise quality lower and has led to de-franchising and channel closure, e.g., Malawi.</td>
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41 Country programs finalize the action plan with the RMA and GMD within 6 weeks after the QTA. Follow-up on the action plan occurs at 3, 6 and 9 months thereafter. If countries have not yet completed the action plan between 9 – 12 months or the next annual QTA, it would be escalated to the GMD and Global Clinical Governance lead, and the country program would be scored down on the clinical governance section.
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<tr>
<td><strong>Data management system (CLIC and ORION)</strong></td>
<td>20 areas – there is a 90% benchmark across channels(^2)</td>
<td>Labor intensive and expensive to scale/rollout. Lack of a formal plan for embedding CLIC; rectified this for ORION, which had a formal plan – “true embedding means not discussing systems but just doing it.” IT support for end user: “Successful ORION implementation relies on country structure and staffing. Without support for the end-user, including basic IT support, it’s hard to implement.” CLIC is not used in the public sector and doesn’t address the various requirements for different countries or issues specific to a country, including HR or stock solutions. Only introduced ORION in social franchising but broader potential. “Challenges were not documented but there should have been a stock taking.”</td>
<td>Pre-ORION, there was limited to no visibility on method mix by facility or region. Now with ORION, MSI can go down to franchisee level. Analysis of CLIC data helped inform MSI’s service delivery for youth. For example, the best hours, fees, etc.</td>
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<tr>
<td><strong>Research – strategy, client exit interviews (CEIs), ethics review committee (ERC)</strong></td>
<td>Research strategy that takes insights to action focused on impact, quality, sustainability Improved CEI protocols to capture and analyze data and reporting</td>
<td>Need to focus more on publishing, external dissemination (a wealth of data but limited time to write)</td>
<td>MSI can report on 2020 strategy objective that 80% of clients are high impact High Impact Client data (specifically data on the youth demographic of MSI clients) was used to inform youth strategy and the youth SuMo</td>
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\(^2\) Final “scores” or results from the QTA consist of two clinical quality metrics: percentage of model sites: the percentage of sites that achieve benchmark score in all areas assessed during the QTA and did not receive any flags for ‘other observations’; and percentage of model areas: the percentage of areas assessed where every site achieved the benchmark score. These metrics are calculated for each QTA and a pdf produced as an attachment to the final narrative report. Overall, these new metrics provide a clear view of where room for improving client safety lies and help country programs to identify where resources for improving client care should be focused.
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<td>Organizational System</td>
<td>Two ERC guidance documents developed, including ethical use of routine data</td>
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<td>ERC best practices shared and promoted through representation in global forums</td>
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<td>Other management systems – Anti-fraud and bribery, FP compliance</td>
<td>FP statutory and policy country compliance plans in place for all SIFP2 buy-in country programs Anti-fraud and bribery system and training package developed and rolled out</td>
<td>No limitations noted; this is an ongoing initiative from SIFPO2</td>
<td>“Rolling out anti-fraud and bribery in 32 countries was a great SIFPO benefit that strengthened the organization.”</td>
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<tr>
<td>Tools, innovations and approaches</td>
<td>Strengths</td>
<td>Limitations</td>
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<td>Management tools – Fleet management</td>
<td>Fleet management used to address efficiency and quality, e.g., monitor time of arrival and time on site to reduce client wait and ensure that services are not rushed — “Driven by feedback from CEIs regarding waiting times. So MSI a better organized team, on-site efficiency and support to the client journey.” Based on initiatives at country level, e.g., Tanzania, which were built up.</td>
<td>Added one country at a time, in first 2 years included all 15 African country programs. For Year 3, planned to add 7-8 country programs in Asia but was put on hold. Wanted to refocus the work in Africa to make sure goals achieved – re-embedding. Some drivers felt that it was policing initially but came to see it as empowering.</td>
<td>Fleet management has reduced costs, increased safety and performance against indicators. “230 outreach teams now plan their journeys using schedule module (online).” Raised the visibility of the role of the drivers and their empowerment (now Transport Assistants)</td>
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<tr>
<td>Behavior change communication (BCC) tools – BCC framework, flipchart, and App for client counseling</td>
<td>BCC framework integrated into SuMos for each channel Framework adapted to address provider behavior change Quality of BCC materials improved and standardized materials for countries, including “Look books” that are tailored to various audiences. Examples include: Good buy-in to BCC framework across support functions but embedding is a process and takes time Flipchart and app support provider counseling on LARC (e.g. advantages side effects, risks, etc) but client choice remained the same.44</td>
<td></td>
<td>Prior to SIFPO2 funding, MSI had no standardized way of discussing BCC Concept of BCC stronger now in MSI than before. Met latent demand, now creating demand Counseling app does not limit method choice but will eliminate a method based on medical eligibility, effectiveness and lifestyle</td>
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44 As one finding of the app evaluation was that providers reported most clients already had a method in mind and left with that method, providers didn’t feel they were able to use the app as designed – with questions on lifestyle preferences, medical eligibility etc, which based on the client’s answers would list a choice of methods. MSI’s counselling and consent guidelines are centered around client choice with the provider’s role to assist clients to make an informed decision on choice of method.
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<td>Lifestyle and Benefits of FP, giving your child more opportunities – target passive mother, You Can Do More for aspiring mother</td>
<td>App revised to be done in the community to reach women who haven’t made up their mind.</td>
<td>preferences. It has increased intimacy with client, reminded what to discuss, and medical eligibility; however, 70-80% of clients in country have already chosen a method before a visit so limited impact on method mix. Result of insight study showed that the term LARC was not useful as the term implies women have to wait a long time to have a child. So, messaging focused on what a woman could achieve with a LARC i.e. growing her business first.</td>
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<td>Data tools – IMPACT2, cost calculator</td>
<td>Version 2.5 of IMPACT2 (original version introduced in 2011). Updated with global and national data including DHS, DALYs, etc.) Cost calculator introduced across channels and teams. This builds off SUN as each team has a cost center. It has improved accountability, for example, trade-offs are easier to understand. The use of data has improved its quality as this is being scrutinized.</td>
<td>IMPACT2 used widely by the FP community and MSI has trained partners and donors on it. The cost calculator has guided value for money analysis and decision making. Has been used in some contexts, such as Kenya, to inform costing of FP within national health insurance packages. FP2020 interested in MSI costing data. Cost calculator methodology has been shared with IPPF and PSI.</td>
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<tr>
<td>Mapping</td>
<td>Using geographic poverty mapping to direct outreach teams using open source software, Q-GIS. Using DHIS2 to select PSS sites (as can analyze service utilization patterns).</td>
<td>While visual maps work for the teams, teams need support thinking through implications.</td>
<td>Equity has been a big focus in West Africa. “If you’re not serving the poor you’re not serving the market.” Through its use in Senegal and Burkina Faso have shifted the teams and seeing an improvement in geographic poverty targeting. In the</td>
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45 The cost calculator is being used in Kenya, Nigeria, Malawi, Bangladesh, Madagascar, Tanzania, and Uganda.
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<td>Health financing approaches - voucher standard operating procedures, health market assessments, “4Ps” (people, package, provider, payment) paper</td>
<td>“Core support has been helpful to build out thinking and innovation.” Assessments looked at how markets are operating and how FP is financed in 20 countries. From these assessments a synthesis paper was published, commonly referred to as the 4Ps. MSI has a good understanding of what it costs to deliver quality services, and can work with governments and other stakeholders on this.</td>
<td>Progress slower than hoped and has taken time to build expertise – “Finance has a lot more to it and a lot more actors in involved.” Continuing to build capacity across the organization. “Intend to continue to build and maintain relationships” developed through SIFPO2.</td>
<td>4Ps used as a framework for other organizations and USAID partners. Health financing team has informed country engagement on domestic financing with some success in securing government contracts (e.g., Papua New Guinea, India, Nepal) as well as engagement on national health insurance (e.g., Kenya and Ghana) MSI voucher program in Uganda has been consulted heavily on a lot of the design and system elements for a national voucher program, which is an example of using a vertical mechanism to influence a broader system.</td>
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<td>Adolescent SuMo and youth strategy</td>
<td>Adolescent content embedded into all channel SuMos Has created a CoP within MSI, supported through the SuMo, updates via webinars on “what works,” and youth leads in country teams. Data driven, projections developed for every country based on DHS unmet need data.</td>
<td>Inadvertent consequence of better data collection/reporting: Some countries have laws where age of consent for FP is 18. It’s unclear if girls always tell their real age because of fear of judgement or being turned away for services. External communications on MSI youth and adolescent work recognized as an area to strengthen</td>
<td>SIFPO2 catalyzed adolescent focus within MSI. Prior to SIFPO2, MSI’s proportion of adolescent clients served stagnated at 5-6%; now at 13% with over 1 million girls reached with core services Jan 2017-April 2018.</td>
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## Organizational System

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| Research studies – task sharing, bespoke studies or projects such as the Malawi vasectomy pilot<sup>46</sup> | Task-sharing working group – coordinated studies (Kenya, Tanzania, Zambia, and Nigeria)  
Vasectomy CoP started with Kenya, Malawi, Uganda, Ghana, and Papua New Guinea to exchange learnings.  
All vasectomies in Malawi attributed to MSI/BLM (according to MOH) | Vasectomy pilot in Malawi as not integrated into channels as effectively as it could have been after it was concluded<sup>47</sup>  
The write-up of the approach and results will be included in the next round of MSI's success models (late 2018). | Task sharing study of implants to CHEWs “supported the change in policy which was a major priority for PRH.” |
| PSI                                                                                  | Development of centralized capacity for QA, including minimum standards, an internal audit orientation guide in multiple languages, standard checklists for PMs (developed with MSI), informed choice (developed with MSI)  
QA scorecard is an evaluative tool but also an action | “Live versions” of standards and tools on SharePoint, some challenges with rolling out according to PSI HQ, “greater standards but some resistance.”  
Adverse event reporting still centrally managed (via partnership with SPIRES)  
PSI acknowledged that there is limited adverse event reporting, which suggests that “clearly” | Viewed by PSI as health systems strengthening by working across the public and private sectors. |

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<sup>46</sup> The vasectomy pilot wasn’t a research study but piloted a vasectomy champion approach to increase knowledge and awareness coupled with a service delivery component.

<sup>47</sup> The approach of using vasectomy/couples’ champions could not continue due to lack of funding, but current BLM (MSI Malawi) providers provide vasectomy. Without the awareness creation aspect there are few clients who are interested in vasectomy compared to tubal ligation.
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<td>planning tool, “becomes a roadmap.” Youth-friendly health services certification incorporated into PSI's global QA system</td>
<td><em>not all countries are reporting.</em> In response, PSI has developed a course on “adverse events versus complications” (this is described as an area for improvement).</td>
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<td>Developed D2A framework. SIFPO2 has allowed global strategy to be tested in country platforms (previously had to rely on bilateral grants). Internally, building movement on data use within PSI as part of long-term commitment to Sara.” DHIS2 and HNQIS viewed by PSI as “innovations, tools and systems all in one.”</td>
<td>There is skepticism as to whether the DHIS2 investments (in apps, etc.) are truly accessible to the wider FP CoP as they are tailored to PSI’s systems/people.</td>
<td>Externally, PSI is a global leader in DHIS2 and considers this an investment in a public good. It is promoting this through the DHIS2 academies and communities of practice Evidence of data engagement through the addition of interpretations section</td>
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48 Core SIFPO2 has mainly been on HNQIS and “Connecting with Sara” apps.
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<td>HNQIS</td>
<td>HNQIS is an app that overlays onto the DHIS2, and allows for:</td>
<td>Complex to use, some difficulty noted to query data (Uganda example). Lack of coaching on interpretation (very basic examples provided). SF providers were not aware of the system (in Uganda). More suitable to environments with stable electricity and internet.</td>
<td>Data dips in Uganda could not be explained (indicated due to staff change which questions rigor, utilization of data). May improve quality, may reduce stockouts but no indication that improved service uptake.</td>
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<td>• Visualization of data</td>
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<td>• Data interpretation and tagging feature (funded by SIFPO2)</td>
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<td>• Prioritization of social franchisees for follow up/areas of weakness</td>
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<td>• Competency based assessment (using simulation or clients)</td>
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<td>SafeCare</td>
<td>Holistic and aspirational – advanced SafeCare benchmarked to international standards.</td>
<td>Time and resource intensive (1 day for SafeCare basic and 2 days for SafeCare advanced assessments). Potential mismatch between SafeCare is considered a core activity “infused into strategic aim of PSI,” e.g., Social franchising clinic management QA model informed by SafeCare. Dropout over time (from 47 initially assessed in Uganda, 33 remain engaged in 2018 and 8 are undergoing assessments). Not necessarily aligned to government systems (e.g., SQIS in Uganda). No evidence of improved FP service delivery (based on PACE presentation).</td>
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49 According to PSI, while alignment in Uganda is the next key challenge, SafeCare and SQIS are fundamentally linked – SafeCare standards were the basis upon which SQIS was designed http://sqis.med.ug/credits/ - this was one key reason we were comfortable proceeding with SafeCare in Uganda.
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<td>Provides a Quality Improvement Plan for individual providers.</td>
<td>system/tool and provider (aspirations and resources). CMS tech and ICT skill dependent (requires a loan for the system).</td>
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**SafeCare: Comparing FP Client Loads**

![Graph showing comparison between SafeCare and Non-SafeCare clinics.]

**Tools, innovations, and approaches**

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<td>Tunza Social Enterprise approach</td>
<td>Seeks to address sustainability for social franchisor and franchisee through a strengthened value proposition. Clear vision of success: robust</td>
<td>Extended pilot, long time horizon beyond SIFPO2 (e.g., modelled out in Uganda over a 10-year horizon to see client modest fee increase).</td>
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<td>value proposition means less donor dependency over time, and reduced franchisor support.</td>
<td>Heavy investment required by the franchisor in CMS, not easily used by all staff. Other components, such as SafeCare, may be heavier than providers are able to absorb. Free FP events as way of cross-selling services but undervalues provider time.</td>
<td>Uganda considered the “center of excellence” for this initiative. Integrated the Uganda MOH HMIS form for ease of reporting (but still done manually). MOH reported to be interested in the tool in Cameroon.</td>
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<td>QoC tool – Client based record management(^5)</td>
<td>Uses a UIC and integrated client record. Links to supportive supervision in HNQIS. Used for all PSI-supported PHC services.</td>
<td>Uganda is lobbying to file alphabetically so can retrieve record more easily.</td>
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<tr>
<td>Interpersonal communications (IPC) tool – Connecting with Sara app</td>
<td>The app facilitates community health workers (CHWs) (IPC) to refer clients to care. It has a number of features, such as tracking referrals</td>
<td>Connectivity may limit its use in contexts where this is limited or erratic Confidentiality and information privacy may be violated if data is shared or The provision of a Smartphone is reported to have validated the role of CHWs within their communities and built their morale. It also allows PSI to track the reach of CHWs through GPS and reduces fraud, as performance can be validated. Mobile phones are viewed as “the most stable thing about Sara” so can work in contexts of migration and mobility. Sara’s data is protected through the use of UIC. The app was not observed in Uganda or Malawi as it has not been introduced as yet.</td>
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\(^5\) Currently implemented in Uganda, Cameroon, Nicaragua, Guatemala, and El Salvador.
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<td>and supporting better quality CHW-client engagement through prompts.</td>
<td>used for other purposes (although consent measures are reported to be in place, it is unclear how well this is adhered to by CHWs/IPCs).</td>
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<td>The Use/Need approach to understanding FP markets</td>
<td>More systematic approach to data for decision making – layer use on top of need, which limits denominator to women at risk and absolute numbers help plan for scale.</td>
<td>Complicated, and may not align with other methodologies such as those used by FP2020.</td>
<td>Helps show what universal coverage could look like and link to FP2020 pledge. Also helps understand market constraints.</td>
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<td>Research – method information index (MII) study and equity tool including Kenya study with M4M, client exit surveys using equity tool.</td>
<td>MII better able to understand unmet need and reasons for discontinuation. Equity tool developed in 2016 and housed by M4M.</td>
<td>MII study done in Uganda, MSI in Pakistan, and will be disseminated to FP community via conferences and journals. Equity tool tied with other metrics, which tells PSI who its reaching vs who they could (use/need).</td>
<td>“Discussing and addressing equity now a norm of program work.”</td>
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<tr>
<td>New technologies/method mix – SP/DMPA study (Malawi)</td>
<td>DMPA study allowed PSI served as a catalyst in moving DMPA work.</td>
<td>PPIUD inserter – Don’t have a good understanding of cost vs benefit, return on investment.</td>
<td>Seeking WHO pre-qualification for the inserter. PPIUD study is undergoing peer review with the GHSP journal; Pathfinder introducing the device into Cote d’Ivoire. Secondary aim of LNG-IUS study was to increase global learning about discontinuation rates.</td>
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51 This was a joint initiative with MSI, M4M and others.
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<tr>
<td>PPIUCD inserter study (Mali)</td>
<td>forward within PSI</td>
<td>Is integrating effective – could reduce quality and be in conflict</td>
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<tr>
<td>ECP study</td>
<td>Designed a dedicated PPIUD inserter, pre-loaded with copper T, replacing need for Kelly forceps and sterilization. ECP landscape and market analysis and barriers to use; informed global best practice guidelines. Introduced LNG-IUS in 40 social franchise clinics (Nigeria), and 6 high volume facilities in Zimbabwe.</td>
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<tr>
<td>LNG-IUS study (Nigeria and Zimbabwe)</td>
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<td>Youth integration</td>
<td>Youth integrated into QA checklists. Youth mainstreamed into some of the social franchises.</td>
<td>Youth and adolescent focus have been a “stretch for some programs” (example of Cambodia provided).</td>
<td>PSI has created a youth movement within the organization and reported a substantial increase in ‘service users’ of PSI services that are age 15-24, across all methods but also for LARCS</td>
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<tr>
<td>Health Financing Options Analysis (HFOA) – led by R4D with PSI</td>
<td>For R4D, it has allowed the organization to deepen its ideas</td>
<td>In terms of the influence, R4D’s self-appraisal was from none</td>
<td>At country level, limited impact on PSI/SFH access to domestic financing at present. At organizational level, health financing is now part of the PSI strategic plan. A key focus was on private sector inclusion, but the 2018 Ghana meeting was cited as an instance where the “private sector was put in the social franchising box” whereas the</td>
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<td>country teams in Nigeria, Cambodia, Tanzania, and Uganda.</td>
<td>on mixed health systems and has been “a major source of learning.” For PSI it was a “meeting in the middle” of service delivery and health financing communities.</td>
<td>(Tanzania) to some (Uganda) to greater influence (Nigeria), but status of country interventions not known – “we’d be curious to find out.” Acknowledged that “if not connected with the GFF investment case or NHI plans, will not work.”</td>
<td>private sector role and need for PPP are far wider than the discussion that takes place in social franchising forums.</td>
</tr>
</tbody>
</table>
### ANNEX IV. ACTIVITY GANTT CHART BY IP

#### IPPF Gantt Chart

<table>
<thead>
<tr>
<th>Activity</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 Data collection, analysis and reporting</td>
<td></td>
<td></td>
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<tr>
<td>1.1.1 a) Strengthen data collection and analysis through collection of District Health Information System (DHIS) data</td>
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<tr>
<td>1.1.1 b) Enable a comprehensive approach to data management across the federation by linking District Management Information Systems (DMIS)</td>
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<tr>
<td>1.1.1 c) Support the development of tools that enable IPPF MAs to assess improve data quality and the use of data for decision making</td>
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<tr>
<td>1.1.1 d) Develop and implement an annual report for data management across the federation</td>
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<tr>
<td>1.1.2 Building the capacity for data use for decision making</td>
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<tr>
<td>1.1.2 a) Strengthen data collection and analysis and reporting</td>
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<tr>
<td>1.1.2 b) Increase supply chain management capacity and establish south to south learning hub to build sustainable approach for supporting IPPF</td>
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<tr>
<td>1.1.3 Strengthening supply chain management of HWN commodities</td>
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<tr>
<td>1.1.3 a) Strengthen the quality of clinical services through the development of a comprehensive Service Delivery Guideline (SDG)</td>
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<tr>
<td>1.1.3 b) Strengthen the quality of FP service delivery through the development of global standard clinical training guidelines for voluntary FP, including</td>
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<td>1.1.4 Development of standard tools on client confidentiality and client satisfaction and apply them to ensure high quality, client-focused, voluntary FP services</td>
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<tr>
<td>1.1.5 b) Enhance compliance with UNAIDS policy and legislative requirements on population and voluntary family planning activities</td>
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<tr>
<td>1.1.6 Strengthening Quality of Care (SoC) systems</td>
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<tr>
<td>1.1.7 Strengthening supply chain management of HWN commodities</td>
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<tr>
<td>1.1.8 Strengthening Quality of Care (SoC) systems (same as activity 1.1.4 per year)</td>
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<td>1.1.9 Testing and documenting innovative FP service delivery approaches</td>
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<tr>
<td>1.1.10 Testing and documenting innovative FP service delivery approaches</td>
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<tr>
<td>1.1.11 Developing and testing tools and approaches to strengthen gender-sensitive programming</td>
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<tr>
<td>1.1.12 Sharing of best practices and lessons learned</td>
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<tr>
<td>1.1.13 Sharing of best practices and lessons learned</td>
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<tr>
<td>1.2.1 Implement and assess the effectiveness of a model which trains providers to work with women experiencing intimate partner violence and</td>
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<tr>
<td>1.2.2 Share best practices and lessons learned across the federation and with the global FP community through the Global Engagement in Global, Regional and</td>
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<td>1.2.3 Strengthening organizational management, planning and learning</td>
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<tr>
<td>1.2.4 Support to MAs to capture new revenue and diversify funding sources</td>
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<tr>
<td>1.2.5 Support to MAs to capture new revenue and diversify funding sources</td>
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<tr>
<td>2.1.1 Implementing promising and proven high impact practices (HIP) to take services to underserved communities</td>
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<tr>
<td>2.1.2 Support the introduction of Sayana Press to informal national urban areas in Uganda and compile lessons for sharing across the federation and</td>
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<td>2.1.3 Increasing access among young people</td>
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<tr>
<td>2.2.1 Strengthening IPF integration to improve access to voluntary FP for young people in Kenya and Malawi districts, including support to and</td>
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<tr>
<td>2.2.2 Strengthening IPF integration to improve access to voluntary FP for young people in Kenya and Malawi districts, including support to and</td>
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<tr>
<td>2.3.1 Expanding and strengthening partnerships with health providers</td>
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<tr>
<td>2.3.2 Expanding and strengthening partnerships with health providers</td>
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<tr>
<td>2.4.1 Support for the promotion and implementation of Sayana Press in Uganda and across Africa</td>
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<tr>
<td>2.4.2 Integrating HIV/ARVs and IPF services in HIV treatment and care services</td>
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</tbody>
</table>
## ANNEX V. DEFINITIONS OF KEY CONCEPTS
**FURNISHED BY EACH IMPLEMENTING PARTNER**

<table>
<thead>
<tr>
<th>Concept</th>
<th>IPPF</th>
<th>PSI</th>
<th>MSI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FP New user</strong></td>
<td>IPPF tracks the number of “First time users of modern contraception” – <strong>First time user</strong> is defined as “an IPPF service user who accepts at least one modern method of contraception in his/her life.”</td>
<td>Globally, PSI no longer uses the term “FP new user.”</td>
<td>A client attending an MSI channel facility for the first time ever and receiving FP at this visit. One client can only be a first-time user once. A first-time FP user is also an adopter.</td>
</tr>
<tr>
<td><strong>FP Adopter</strong></td>
<td>A client who was not using a modern method of family planning on the day he/she received his/her FP product or service.52</td>
<td>A client who is not currently using modern contraception at the time of their visit (either never used or has not used in the last three months). A person could be an adopter several times in their life if they stop and start using contraception.</td>
<td>A client who is not currently using modern contraception at the time of their visit (either never used or has not used in the last three months). A person could be an adopter several times in their life if they stop and start using contraception.</td>
</tr>
<tr>
<td><strong>Additional users</strong>53</td>
<td>Not calculated</td>
<td>Not calculated</td>
<td>Calculated using IMPACT2 (v5) which uses service statistics and client profile (three options: no use in last three months, method continuer and switcher [from one provider to another]) to generate estimates.</td>
</tr>
<tr>
<td><strong>Youth</strong></td>
<td><strong>Young people</strong> are defined by IPPF as aged 10–24.</td>
<td>PSI uses the term “youth” to refer to individuals aged 15–24.</td>
<td>15–24 years of age</td>
</tr>
<tr>
<td><strong>Social franchising</strong></td>
<td>Social Franchising in IPPF applies to the development of a formal partnership between an MA and a privately-owned health facility to provide specific sexual and reproductive health services by skilled health workers in line with quality standards. MAs, who act as the franchisor, have a written agreement with the private provider, who becomes the franchisee.</td>
<td>The classic definition of social franchising is a network of private-sector health care providers that are linked through agreements to provide socially beneficial health services, such as family planning, under a common franchise brand. Increasingly, PSI and other social franchising implementers are programming variants of the classic social franchising model. These include franchising public-sector providers and/or facilitating more loosely affiliated networks of health providers, A network of private-sector health care providers that are linked through agreements to provide socially beneficial health services under a common franchise brand. For MSI, this is the BlueStar brand.</td>
<td>A network of private-sector health care providers that are linked through agreements to provide socially beneficial health services under a common franchise brand. For MSI, this is the BlueStar brand.</td>
</tr>
</tbody>
</table>

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52 NB This is not the definition given to use during the presentations by PSI in Washington when they defined an adopter as a client who was not using the day before.

53 “The net number of current contraception users above a specified baseline; in the case of FP2020, the baseline is the number of current contraception users in 2012 in the world’s 69 poorest countries. Note that this concept does not apply to an individual but rather to an aggregate population. From: Dasgupta, A, Weinberger, M, Bellows, B and W. Browne, 2017. “New Users” Are Confusing Our Counting: Reaching Consensus on How to Measure “Additional Users” of Family Planning. Global Health: Science and Practice 2017, Volume 5, Number 1.
<table>
<thead>
<tr>
<th>Concept</th>
<th>IPPF</th>
<th>PSI</th>
<th>MSI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sustainability</strong></td>
<td><strong>Programmatic sustainability:</strong> The likelihood that projects and initiatives initially supported by SIFPO2 will continue in the absence of USAID/PRH support. <strong>Organizational Sustainability:</strong> The extent to which SIFPO2-supported work increased IPPF’s capacity to continue operating and delivering quality FP services beyond the life of the Project. <strong>Financial sustainability:</strong> The extent to which SIFPO2-supported work will ensure a steady flow and will generate revenue for maintaining and continuing IPPF’s work.</td>
<td>In the broadest sense, PSI defines sustainability as continued health impact over time. PSI works to support this through strategic priorities, such as shaping markets and shifting policy and funding. We think continued health impact over time is best supported by strong mixed health systems where public and private sectors collaborate to meet the health needs of a population and where local organizations and governments take the leadership role, with strategic support from global actors and global networks like PSI.</td>
<td>MSI looks at sustainability in two ways: <strong>Growing a sustainable organization:</strong> Strategic resource management across all programs, followed by diversified funding (e.g., donor funding, service income, contracting and insurance) that responds to opportunities in countries <strong>Growing a sustainable health market for choice:</strong> Aims to catalyze a future in which supply, demand, and policy come together in a health market that makes reproductive choice a long-term reality for all women. In other words, we aim to positively influence the development of more effective health markets for our clients.</td>
</tr>
<tr>
<td><strong>Capacity building</strong></td>
<td>IPPF does not have an official definition of capacity building. However, the federation is currently working on a technical assistance strategy that outlines various approaches and models for building the capacity of MAAs. The aim of <strong>technical assistance</strong> within IPPF is “address the challenges and constraints faced by MAAs as they perform their day-to-day work, and to help MAAs identify opportunities for institutional growth, improving performance and ensuring long-term sustainability.”</td>
<td>A process that involves the transfer of skills, knowledge, experience, and decision-making authority from one individual or group to another. At PSI, capacity building takes place between HQ and field – with capacity building going in both directions – and increasingly through South-South technical assistance among network members and health systems actors.</td>
<td>MSI does not have one definition for the organization, but uses capacity building as commonly used in the development sector: developing and strengthening skills/abilities/processes etc. in individuals, organizations, other.</td>
</tr>
</tbody>
</table>
ANNEX VI. DATA COLLECTION INSTRUMENTS

SUPPORTING INTERNATIONAL FAMILY PLANNING ORGANISATIONS (SIFPO II) PROJECT EVALUATION

PARTNERS' QUESTIONNAIRE
You are being contacted in order to answer some brief questions which will assist with the evaluation of core support delivered via the SIFPO II program.

The main aim of the evaluation is to document how SIFPO II core funding strengthened central and country-level capacity, systems, platform and service quality, for example, by using systems, tools, protocols etc., developed at HQ with core funds. We are interested in your role with regard to how you supported or shaped some of these systems and tools.

It would be helpful if your answers could reflect the overall expected program results.

It is kindly requested that you answer all of the questions, providing sufficient detail for analysis. We ask that you also include evidence as to the impact of your support on SIFPO II initiatives.

This questionnaire is for evaluation purposes and was commissioned by USAID. Results of the questionnaires will be shared and will be presented in a format that protects the specific identity of respondents while providing country-specific information. Responding to the survey is voluntary and implies consent.

The questionnaire will take about 30 minutes to complete. We are asking that you complete the question survey by July 6, 2018 at the close of business. If you wish to have a more detailed discussion via telephone or Skype please provide contact details and indicate this on your returned survey. All responses will be confidential. If you agree, please proceed with the questionnaire.

Thank you for your assistance with this evaluation.

Regards,

Sarah Castle & Gabrielle Appleford (GH Pro Consultants)

1. Include your personal information
   Name
   Email Address
   Phone Number

2. Organization and Title
   Partner Organization
   Position in partner organization

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SUPPORT FOR INTERNATIONAL FAMILY PLANNING ORGANIZATIONS (SIFPO) II PROJECT EVALUATION / 73
3. What does your organization do under SIFPO2? (tick all relevant boxes)

- Social franchising
- Mobile outreach
- Develop data platforms (i.e., data for decision making)
- Address quality assurance
- Youth friendly health services
- Expand method choice
- Integrate FP with other health care service delivery
- Strengthen policy/service delivery with Ministries of Health
- Research/Monitoring and Evaluation
- Disseminate shared learnings
- Strengthen workforce capacity to provide FP services and information
- Explore and advise on health financing
- Other (please specify)

4. What is your exact role in terms of supporting SIFPO2 activities? For example, have you improved organizational systems, developed, tested or disseminated an approach or tool? Has this role evolved or changed over time?

5. How has your involvement influenced the centralized organization of your SIFPO partner (MSI, PSI or IPPF)?

<table>
<thead>
<tr>
<th>No influence</th>
<th>Contributed very little</th>
<th>Contributed moderately</th>
<th>Significantly contributed</th>
<th>N/A</th>
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</table>

Other (please specify)

6. Under SIFPO2, how has your organization contributed to the strengthening of your SIFPO2 partner’s country level program and networks?

<table>
<thead>
<tr>
<th>No contribution</th>
<th>Contributed very little</th>
<th>Contributed moderately</th>
<th>Significantly contributed</th>
<th>N/A</th>
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</table>

Other (please specify)

7. How likely is it that your contribution be sustainable after SIFPO2 ends?

<table>
<thead>
<tr>
<th>Not sustainable</th>
<th>Somewhat sustainable</th>
<th>Moderately sustainable</th>
<th>Highly sustainable</th>
<th>N/A</th>
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Other (please specify)
8. What are your impressions as to the general sustainability of SIFPO-funded core activities (please comment in relation to i) Organizational, ii) Programmatic and iii) Financial sustainability

9. Were there any technical, financial or operational gaps that prevented your agency from achieving some of the intended results of SIFPO2?

Please explain

Were you able to help find a solution to these problems? If so, how? If not, why not?

Comments

10. What would be your recommendations for the future direction of SIFPO2 or a similar funding initiative? (What opportunities are there to engage new partners? Are there any unaddressed opportunities in the private sector? How can the capacity of local organizations be better built?)

11. Has your involvement in SIFPO2 resulted in any changes in the way your own organization operates or thinks? (Has the collaboration with SIFPO2 led to an increased awareness about technical opportunities, organizational capacity building or new models of service delivery? Will these new perspectives alter the way your own organization operates in the future?)

12. Were there any difficulties or barriers with regard to the funding from SIFPO2 influencing your collaboration with your SIFPO2 partner?

13. In your view, how can organizations like IPPF, MSI or PSI transition away from this type of assistance?
14. If SIFPO were to be replicated in the future, what recommendations would you make from the point of view of a partner/funder? (What could be done differently? What could be changed or dropped?)
COUNTRY OFFICE/MA QUESTIONNAIRE

You are being contacted in order to answer some brief questions which will assist with the evaluation of core support delivered via the SIFPO 2 program.

The main aim of the evaluation is to document how SIFPO 2 core funding strengthened country-level capacity, systems, platform and service quality, for example, by using systems, tools, protocols etc., developed at HQ with core funds. We are also interested in core funding which directly supported specific country-level service delivery initiatives. We are NOT (for the purposes of this evaluation) interested in country level SIFPO II buys-ins with USAID Missions.

If you have more than one example of a system, tool, innovation etc. in your country program that is a result of core funding, please consult with your colleagues in the country office and send back one questionnaire only which reflects the different initiatives.

It would be helpful if your answers could reflect the overall expected program results.

It is kindly requested that you answer all of the questions proposed, providing sufficient detail for analysis. In particular, please provide evidence and examples to back up your statements relating to improved capacity or the barriers in relation to it.

This questionnaire is for evaluation purposes and was commissioned by USAID. Results of the questionnaires will be shared and will be presented in a format that protects the specific identity of respondents while providing country-specific information. Responding to the survey is voluntary and implies consent.

The questionnaire will take about 30 minutes to complete. We are asking that you complete the question survey by July 6, 2018 at the close of business. If you wish to have a more detailed discussion via telephone or Skype please provide contact details and indicate this on your returned survey. All responses will be confidential. If you agree, please proceed with the questionnaire.

If you require further clarification as to what should be included in your responses, please contact your SIFPO II Director at your head office/Secretariat.

Thank you for your assistance with this evaluation.

Regards,

Sarah Castle and Gabrielle Appleford (GH Pro Consultants)
1. Include your personal information

Name

Email Address

Phone Number

2. What is your position or title?


3. Please tick the country in which you work using SIFPO2 core funding

- Afghanistan
- Bangladesh
- Benin
- Burkina Faso
- Cambodia
- Cote d'Ivoire
- DRC
- Ethiopia
- Ghana
- Haiti
- India
- Kenya
- Liberia
- Madagascar
- Mali
- Mauritania
- Mozambique
- Nepal
- Niger
- Nigeria
- Pakistan
- Philippines
- Rwanda
- Senegal
- Sierra Leone
- South Sudan
- Tanzania
- Togo
- Uganda
- Yemen
- Zambia
- Zimbabwe

4. Please indicate which organization you represent

- PSI Country Office / Local affiliate
- MSF Country Office / Local affiliate
- IPPF Member Association
5. How have SIFPO 2 core resources strengthened your country-level network? Rate the following statements about SIFPO2’s contribution

<table>
<thead>
<tr>
<th>Improved organization systems</th>
<th>No contribution</th>
<th>Contributed very little</th>
<th>Moderately contributed</th>
<th>Significantly contributed</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Enabled the testing, implementation, and dissemination of innovative tools and approaches</td>
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<td>Improved service coverage/reach</td>
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<td>Improved service quality</td>
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<tr>
<td>Strengthened partnerships</td>
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<tr>
<td>Improved financing mechanisms (e.g. domestic financing)</td>
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<tr>
<td>Improved data management and use</td>
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6. Please provide details as to how SIFPO2 core funding has influenced these changes.

7. What processes and/or models developed with core funds were used to transfer capacity to the field? Please refer to question 1 to exemplify responses?

8. Were these processes/models effective in achieving desired results?

<table>
<thead>
<tr>
<th>Effective at all</th>
<th>Not very effective</th>
<th>Somewhat effective</th>
<th>Very effective</th>
<th>N/A</th>
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<tr>
<td>Other (please specify)</td>
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9. Were tools and/or systems rolled out in settings where there was no USAID donor money? If so, please give an example. If not, why not.

10. To what degree has core funding from SIFPO2 improved the sustainability of your country-level activities? Please refer to organizational, programmatic and financial sustainability.

<table>
<thead>
<tr>
<th>No contribution</th>
<th>Contributed very little</th>
<th>Moderately contributed</th>
<th>Significantly contributed</th>
<th>N/A</th>
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Other (please specify)

11. How have management practices within your country office been affected by SIFPO2? (both positively and negatively)

12. How has a central office or global project supported improvements related to SIFPO2?

13. What are the gaps (e.g. technical, operational, financial) in relation to core-funded activities, tools or mechanisms which have prevented you reaching intended results at a country level?

14. Have you implemented (or could you implement) any innovative solutions to address the gaps outlined in the question above? Have core funds helped with this (or could they help)?

15. What additional partners could be engaged in SIFPO-funded activities? (for example, faith-based organizations?) What could they add to your activities? What are the barriers to their involvement?
16. In your country-setting, what are the challenges and opportunities in private sector family planning delivery that could be addressed by SIFPO?

17. In your view, what are the elements of the SIFPO program which could be maintained, changed or eliminated for future design?
   
   - Maintained
   - Changed
   - Eliminated

18. How can country programs maximize the efficient use of core SIFPO funds

19. How can country programs strategically transition away from this type of assistance

Thank you!
ÉVALUATION DU PROJET SIPFO2 (SUPPORTING INTERNATIONAL FAMILY PLANNING ORGANIZATIONS)

QUESTIONNAIRE BUREAU DE PAYS / ASSOCIATIONS MEMBRES

Nous vous contactons pour vous poser quelques questions brèves qui nous aideront à évaluer l’appui fondamental apporté via le programme SIPFO2.

L’objectif principal de l’évaluation est de documenter comment le financement de base par SIPFO2 a renforcé les capacités, systèmes, plateformes et la qualité des services au niveau central et du pays en utilisant, par exemple, des systèmes, outils, protocoles, etc., développés au siège grâce aux fonds de base. Nous nous intéressons aussi au financement de base ayant directement appuyé les initiatives de prestations de services au niveau de pays. Nous ne nous intéressons PAS (pour les besoins de la présente évaluation) aux adhésions de SIPFO2 aux missions de l’USAID au niveau de pays.

Si, dans votre programme de pays, vous avez plus d’un exemple de système, outil, innovation, etc., qui résulte du financement de base, veuillez consulter vos collègues au bureau de pays et renvoyer seulement un questionnaire qui illustre les différentes initiatives.

Il serait utile que vos réponses reflètent les attentes globales à l’égard des résultats du programme.

Nous vous prions de bien vouloir répondre à toutes les questions suggérées en donnant suffisamment de détails pour permettre une analyse. Surtout, veuillez donner des preuves et exemples pour appuyer vos déclarations portant sur la capacité améliorée ou les obstacles afférents.

Prière de noter que les résultats du questionnaire seront partagés et présentés dans un format qui protège l’identité des répondants tout en offrant des informations par pays. Répondre au questionnaire est volontaire et implique le consentement.

Vous aurez besoin de 30 minutes environ pour participer au questionnaire. Nous vous demandons de remplir le questionnaire le 6 juillet 2018, à la fermeture des bureaux. Si vous désirez avoir une discussion plus détaillée par téléphone ou Skype, veuillez nous préciser vos coordonnées et l’indiquer dans le questionnaire rempli. Toutes les réponses seront confidentielles. Si vous acceptez, veuillez procéder.

Au cas où vous auriez besoin d’explications supplémentaires sur ce qui devrait être inclus dans vos réponses, veuillez prendre contact avec votre directeur / directrice de SIPFO2 à votre siège social / secrétariat.

Nous vous remercions de votre aide avec la présente évaluation.

Cordialement,
Sarah Castle et Gabrielle Appleford (GH Pro Consultantes)

1. Incluez vos informations personnelles
   <input name="moepastebin" type="hidden">
   Nom du répondant / de la répondante

   Email du répondant / de la répondante

   Numéro de téléphone du répondant / de la répondante

2. Quelle est votre poste ou son intitulé?

3. Veuillez cocher le pays dans lequel vous travaillez en utilisant le financement de base de SIFPO2
   - Madagascar
   - Mali
   - Nigeria
   - Sénégal
   - Bénin
   - Burkina Faso
   - Côte d'Ivoire
   - Niger
   - Togo

4. Veuillez indiquer l'organisation que vous représentez:
   - PSI Bureau de pays / Filiale locale
   - MSI Bureau de pays / Filiale locale
   - IPPF Association membre
5. Comment les ressources de base de SIFPO2 ont-elles renforcé votre réseau au niveau du pays?

<table>
<thead>
<tr>
<th>Services organisationnels améliorés</th>
<th>aucune contribution</th>
<th>contribution très négligeable</th>
<th>contribution modérée</th>
<th>contribution importante</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A permis la mise à l'épreuve, mise en œuvre et désémination d'outils et approches novatrices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couverture / portée améliorée des services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partenariats renforcés</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mécanismes de financement améliorés (par ex., financement intérieur)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestion et utilisation des données améliorées</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Veuillez indiquer de manière détaillée comment le financement de base de SIFPO2 a influencé ces changements.

7. Quels sont les processus et/ou modèles, développés avec le financement de base, utilisés pour transférer les capacités sur le terrain ? Veuillez consulter la question 1 pour illustrer les réponses.

8. Ces processus / modèles, ont-ils été efficaces pour atteindre les résultats voulus?

<table>
<thead>
<tr>
<th>pas du tout efficaces</th>
<th>pas très efficaces</th>
<th>un peu efficaces</th>
<th>très efficaces</th>
<th>N/A</th>
</tr>
</thead>
</table>

Ajoutez une case commentaires
9. Est-ce que les outils et/ou systèmes ont été déployés dans des contextes sans moyens financiers donnés par l’USAID ? Si oui, veuillez en donner un exemple. Si non, pourquoi?

10. Dans quelle mesure est-ce que le financement de SIFPO2 a-t-il amélioré la pérennisation de vos activités au niveau du pays ? Veuillez faire référence à la pérennisation organisationnelle, programmatique et financière.

   <input name="moepestebin" type="hidden">
   <table>
     <tr>
       <td>aucune contribution</td>
       <td>très faible contribution</td>
       <td>contribution modérée</td>
       <td>contribution importante</td>
       <td>N/A</td>
     </tr>
     <tr>
       <td>□</td>
       <td>□</td>
       <td>□</td>
       <td>□</td>
       <td>□</td>
     </tr>
   </table>

   Ajoutez une case commentaires

11. Quel est l’impact de SIFPO2 sur les pratiques de gestion dans votre bureau de pays ? (Aussi bien positif que négatif.)

12. Comment le bureau central ou projet global ont-ils supporté les améliorations liées à SIFPO2 ?

13. Quelles sont les insuffisances (par exemple techniques, opérationnelles ou financières) au niveau des activités financées par les ressources de base qui auraient empêché votre agence à réaliser certains des résultats escomptés au niveau du pays?

   <input name="moepestebin" type="hidden">


   <input name="moepestebin" type="hidden"/>
15. Quels autres partenaires pourraient participer aux activités financées par SIFPO ? (Par exemple, les organisations confessionnelles ?) Que pourraient ils ajouter à vos activités ? Quels seraient les obstacles à leur participation ?

16. Dans le contexte de votre pays, quels sont les défis et opportunités en matière de prestation de planning familial au niveau du secteur privé que SIFPO pourrait aborder ?

17. À votre avis, quels éléments du programme SIFPO à retenir, changer ou éliminer dans la conception future ?

Retenir
Changer
Éliminer

18. Comment les programmes de pays peuvent-ils maximiser l’utilisation efficace des fonds de SIFPO ?

19. Comment est-ce que les programmes de pays peuvent-ils abandonner progressivement ce type d’assistance ?

MERCI !
## ANNEX VII. LIST OF PERSONS INTERVIEWED

<table>
<thead>
<tr>
<th>IPPF Key Informant Interviews</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abok Barnabas</td>
<td>Project Officer (SIFPO2)</td>
</tr>
<tr>
<td>Paulin Tra</td>
<td>Technical Manager, Performance Knowledge and New Technology</td>
</tr>
<tr>
<td>Dr. Elias Girma</td>
<td>Lead Technical Advisor</td>
</tr>
<tr>
<td>Dr. Lawrence Oteba</td>
<td>Technical Advisor</td>
</tr>
<tr>
<td>Jackson Chekweko</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Dr. Kenneth Buyinza</td>
<td>Clinical Services Manager</td>
</tr>
<tr>
<td>Annet Kyarimpa</td>
<td>Technical Coordinator- Safe Motherhood/ Program Coordinator</td>
</tr>
<tr>
<td>Diana Kabahuma</td>
<td>Communications Coordinator</td>
</tr>
<tr>
<td>Demeter-M Namuyobo</td>
<td>Medical Coordinator/ QOC Champion</td>
</tr>
<tr>
<td>Edward Kiggundu</td>
<td>M&amp;E Coordinator</td>
</tr>
<tr>
<td>Lawrence Muhangi</td>
<td>M&amp;E Manager</td>
</tr>
<tr>
<td>Dr. Moses Okilipa</td>
<td>Medical Officer – RHU Mbale clinic</td>
</tr>
<tr>
<td>Eric Owot</td>
<td>District Education Office – Mbale District</td>
</tr>
<tr>
<td>Thokozani Mbendera</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Tazirwa Chipeta</td>
<td>Director of Clinical Services</td>
</tr>
<tr>
<td>Tusekele Mwakasungula</td>
<td>Programs Manager</td>
</tr>
<tr>
<td>Dezio Banda</td>
<td>M&amp;E Coordinator</td>
</tr>
<tr>
<td>Mrs. Fannie Kachale</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Patricia Kamoto</td>
<td>District Health Officer representative Machinga</td>
</tr>
<tr>
<td>Given Chilimila</td>
<td>FPAM District Manager Machinga</td>
</tr>
<tr>
<td>Matilda Banda</td>
<td>FPAM Field Officer Machinga</td>
</tr>
<tr>
<td>Taona Tembo</td>
<td>FPAM District Manager Dowa</td>
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</table>

<table>
<thead>
<tr>
<th>MSI Key Informant Interviews</th>
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</thead>
<tbody>
<tr>
<td>Evi Phiri</td>
<td>Senior Program Manager</td>
</tr>
<tr>
<td>Sam Kanyemba</td>
<td>Outreach Coordinator</td>
</tr>
<tr>
<td>Vincent Sinda</td>
<td>Outreach Coordinator</td>
</tr>
<tr>
<td>Juvenalis Mambo</td>
<td>Head of IT</td>
</tr>
<tr>
<td>Konzekerani Chigwenembe</td>
<td>Internal Auditor</td>
</tr>
<tr>
<td>Patrick Zgambo</td>
<td>BCC Manager</td>
</tr>
<tr>
<td>Davie Zolowere</td>
<td>Director of Clinical Quality</td>
</tr>
<tr>
<td>David Makwaka</td>
<td>Director of Strategy and Partnerships</td>
</tr>
<tr>
<td>Harrison Limwame</td>
<td>Deputy Country Director</td>
</tr>
<tr>
<td>Chawanankwa Mwale</td>
<td>M&amp;E Manager</td>
</tr>
<tr>
<td>Francesca Mumthall</td>
<td>Nested Provider Coordinator</td>
</tr>
<tr>
<td>Maarten VanDeReep</td>
<td>Country Director</td>
</tr>
<tr>
<td>Charles Mumba</td>
<td>Outreach Coordinator</td>
</tr>
</tbody>
</table>
### MSI Key Informant Interviews

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Khumbo Zonda</td>
<td>M&amp;E Manager</td>
</tr>
<tr>
<td>Patrick Zgambo</td>
<td>BCC Manager</td>
</tr>
<tr>
<td>Dr. Peter Ddungu</td>
<td>Director of Programs</td>
</tr>
<tr>
<td>Dr. Fred Nsubuga</td>
<td>Head of Social Franchise</td>
</tr>
<tr>
<td>Dr. Andrew Kirima</td>
<td>Head of Outreach</td>
</tr>
<tr>
<td>James Kiboigo</td>
<td>ICT Officer</td>
</tr>
<tr>
<td>Martin Agaba</td>
<td>Head of Public Sector Support</td>
</tr>
<tr>
<td>Sam Arikko</td>
<td>Head of Communication</td>
</tr>
<tr>
<td>Diana Amanyire</td>
<td>Head of Youth &amp; Adolescents</td>
</tr>
<tr>
<td>Fred Barongo</td>
<td>Director Corporate Services</td>
</tr>
<tr>
<td>Dr. Richard Tuyiragize</td>
<td>Head of RME</td>
</tr>
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### PSI Key Informant Interviews

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeptha Mtema</td>
<td>Country Representative</td>
</tr>
<tr>
<td>Caroline Bakasa</td>
<td>RH Technical Advisor</td>
</tr>
<tr>
<td>Gift Kambandanga</td>
<td>Tunza Manager</td>
</tr>
<tr>
<td>Chifundo Kuyeli</td>
<td>RH Programs Manager</td>
</tr>
<tr>
<td>Wyson Gowelo</td>
<td>RH Service Delivery Coordinator</td>
</tr>
<tr>
<td>Steven Mkandawire</td>
<td>RH Demand Creation Coordinator</td>
</tr>
<tr>
<td>Patuma Chikopa</td>
<td>Tunza Quality Advisor</td>
</tr>
<tr>
<td>Goodson Chikopa</td>
<td>Tunza Business Operations Analyst</td>
</tr>
<tr>
<td>Joan Phiri</td>
<td>Tunza Marketing Advisor</td>
</tr>
<tr>
<td>Phillip Mkandawire</td>
<td>Acting Head of M&amp;E and Research (Data Manager)</td>
</tr>
<tr>
<td>Patricia Kalima</td>
<td>RH Quality Assurance Officer</td>
</tr>
<tr>
<td>Chimwemwe Phiri</td>
<td>RH Outreach Team Leader</td>
</tr>
<tr>
<td>Henry Kaula</td>
<td>Strategic Information and Learning Manager</td>
</tr>
<tr>
<td>Dorothy Muttu</td>
<td>Marketing Manager</td>
</tr>
<tr>
<td>Pamela Muhumuza</td>
<td>Tunza Business Support</td>
</tr>
<tr>
<td>Hanna Baldwin</td>
<td>Director of Operations and Management</td>
</tr>
<tr>
<td>Luigi Nunex</td>
<td>E-Learning Officer</td>
</tr>
<tr>
<td>Moses Odot</td>
<td>Health Services Coordinator</td>
</tr>
<tr>
<td>Milly Kaggwa</td>
<td>Programs Director and Acting CR</td>
</tr>
<tr>
<td>NAD Tunza</td>
<td></td>
</tr>
<tr>
<td>Dr. Mihayo Placid</td>
<td>MOH, Director of Reproductive Health</td>
</tr>
<tr>
<td>Jean Mwalabu</td>
<td>QA Manager</td>
</tr>
</tbody>
</table>
ANNEX VIII. BIBLIOGRAPHY OF DOCUMENTS REVIEWED

SIFPO2 EVALUATION - DOCUMENT INVENTORY

GH Pro KII Contact List Template.xlsx
MSI-SIFPO1.pdf
PSI-SIFPO1.pdf

PSI FOLDER

SIFPO2 Deliverables

- Explaining these folders!
  - Untitled Document
- Partners plans and newsletters Yr 1-3
  - SIFPO_June_2015
  - SIFPO2 Partner Kickoff Report
  - SIFPO2 Partner update Jan 2015
- Year 1
  - 1.1.1 Providing country-level AQ training and supervision
    - EQA Kenya Matrix 2015-Country Response_Final.xlsx
    - EQA Kenya Scorecard 2015 pb.xls
    - QA Matrix scorecard combined Kenya EQA 207 mk(1).xls
    - Trip Report – Mariah Preston, KEN RWA PAK, 2015.doc
  - 1.1.2 QA
    - EQA Kenya Matrix 2015-pb final (1).xls
    - Kenya EQA 2017 Debrief Presentation (1)(1).pptx
    - QA Matrix Scorecard Combined Kenya EQ 2017 mk (1)(1).xlsx
  - 1.1.3 CME Assessment
    - Final PSI CME Needs Assessment Jan 5 2014.docx
    - Global Landscape Assessment on CME.pdf
  - 1.1.6 Data for Decision Making
    - Data to Decision Making one Pager.docx
  - 1.1.7 Social Franchise Dashboard Tool within DHIS2
    - SIFPO DHIS2 Hand-out_Brochure.pdf
  - 1.1.11 Desk Review and Qualitative Field Research in Zambia
    - SIFPO2 Brown Bag PPT_Zambia couple communication.pptx
• SIFPO2 Couple Communication Presentation_Dec 1 2016 at PSI.pptx
• SIFPO-2 Journal Manuscript Final_Oct26_1104.docx
• Zambia report_final.pdf
  o 1.1.12 Qualitative Research in India
    • SIFPO2 South and SE Asia Youth Jan 10.pptx
  o 1.1.14 YFHS
    • 5. Consensus Global_jeunes et MLDA.pdf
    • Curriculum SSAJ_PSI_2016.docx
    • TOT detailed curriculum.docx
    • YF Health Services Guide FRENCH.pdf
  o 1.1.18 RHSC
    • Jen Pope presentation for RHSC meeting – Mexico City, Oct 2014.pdf
  o 1.2.1 TMA
    • 1.2.1 Yr 1 TMA summary – Senegal.pdf
    • Approche du marché Total PF Senegal.ppt
    • PSI FP TMA 8.4.15.ppt
  o 1.2.2 and 1.2.4 and 1.2.6 Telemedicine
    • 2015.10.10_Travel Report_AKS.pdf
    • WHP Country Selection Analysis.pdf
    • WHP Lit Review Oct 2015.pdf
    • WHP status update Dec 2015.docx
    • WHP Telemedicine Metrics.xlsx
  o 1.2.8 PPIUD inserter
    • Dedicated PPIUD vs Conventional-ppt.pptx
    • DRAFT_How to us Mama-U with Long Inserter Story Board (003).ppt
  o 1.2.12 South Asia market assessment
    • Phase 3 Debrief Presentation – final.pptx
    • Phase 3 Executive Debrief Presentation.pptx
  o 2.1.1 Health Financing R4D Framework
    • Guide to R4D’s Health Financing Options Analysis for Sustainability – October 2015.pdf
  o 2.1.3 Profitability
    • Profitability.pdf
    • Reflections by PSI Tanzania in the application of the PSI profitability tool.pdf
    • User Manual for facility – Profitability model-3.docx
    • User Manual for facility – Profitability model-3_FRENCH (1).docx
    • User Manual for PSI – Profitability model.docx
    • User Manual for PSI – Profitability model_FRENCH (1).docx
  o 2.1.4 Costing tool work
    • Cost-Accounting Intro – TZ.pptx
    • Cost-Accounting Working Group Update 2016-02-29.pptx
  o 2.1.5 Materials on SF sustainability
    • 150727 Recommendations for New Tunza MainDeck.pdf
    • 150921 New Tunza Network – Brown bag.pdf
  o 2.2.1 Quality Accreditation
    • Accreditation Landscape Summary Aug 2017.pdf
• PSI Accreditation Landscape Analysis – 2017 External.pdf

○ 2.2.4 QA workshop report
  ▪ FINAL QARL Meeting Agenda July 2016.docx
  ▪ QARL Meeting Notes_July 2016.docx

○ 2.2.5 YFHS Zimbabwe Workshop report
  ▪ Trip report – Eva Fidel, YFHS TOT Trip Report_Zimbabwe Sept 2015.docx
  ▪ Trip Report – Eva Fidel, YFHS TOT, Zimbabwe, Sept 2015.docx

○ 2.2.9 Needscope
  ▪ Project Miaro Qual Report – Final French.pptx

• Year 2

○ 1.1.1 Pilot expanded QA system
  ▪ Alexandra to UPDATE IQA guidebook August.docx

○ 1.1.5 Accenture Report
  ▪ Accenture Internal Report.pptx

○ 1.1.7 Equity Analysis in Social Franchising
  ▪ Longfield Equity in Health and Health Care wo notes 7-13-15.pptx
  ▪ Simplified Asset Indices to Measure Wealth and Equity in Health Programs.pdf

○ 1.1.11 Telemedicine criteria and telemedicine value-add summary report
  ▪ 1.1. WHP Country Selection Analysis.pdf
  ▪ 1.4 WHP Telemedicine Metrics.xlsx
  ▪ WHP Lit Review Oct 2105.pdf

○ 1.2.3 PPIUD Provider Materials
  ▪ DRAFT_How to use Mama-U with Long Inserter Story Board (003).pptx
  ▪ LISTE DE VERIFICATION_INSERTEUR DIUPP_Corrige 26 08 15.doc

○ 1.2.10 The Mozambique-Movercado Survey and Dataset Analysis Results
  ▪ ICFP Presentation_Mover.pptx

○ 2.1.1 R4D Financing Framework
  ▪ PACE Uganda
  ▪ Guide to R4D’s Health Financing Options

○ 2.3.1 Senegal TMA analysis
  ▪ FP Market Landscape Analysis in Senegal.pptx

○ PM 1.1.14 Retail Panel
  ▪ TMA for Family Planning_youth Focus_11 11 2016.pptx
  ▪ TMA for FP in Mozambique 2016.pdf

○ SIFPO Yr 2 supporting docs and Annual Report response Comments.docx

• Year 3

○ 1.1.1 YFHS Asia
  ▪ Workbook for Asia AYSRH champion training.docx
  ▪ YFHS training curriculum for providers_Feb 2017 for Asia.docx

○ 1.1.3 Voluntarism and Informed Choice in FP
• Adverse Event Training Materials
  – OneDrive_1_2-26-2018 (2).zip
• Service Delivery Standards_Protocols – Provider Training
  – PPIUD_2016_Part 2 FRE.pptx
  – PPIUD Part 1.ppt
  – PPIUD Part 1_french.ppt
  – PPIUD Part 2.ppt
  – PPIUD Part 3.ppt
• Final Agenda EA SA Medical Meeting Dar March 15.docx
• Link to Service Deliver Quality Webpage.docx
• PSI QA Manual.pdf
• Service Delivery Master Tracker_Sept 15 2016.xlsx
  ◦ 1.1.5 Client-based record systems for FP follow up
    – CBRMGuidance v1.0 English.pdf
    – Links.docx
  ◦ 1.1.7 Scale up of NHQIS to SIFPO2 countries
    – HNQIS review (short) Jan 2017KM.pdf
    – HNQIS status Nov 17th_PAC removed.pptx
  ◦ 1.1.8 results of research, lessons, best practices
    – Mali PPIUD Program-Brief_Final.pdf
    – MII Abstract_29Sept2017.docx
  ◦ 1.2.1 Uganda quality study
    – DATA
      – Sifpo_3month_clean_m4m.csv
      – Sifpo_6month_clean_m4m.csv
      – Sifpo_9month_clean.csv
      – Sifpo_baseline_clean.m4m.csv
    – MII Abstract_29Sept2017.docx
  ◦ 1.2.2 Expand LNGIUS
    – LNG IUS Study Protocol.pdf
    – Nigeria_LNG-IUS.pdf
  ◦ 1.2.3 Moz youth friendly pharmacies
    – FYI Mali and Moz Briefs no IRB needed.pdf
    – Mozambique Research Highlights unformatted Feb 2018.docx
  ◦ 1.2.4 document the effects of YFHS in clinic setting
    – FYI Mali and Moz Briefs no IRB needed.pdf
    – SIFPO2 Mali YFHS research brief revised version Feb 2018.docx
  ◦ 1.2.5 CME video
    – ACOG_Abstract_FINAL.docx
    – AIUM Abstract_EChin_Deep Implant Localization and Removal.docx
    – DIR_Dissemination Plan_Final.docx
    – Link to CME video.docx
1.2.6 Support roll out of PPIUD inserter MALI
- Haiti Scale Up 1.6.17.pptx
- Link to PPIUD post on PSI page.docx
- PPIUD RCT RCOG ORAL.pptx
- Program-Brief_Final.pdf

2.1.1 Health financing strategies
- PSI Tanzania
- SFH Nigeria
  - Deliverable 1_Executed Brief_Health Financing Engagement Strategy_SFH Nigeria_R4D-PSI-SFH (SIFPO2) (002).docx
  - Deliverable 2_Summary of Health Financing Engagement Strategy for SFH Nigeria_R4D-PSI-SFH (SIFPO2).docx
  - Deliverable 3_HFES Priority Option Pagers_R4D-PSI-SFH (SIFPO2).docx
  - Deliverable 4_HFES PPT_R4D-PSI-SFH (SIFPO2).pptx

2.1.2 Increasing the financial sustainability of PSI-network social franchises in East Africa
- Tunza Social Enterprise Business Model_Revenue Streams Oct 12 2016.pptx
- Tunza Social Enterprise Concept August 2016.pptx
- Tunza Social Enterprise Update Sept 20 2016.pptx

2.2.1 Enhance the sustainability of PSIs QA audit system
- EQA Narrative Report Template final 11.8.17.docx
- EQA Preparation Checklist for PSI Country_Mar 2016.docx
- Internal Audit Orientation_for QA staff.pptx
- The QA System Scorecard + Criteria ENG(1).xlsx
- The QA System Scorecard + Criteria ENG.xlsx

2.2.2 QARL program
- Action Plans
  - Benin
    - QA System Scorecard + Criteria IQA BENIN+ QARL Comments(1).xlsx
    - QA System Scorecard + Criteria IQA BENIN + QARL Comments.xlsx
  (LAC)
  - El Salvador
    - IQA audit Report_El Salvador 2016 Rev. lilian-Marcia.doc
    - Plan de Qa 2017.xls
    - QA Matrix Scorecard Combined El Salvador(1).xlsx
    - QA Matrix Scorecard Combined El Salvador.xlsx
  - Honduras
- Honduras Model Clinic Cash Incentive for Referral (1).docx
  - Malawi
    - EQA Audit Malawi 2017 – final narrative report.doc
    - Malawi 2017 EQA Scorecard final_9_7_17(1).xlsx
    - Malawi 2017 EQA Scorecard final_9_7_17.xlsx
    - Tunza Family Health Network Quality Assurance Plan.pdf
  - Mozambique
    - EQA Narrative Report_Mozambique_12.15_final.pdf
    - Mozambique incentive schemes_summary Approved April 6 2017.doc
    - MozambiqueEQA Scorecard 19 to 30 Nov 2017 final-pb(1).xlsx
    - MozambiqueEQA Scorecard 19 to 30 Nov 2017 final-pb.xlsx
  - Myanmar
    - Myanmar_PSI QA System Scorecard 2017 Nov 10_with comments(1).xlsx
    - Myanmar_PSI QA System Scorecard 2017 Nov 10_with comments.xlsx
  - Nigeria
    - HEALTH FACILITIES SFH Reproductive Health Reward_Recognition Scheme Approved copy.xls
    - IPCA SFH Reproductive Health Reward_Recognition Scheme Approved copy.xls
    - Providers SFH Reproductive Health Reward_Recognition.xls
  - Tanzania
    - IQA Report Matrix Tanzania.xls
  - Uganda
    - IQA Audit – Scorecard PSI Uganda 2017.xls
  - Zimbabwe
    - PSI Zimbabwe IQA 2016 Narrative report.docx
    - Zimbabwe IQA 2016 score card.xls
      - AE and Complication meeting with QA Regional Lads_10.1717.docx
      - AE and Complication meeting with QA Regional Leads_12.7.17.docx
      - 2.2.3 Practitioners Forum on social franchising
        - Ghana – External 2 day Global Social Franchising Workshop – two page summary.pdf
      - 2.2.4 Disseminate Social Franchising data
        - PSI_Social-Franchising-Innovations.pdf
      - 2.2.5 DMPA-SC
        - E2P brief.docx
        - Increasing Access to Next Generation Injectables Meeting Report Final.pdf
      - 2.3.1 Enhance TMA in PRH priority countries
        - SBC + MDA Infographic_v2_10-24.pdf
        - SBC_TMA_pic.jpg
        - TMA Workshop Summary Sept 23rd 2016 Final.pdf
      - 2.3.2 LARC-PM CoP
        - Counseling TC Mtg Report 050417 (1).pdf
        - Link to Community of Practice website.docx
- September 7, 2017 Consultation presentation slide deck.pdf
  - NEED DOCS 1.1.4 SafeCare standards in Uganda QA approach
    - SafeCare Study Tour (MO).docx
  - NEED DOCS 1.1.4 QA framework across FP programs
    - FP RH QA System for all PSI July 2016 for QARLs.pptx
    - PSI integrated facility checklist Final.xlsx
    - PSI QA Regional Leads Staff llst.docx
  - NEED DOCS 1.2.7 Using Data to Strengthen FP Program Decision Making
    - Link to blog about interpretation feature.docx
  - NEED DOCS 2.1.3 SF Business Skills
    - Business Skills Workshop Agenda.docx
    - Ghana – External 2 day Global Social Franchising Workshop – two page summary.pdf
    - PSI Social Franchising Workshop Agenda.docx
    - SF workshop agenda 9.8.17.docx

**MSI FOLDER**

- LTFP Final Report_30.10.17 v2
- MSI Guidelines for Client Counselling and Informed Consent V1.0
- MSIU Factsheet
- MSIU-MSU adolescent-youth strategy
- MSI Work Plan
  - SIFPO2-MSI Year 2 Work Plan v4 (updated Feb 16)
  - SIFPO2-MSI Core Year 3 Work Plan Revised October 2017
  - SIFPO 2-MSI Year 1 Work Plan updated February 2nd 2015
- MSI Annual Reports
  - SIFPO2-MSI Year 3 Semi-Annual Report
  - SIFPO2-MSI Year 3 Annual Report November 2017
  - SIFPO2-MSI Year 2 Semi-Annual Report Final 12May16
  - SIFPO2-MSI Year 2 Annual Report Final updated CYPs and impact
  - SIFPO2-MSI semi-annual PMR (May 15)
  - SIFPO2-MSI Annual PMR (Nov 15)
- Management Reviews
  - SIFPO2-MSI Management review memo_15_final
  - SIFPO2-MSI Memorandum 2016-2017
- Internal
  - Washington Voucher Presentation – Managing Voucher System
  - SIFPOII Financial Services Literature Review
  - MSI Voucher SOPM
  - MSI Policy on Infection Prevention v2.0
  - MSI Policy on CS V1.0
  - MSI Policy on Client Counselling and Informed Consent v1.0
o Guidelines for Training MSI Clinical Personnel v1.0
o Gender 1001 Training_MSI V1 10Jun17 Final
o Evaluation of 9Cs program – Final Report 31May2018
o Ethiopia Trip Report on Finance and Small Enterprises
o MSI Self-Assessment
  ▪ SIFPO 2 Evaluation Self-assessment_MSI Final
  ▪ SIFPO 2 Evaluation Self-assessment_MSI Final
o Evaluation Presentation
  ▪ USAID presentation ORION-CLIC_Final
  ▪ USAID evaluation adolescents-June 2018_FINAL
  ▪ SIFPO2_MSI Global Fleet 22Jun18 FINAL
  ▪ SIFPO2 Eval_Gender and Compliance
  ▪ SIFPO Impact and Cost Calculator Final
  ▪ SIFPO 2-MSI Evaluation overview presentation_FINAL
  ▪ OR_PSS SuMO Presentation for SIFPO2 Eval FINAL
  ▪ MSI Clinical Quality & Governance – An Overview
  ▪ Global Marketing SIFPO evaluation
  ▪ ERC Overview for USAID Evaluators_ORN

• External
  o Tools and Resources
    ▪ TMA Working Group Meeting Notes 30 Oct 2017
    ▪ TMA Working Group Meeting Notes 19 April 2017
    ▪ The Role of Vouchers for Family Planning
    ▪ LARCs and Youth Consensus Statement
    ▪ Cambodia Garment Factory Report
    ▪ Technical briefs
    ▪ Sahel Research Brief
    ▪ Papua New Guinea Vasectomy Report
    ▪ Nigeria PPMV pilot findings brief
    ▪ Kenya NHIF Brief
    ▪ FP integration presentation
    ▪ CHEW Nigeria task-sharing brief
    ▪ Brief on male engagement and voluntary vasectomy pilot in Malawi
  o Papers and Research
    ▪ Youth Voucher Program in Madagascar Increases Access to Voluntary Family Planning and STI Services for Young People
    ▪ Social Franchising Approach (MSI,PSI)
    ▪ MSI Social Franchising Results
    ▪ Increasing Contraceptive Access for Hard-to-Reach Populations with Vouchers and Social Franchising in Uganda
- Increasing Access to Family Planning Choices through Public-Sector Social Franchising, The Experience of MSI in Mali

  - External Presentations
    - Training for USAID on Impact2 2017
    - MSI learning on adolescents – March 2018
    - MSI at the ICFP 2016 flyer 2
    - LNG-IUS Nigeria presentation for ICA Foundation – May 2018
    - Implant Removal Task-Force 2
    - Implant Removal Task-Force 1
    - IBP concurrent session flyer scaling up effective approaches to reach the underserved

**IPPF FOLDER**

All files (except one) are pdf version. No subfolders.

- 1. SIFPO Integrated Service Delivery
- 1. What is Rights Based Approach
- 2. Integrating HIV and FP for Youth
- 2. RBA project overview Uganda
- 3. Impact evaluation of RBA in Uganda
- 3. Zika and SRH integration
- Africa Regional Office – HMIS Strategy
- CMIS in Liberia
- Engaging Men and Boys – Zika Honduras
- Ethiopia Social Franchising Cost Effectiveness Analysis
- Introducing DMPA-SC in Uganda
- EPPF’s vision on Social Franchising
- Measuring client satisfaction with the Net Promoter Score
- Nepal Method Mix
- Quality of Care in non-clinic setting – South Asia Region
- RDQA Uganda
- Reproductive Coercion – ARCHES in Kenya
- SBCC and DMPA-SC
- SBCC and Rights Literacy Uganda
- SBCC and Youth Togo
- SBCC and Zika
- SBCC in Nepal
- SBCC Liberia
- SIFPO Technical Dissemination Final.docx
- Social Franchising Session Introduction
- South Asia Region – DHIS2 roll out
- Strengthening quality in the Africa Region
- VASECTOMY in Togo
# ANNEX IX. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

<table>
<thead>
<tr>
<th>USAID Non-Disclosure and Conflicts Agreement - Global Health Program Cycle Improvement Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form,</td>
</tr>
<tr>
<td>&quot;sensitive but unclassified information,&quot; procurement sensitive and source selection information, and</td>
</tr>
<tr>
<td>information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information</td>
</tr>
<tr>
<td>which, if released, could result in harm or unfair treatment to an individual or group, or could have a</td>
</tr>
<tr>
<td>negative impact upon foreign policy or relations, or USAID’s mission.</td>
</tr>
</tbody>
</table>

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 |

Page 113 of 131
I believe the facts in this witness statement are true.

Signed: [Signature]

Dated: 9th April 2015
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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 April 27th, 2018

Name Gabrielle Appleford
Title FP/RH Specialist
ANNEX X. SUMMARY BIOS OF EVALUATION TEAM

Sarah Castle, Team Leader, carried out the SIFPOI midterm evaluations for MSI and PSI. She has a background in demography, epidemiology, and program evaluation, and focused on the evaluation process, developing the project’s tools and carrying out structured analysis. She holds a PhD from the Centre for Populations Studies at the School of Hygiene and Tropical Medicine in London and has held fellowships at the Harvard Center for Population and Development Studies and the Population Studies and Training Center at Brown University.

Gabrielle Appleford, FP/Reproductive Health Expert, is an FP expert with specific subject experience in health financing, community and health systems strengthening, and private sector engagement. She holds a master’s in Public Health from the London School of Hygiene and Tropical Medicine and a master’s in Development Planning from the School of Development Studies from the University of East Anglia (UK).

The evaluators were assisted by Pellavi Sharma and Erika Houghtaling, both program analysts at USAID with experience in similar evaluations. They helped with the research design, note-taking, and collation of findings.

GH Pro assisted with coordinating the administrative aspects of the project, including the managing the timeline. They also coordinated dissemination of the SurveyMonkey questionnaires.
For more information, please visit
http://ghpro.dexisonline.com/reports-publications