MIDTERM EVALUATION
MATERNAL AND CHILD SURVIVAL PROGRAM (MCSP)

August 2017

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Cover Photo: A health worker (right) in Bungoma, Kenya, looks at the baby she helped save by teaching the parents about malaria prevention. Credit: Allan Gichigi/MCSP, Kenya, February 2016.
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DISCLAIMER
The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
ABSTRACT

This qualitative midterm evaluation of the Maternal and Child Survival Program (MCSP), a five-year global program (March 2014 – March 2019), was conducted to provide the U.S. Agency for International Development’s (USAID) Global Health Bureau’s Maternal and Child Health and Nutrition Office (MCHN) with an assessment of the progress of its flagship program, to make recommendations to improve implementation of the current program, and to inform follow-on award design. Methods used were document review, in-depth interviews with key informants using structured guides, and a semi-structured electronic survey distributed to MCSP’s supporting Missions and their in-country programs. USAID and MCSP chose the informants. Interviews were coded, and themes were identified with reference to the evaluation questions. Based on the qualitative analysis of the responses, the evaluation concluded that informants consistently recognized the technical excellence and leadership of MCSP global and national staff in working with client countries and global stakeholders. Informants also reported that MCSP’s support for scale-up of high-impact interventions was complementary to their work in quality improvement. In most instances, MCSP was perceived to be maximizing opportunities for comprehensive reproductive maternal neonatal child health (RMNCH) platforms. At the global level, evaluation respondents have cited the significance of MCSP’s technical guidance to the formulation of global RMNCH policies and guidelines. Recommendations for the program’s remaining 18 months include a call for MCSP to focus its reporting efforts on finding compelling ways to present aggregated quantitative data from across multiple countries in order to further demonstrate MCSP’s progress toward achieving its overall goals and objectives.
ACKNOWLEDGMENTS

The Global Health Program Cycle Improvement Project (GH Pro) evaluation team acknowledges with appreciation the contribution and collaboration of the evaluation’s many respondents. We are grateful for the participation and patience of all the evaluation’s respondents, both through key informant interviews and the electronic survey. The collaboration of representatives of Maternal and Child Survival Program (MCSP); of USAID in Washington, DC; of USAID Missions supporting MCSP country programs; of the country programs themselves; and of MCSP’s many stakeholders in the United States and in the global arena in sharing their perspectives was essential to the team’s interest in obtaining a qualitative understanding of the program’s progress and contribution toward accelerating intensive reductions in maternal, newborn, and child mortality.

We appreciate the extraordinary contribution of MCSP staff in freely providing the team with in-depth information on the program’s progress in responding to the cooperative agreement’s scope of work. We also note, with deep appreciation, the time and the effort of MCSP staff in Rwanda, Ghana, and Madagascar in assisting the team to address the many logistical issues associated with our admittedly all-too-brief visits to their programs and their countries. Without this important assistance, we could not have carried out our assigned tasks.

With thanks and appreciation, we acknowledge the positive collaborative environment established, from the outset of the evaluation, by the USAID/Global Health/Maternal and Child Health and Nutrition Office technical and Agreement Officer’s Representative (AOR) team and the MCSP/Washington technical staff for giving us guidance and direction as we analyzed data associated with this report.

Finally, we recognize with real sincerity that we could not have progressed in our evaluation without the full support we received from Ms. Bezawit Mamo, GH Pro’s multi-talented associate program manager. Without Beza’s assistance in scheduling interviews and in overseeing the electronic survey process from conception to analysis, the evaluation team would not have been able to develop this document.
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<th>ACRONYMS</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADMSA</td>
<td>Advance distribution of misoprostol for self-administration</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>AOR</td>
<td>Agreement Officer’s Representative</td>
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<tr>
<td>APR</td>
<td>A Promise Renewed</td>
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<td>ARV</td>
<td>Antiretrovirals</td>
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<tr>
<td>BASICS</td>
<td>Basic Support for Institutionalizing Child Survival</td>
</tr>
<tr>
<td>bCPAP</td>
<td>Bubble Continuous Positive Airway Pressure</td>
</tr>
<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>BF</td>
<td>Breastfeeding</td>
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<tr>
<td>CDCS</td>
<td>Country Development Cooperation Strategy</td>
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<tr>
<td>CH</td>
<td>Child Health</td>
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<td>CHPS</td>
<td>Community-Based Health Planning Services</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>EMT</td>
<td>Executive Management Team</td>
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<tr>
<td>EMTCT</td>
<td>Ending Mother to Child Transmission</td>
</tr>
<tr>
<td>ENAP</td>
<td>Every Newborn Action Plan</td>
</tr>
<tr>
<td>ENC</td>
<td>Essential Neonatal Care</td>
</tr>
<tr>
<td>EPCMD</td>
<td>Ending Preventable Child and Maternal Deaths</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>EPMM</td>
<td>Ending Preventable Maternal Mortality</td>
</tr>
<tr>
<td>EQ</td>
<td>Evaluation question</td>
</tr>
<tr>
<td>ETAT</td>
<td>Emergency Triage Assessment and Treatment</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>GDA</td>
<td>Global Development Alliance</td>
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<tr>
<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<tr>
<td>GH</td>
<td>Global Health</td>
</tr>
<tr>
<td>GH/MCHN</td>
<td>Global Health Bureau’s Maternal and Child Health and Nutrition Office</td>
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<tr>
<td>GIS</td>
<td>Geographic Information System</td>
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<tr>
<td>GVAP</td>
<td>Global Vaccine Action Plan</td>
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<tr>
<td>HII</td>
<td>High Impact Intervention</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HQ</td>
<td>Headquarters</td>
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<tr>
<td>HSS</td>
<td>Health Systems Strengthening</td>
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<tr>
<td>iCCM</td>
<td>Integrated Community Case Management</td>
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<tr>
<td>ICF</td>
<td>International Development Consulting</td>
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<tr>
<td>ICHC</td>
<td>Institutionalizing Community Health Conference 2017</td>
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<tr>
<td>IFA</td>
<td>Iron and Folic Acid</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention Control</td>
</tr>
<tr>
<td>IPTp</td>
<td>Intermittent Preventive Treatment of Malaria in Pregnancy</td>
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<tr>
<td>ITN</td>
<td>Insecticide Treated Net</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
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<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow Incorporated</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>KMC</td>
<td>Kangaroo Mother Care</td>
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<tr>
<td>LiST</td>
<td>The Lives Saved Tool</td>
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<tr>
<td>LLINs</td>
<td>long-lasting insecticide-treated net</td>
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<tr>
<td>LWA</td>
<td>Leader with Associate Mechanism</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MCH</td>
<td>maternal and child health</td>
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<tr>
<td>MCHIP</td>
<td>Maternal and Child Health Integrated Program</td>
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<tr>
<td>MCHN</td>
<td>Maternal and Child Health and Nutrition Office</td>
</tr>
<tr>
<td>MCSP</td>
<td>Maternal and Child Survival Program</td>
</tr>
<tr>
<td>MIP</td>
<td>Malaria in Pregnancy</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, neonatal, and child health</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal Neonatal Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>OCP</td>
<td>Oral Contraceptive Pill</td>
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EXECUTIVE SUMMARY

Background: The U.S. Agency for International Development’s (USAID) Office of Maternal and Child Health and Nutrition (MCHN) within the Bureau for Global Health (GH) commissioned an external midterm performance evaluation of the Maternal and Child Survival Program (MCSP) to (i) assess whether MCSP is achieving its objectives and planned outputs as stated in the MCSP agreement’s program description and in approved implementation plans, and to (ii) make recommendations to improve implementation of the current program and to inform follow-on programs.

In expanding this focus, the evaluation’s Statement of Work (SOW) posed four questions, one of which is procurement-sensitive and will be addressed in a separate report for internal USAID use. Accordingly, this report addresses these three questions:

1. **Country Results:** To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality reproductive maternal neonatal child health (RMNCH) interventions?

2. **Global Leadership:** To what extent and in what ways has MCSP contributed to key programs, priorities, and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level?

3. **Integration and Cross-cutting Areas:** To what extent and in what ways has MCSP, as an integrated flagship RMNCH project, been successful in maximizing opportunities for comprehensive RMNCH platforms at the country and global levels?

From March – April 2017, the evaluation team collected data from 166 structured key informant interviews; from site visits to three pre-selected countries with MCSP field operations (Rwanda, Madagascar, Ghana); from a structured electronic survey submitted to 19 of 26 USAID Missions with buy-ins to MCSP and to 20 MCSP country programs funded through buy-ins provided by these Missions; from in-depth briefings provided by MCSP headquarters and MCSP country staff; and from a review of relevant documentation. Key informants represented a broad range of stakeholders: in Washington, 23 USAID/Global Health staff, four USAID/Regional Bureau staff, five MCSP/Washington senior staff, five staff from US-based health programs, and four staff from the World Health Organization, and two staff from the Harvard School of Public Health were interviewed. In addition, in the three countries visited, the evaluation team interviewed 30 senior MCSP program staff, eight USAID Mission representatives, 17 service providers, eight representatives from civil society organizations (CSOs), 17 Ministry of Health stakeholders, and four representatives of international agencies. For the electronic survey, the evaluation received responses from 15 (79 percent) of the 19 Missions contacted and from 15 (74 percent) of the 20 MCSP Mission-funded country programs contacted.

Qualitative data from the structured key informant interviews, with identifying information removed, were merged into five Microsoft Word master files, organized thematically by question and respondent affiliation, and subsequently grouped based on recurring responses to each question. For the electronic survey, open-ended responses were similarly grouped by question and thematically analyzed. Analysis of the electronic survey’s close-ended questions that employed Likert-type scales were used to provide an opportunity for quantitative analysis of qualitative responses. MCSP-related documents were reviewed...
with a focus on validating the evaluation team’s qualitative findings. Following the analysis, the evaluation team developed a set of findings, conclusions, and recommendations.

What is MCSP? MCSP is USAID’s flagship maternal, neonatal, and child health award designed to accelerate reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. MCSP is a centrally managed, five-year award (2014 – 2019) that strives to deliver a full range of high-impact, evidence-based RMNCH interventions. MCSP has received 78 percent of the total budget ceiling, as of April 2017. Seventy-seven percent of the total funds received are through field support from Missions. Of the total core funding received, 62 percent represent funds essentially directed to the field for implementation (e.g., for Ebola and Zika activities). Accordingly, of the funds obligated as of April 2017, 91 percent of the overall obligation, was directed to field activities.

EVALUATION QUESTIONS 1-3: SUMMARY OF FINDINGS

MCSP Achievements: Key informants consistently recognized the technical excellence and leadership of MCSP global and country staff in working with the host-country governments and other key stakeholders, and reported that MCSP’s support for scale-up of high-impact interventions (HIIs) complemented their work in quality improvement. MCSP records indicate that the program’s emphasis on responding to RMNCH priorities has reportedly resulted in an increase in the number of clients served. Similarly, 66 percent of Missions and 100 percent of MCSP country office representatives agree that MCSP has been effective in linking learning between country and global levels to enhance and inform both levels’ engagement in responding to RMNCH priorities. In most instances, informants perceive that MCSP technical staff have effectively focused their technical assistance toward promoting high-impact RMNCH interventions, and 73 percent of e-survey respondents support the statement that “MCSP has advanced health systems strengthening towards improved RMNCH outcomes at country level.” MCSP’s learning agenda has the potential for providing groundbreaking evidence to improve RMNCH outcomes in the longer term. Finally, at the global level, evaluation respondents have cited the significance of MCSP’s technical guidance to the formulation of global RMNCH policies and guidelines.

Challenges: The diversity of MCSP’s portfolio in terms of geographic and technical scope, funding, and country program duration has made it difficult to compare activities and results across countries. In addition, MCSP’s monitoring and evaluation system has not collected a standard set of indicators systematically across the portfolio in a manner that would allow the program to fully demonstrate the extent to which MCSP, as a global RMNCH program, is achieving its objectives and planned outputs. That said, it is possible to see changes in key indicators within countries, and it is important to note that the scope of this evaluation included neither a systematic review of quantitative program data nor a detailed review of MCSP’s global and country-level indicators. Finally, discussions with informants both within the program and those with direct experience working with the program at its global level would indicate that separate teams at the global level for cross-cutting areas appear to make them function as distinct technical areas instead of a truly integrated whole across and within programs.

KEY CONCLUSIONS AND RECOMMENDATIONS

Below, we summarize the evaluation’s full set of conclusions and recommendations. A full discussion of findings associated with these conclusions and recommendations can be found in the body of the report.
Evaluation Question 1 (EQ1): Country Results

EQ1-Conclusion 1
Based on its analysis of discussions with informants, responses provided through the e-survey, and available program documentation, the evaluation team has concluded that MCSP’s assistance to country programs has been responsive to the needs and expectations of Mission buy-ins.

EQ1-Recommendation 1: During the remaining 18 months of the cooperative agreement, MCSP should maintain the reported quality of its technical assistance in an effort to ensure that, to the extent possible, continued gains in reducing maternal and child mortality are accelerated.

EQ1-Conclusion 2
Despite MCSP’s acknowledged technical excellence and the reported and directly observed strength of its country-specific interventions, its limited focus on collecting a standard set of indicators and lack of coverage indicators to measure progress at a program level has limited its ability to measure progress achieved in responding to program objectives. Furthermore, in its annual reports and in documentation provided to the evaluation team, MCSP did not use data conclusively in summarizing its global progress on scaling up HIls.

EQ1-Recommendation 2.1: Insufficient time remains for MCSP to address this issue during the remaining months of its award. However, for the benefit of a potential follow-on—one that would assumedly continue to focus on maternal and child survival—MCSP and USAID/Washington should immediately begin working together on an analytical process to select indicators among its data sets that will serve as a guide for a follow-on as it establishes a program-wide approach to measuring progress achieved in responding to program objectives. This analytical process would include engaging Missions that have provided buy-ins to MCSP to arrive at a set of common indicators that could be applied to all buy-ins focused on introducing HIIs as a means of accelerating efforts to improve mother and child survival.

EQ1-Recommendation 2.2: As it is working on the analytical process described above, MCSP should re-examine the existing set of case studies included in its legacy briefs to determine the extent to which they adequately illustrate global progress on scaling up HIIs for each of the program’s technical areas. If the analysis indicates that specific HIIs are under-represented or not represented in the case studies, it is further recommended that such case studies be developed. Once completed, the set of HII-focused case studies should form the basis for an end-of-program symposium for key national and global stakeholders.

EQ1-Conclusion 3
The evaluation team and MCSP’s ability to determine if the global program is “on track to achieve its objectives” is significantly constrained because MCSP’s 26 countries have different startup and completion dates and SOWs. In the evaluation team’s experience, MCSP should be in a consolidation and documentation phase at this point in the award cycle. The time and effort devoted to starting up new country programs is detracting from other activities that would be taking place in a typical award related to learning, refining, consolidating, and documentation of experience.

EQ1-Recommendation 3: MCSP should not expand to take on any new work in the remaining 18 months of implementation. This recommendation would apply to new countries that request to buy in, as well as significant expansions within existing country programs. Currently, program startup efforts should be redirected to systematic program learning; intervention refinement based on learning, lessons
learned, and other forms of reflective, end-of-program documentation; high-quality and effective dissemination of the large volume of learning activities in the portfolio; and, eventually, a high-quality closeout.

**EQ1-Conclusion 4**
Due to time and resource constraints for this evaluation, it was not possible to arrive at an in-depth and conclusive understanding of the extent to which MCSP’s management structure has contributed to effective program management. However, based on the evaluation team’s experience with similarly structured global programs, it would appear that MCSP/Washington’s “silod” organizational structure may have constrained the program’s ability to think creatively in defining a common strategy for addressing ways in which to holistically work toward accelerating the reduction in maternal, neonatal, and child mortality.

**EQ1-Recommendation 4:** MCSP should engage an outside facilitator to promote an internal staff program appraisal process designed to determine the extent to which the program’s structure both enhanced and constrained the program’s ability to work holistically toward accelerating the reduction in maternal, neonatal, and child mortality. The results of this appraisal would be of significant importance to USAID as it deliberates on the value added to a similar structure for a potential follow-on.

**EQ1-Conclusion 5**
Weaknesses in host-country information collection systems continue to constrain governments’ abilities to identify evidence-based priorities.

**EQ1-Recommendation 5:** In the time remaining, MCSP should continue and even more heavily emphasize program efforts to improve country-level health information systems/health information management systems and other forms of country data collection, including the harmonization of indicators in country systems. Given the time remaining in the program cycle, MCSP’s efforts to improve governments’ data collection systems may achieve only minimal immediate benefits; however, efforts to strengthen host countries’ data collection environment for the benefit of future programs are entirely within MCSP’s mandate as USAID’s flagship maternal, neonatal, and child health program.

**Evaluation Question 2 (EQ2): Global Leadership**

**EQ2-Conclusion 1**
MCSP’s contributions to the development and revision of national policies are broadly defined, and its role in the policy development and revision process are not well captured in the global performance monitoring plan (PMP).

**EQ2-Recommendation 1:** To facilitate greater understanding of MCSP’s contribution to the development and revision of national policies, the program should consider adding an indicator to measure the number of MCSP-supported policies that have been adopted or utilized in the global PMP for Program Years (PYs) 4 and 5. It should also look for opportunities to clearly and succinctly communicate its role in the development and revision of national policies.

**EQ2-Conclusion 2**
Global partners value and rely on MCSP’s ability to bridge the gap between global policy and best practice development and country-level advocacy, adaptation, and implementation; however, stakeholders expressed concern with the program’s bandwidth to manage all the demands on Washington-based staff, who are in high demand.
EQ2-Recommendation 2: To enhance and harmonize its use of high-demand but limited Washington-based technical advisers, MCSP should increase and institutionalize regional or country-to-country models of support to meet technical assistance needs, where and when appropriate. The program should take care to acknowledge and assuage concerns of USAID Missions when drawing upon in-country staff in this way.

EQ2-Conclusion 3
There have been no reported missed opportunities or gaps within the program’s sphere of control or influence that have constrained its performance in global leadership.

EQ2-Recommendation 3: Given that there were no gaps or missed opportunities identified within the scope of MCSP’s global leadership, the program should maintain its current emphasis in this area and continue to look for opportunities to document and share its lessons learned and accomplishments.

Evaluation Question 3 (EQ3): Integration and Cross-cutting Areas

EQ3-Conclusion 1
The MCSP award does not mandate integration in all activities; however, de facto USAID stakeholders expect MCSP to integrate at every reasonable opportunity, and most operation-level key informants (KIs) did not question the need to work toward integration. The conversation over comprehensiveness versus integration is largely between USAID and MCSP management teams, and is related to what the program should be held accountable for. It does not appear to be affecting the quality of programming, integrated or otherwise.

EQ3-Recommendation 1: MCSP should reconsider and carefully word any public statements to indicate that it is not “integrated” and does not have a mandate to be “integrated.” The discussion around this issue does not add value to USAID’s or MCSP’s communication about the good work the program is doing to support the essential service package in RMNCH to the greatest extent possible.

EQ3-Conclusion 2
With the exception of its limited focus on promoting water, sanitation, and hygiene (WASH) interventions, MCSP is maximizing opportunities for comprehensive RMNCH platforms that incorporate HIIIs related to its technical mandate.

EQ3-Recommendation 2: MCSP should maintain the focus on preventing “missed opportunities” to provide mothers and children with care by supporting the most comprehensive service provision allowable within funding constraints.

EQ3-Conclusion 3
Gender and equity are partially integrated in MCSP’s programming, but missed opportunities exist.

EQ3-Recommendation 3: To ensure that the principles and equity are fully integrated into its technical interventions, MCSP should seek to apply a gender and equity lens to all work planning moving forward. With regard to gender as well as to gender drivers of inequity, the USAID Agreement Officer’s Representative (AOR) Team and MCSP should use the guidance in USAID’s Gender Equality and Female Empowerment Policy to facilitate this process. Per this guidance, USAID Missions and implementing partners should support efforts to thoughtfully respond to gender and gender equity within country programs. With regard to other drivers of health inequity, USAID subsector strategies1 provide

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1 See, for example, the Maternal Health Vision for Action, p. 11, and USAID’s Multi-Sectoral Nutrition Strategy, p. 16.
guidance on the equity principles Missions and implementing partners should be considering when programming funding. Similarly, these principles can be used to facilitate greater integration of equity principles into program designs. Gender and equity should not be viewed as distinct technical interventions that require their own set-aside funds; rather, to best align with USAID policy and guidance, they should be included as a lens that is applied to all MCSP programming.

**EQ3-Conclusion 4**
A narrow definition of “innovation” constrains the program’s ability to fully convey its scope and success in this area.

**EQ3-Recommendation 4:** MCSP should continue to support USAID’s innovation agenda at the global level with USAID core funds. For MCSP’s country-level programming, innovation should continue to be defined by the country context, and remain focused on scaling up interventions (new or old) that will result in the greatest reduction of preventable maternal and child death per dollar invested. MCSP should broaden its innovation messaging to include the “context-appropriate innovation” that is being done at the country level, which is considered a hallmark of the program and fundamental to its success at the country level.

**EQ3-Conclusion 5**
The evaluation team recognizes that it is difficult to propose a reasonable and manageable number of high-quality indicators for a program of this size and scope, and that MCSP has made a strong effort to set up good monitoring and evaluation systems. However, the health systems strengthening indicators do not provide the program with a sufficient understanding of how the health systems in which it is working are functioning or improving over time with MCSP’s assistance.

**EQ3-Recommendation 5:** The evaluation team recommends adding indicators to the global PMP to capture MCSP’s “system drivers” work, which is led by Results for Development.

**EQ3-Conclusion 6**
The evaluation team’s ability to use program-derived quantitative data in this evaluation was limited due to concerns about data consistency and precision. These concerns were underscored by the variability in reporting by program source. This issue was widespread and not limited to only HSS data.

**EQ3-Recommendation 6:** MCSP should continue to refine monitoring and evaluation reporting systems to make publicly reported data more consistent. User-friendly “dashboards” and other attempts to increase transparency of program data should be reviewed to ensure that the take-away message understood by stakeholders is consistent and accurate.

**EQ3-Conclusion 7**
The role of HSS in MCSP remains unclear, largely due to an unclear mandate from USAID. Based on available information, MCSP’s HSS activities to date appear to have made important contributions to the program goal despite the nebulous mandate. MCSP is positioned to contribute more in this area if provided the opportunity.

**EQ3-Recommendation 7:** To enhance MCSP’s understanding of its responsibility for integrating HSS into its technical initiatives, the USAID AOR team should continue to try to clarify the program’s role in meeting broader Agency goals in HSS through dialogue with USAID’s Office of Health Systems and Missions. USAID should provide MCSP with a clear understanding of how its HSS capacity will be used in its remaining 18 months, and the approximate funding level for which it should plan. Despite MCSP’s
current position to contribute to HSS needs in ending preventable child and maternal deaths (EPCMD) in priority countries, if USAID does not intend to use the program for this purpose, then the program should consider how to resource the program to be commensurate with the anticipated level of effort. Given the evaluation team’s understanding of the current budget environment, it is possible that this could mean a downward revision of the HSS activities or the staff devoted to this work.

**EQ3-Conclusion 8**
There is evidence of a lack of clarity and understanding among USAID personnel in other technical areas about the importance and role of community health in the EPCMD agenda. This may result in insufficient emphasis on community health in USAID requests for buy-in (e.g., in program descriptions).

**EQ3-Recommendation 8:** USAID should look for ways to increase understanding of community health in EPCMD programming among those primarily responsible for developing project descriptions and negotiating work plans with MCSP at the Washington and Mission levels. Possible avenues include webinars, state-of-the-art meetings, and Continuing Learning Points for AOR certification.

**EQ3-Conclusion 9**
In a complex USAID portfolio in-country, community health may be the mandate of another award. In these cases, MCSP does not necessarily need to take on the community health work, but the work must be well-coordinated to maximize effectiveness and impact.

**EQ3-Recommendation 9:** During scoping visits and work plan development, MCSP should review the community health landscape and identify needs and gaps in programming that must be addressed for its technical approach to be successful. Where the community health work is led by another award, careful consideration should be given to how the coordination function between the two programs will be handled. The USAID AOR should support MCSP to advocate to Missions when needed to ensure that the necessary coordination mechanisms are in place.

**EQ3-Conclusion 10**
Much of MCSP’s formal “learning agenda” will benefit future programming, not programming within MCSP’s life span.

**EQ3-Recommendation 10:** To enhance the learning agenda’s potential benefit to RMNCH priorities within the life of the program, MCSP should begin planning now for how it will document and robustly disseminate findings and manage the knowledge from the significant number of studies that will conclude near close-out. Dissemination should not be truncated due to time constraints. This should be managed as a priority of the final year work plan, with measures of accountability in place and an agreed-upon a priori definition of what would constitute a successful dissemination process.

**EQ3-Conclusion 11**
Significant, high-quality, real-time learning is taking place within the program and between MCSP and other development partners in country, but documentation on this is limited.

**EQ3-Recommendation 11:** MCSP should develop a clear plan to document its lessons learned and best practices for real-time learning in programs of a similar size, and include this in its dissemination plan (mentioned above). This is an important component of the program’s knowledge management, and future programs should be able to learn from and build on this experience.
I. INTRODUCTION

1.1 PURPOSE OF THE EVALUATION

The U.S. Agency for International Development’s (USAID) Global Health Bureau’s Maternal and Child Health and Nutrition Office (GH/MCHN) commissioned an independent midterm performance evaluation of the Maternal and Child Survival Program (MCSP) to (i) assess whether MCSP is achieving its objectives and planned outputs as stated in the MCSP agreement’s program description and in approved implementation plans; and to (ii) make recommendations to improve implementation of the current program.

The results of this evaluation will be used to inform implementation plans for Years 4 and 5 of MCSP in support of ending preventable child and maternal deaths (EPCMD).

1.2 BACKGROUND: THE MCSP GOAL, STRATEGY, AND ACTIVITIES

Reduction of maternal and neonatal mortality (defined as the first 28 days of life) continues to be one of the world’s priority health concerns. It is currently estimated that 210 million women become pregnant every year, and 140 million babies are born. While the worldwide annual number of maternal deaths per 100,000 live births fell by 44 percent between 1990 and 2015, from approximately 385 to 216, the disparity “… between countries with the lowest level of maternal deaths and the highest doubled between 1990 and 2013, [and reached] a 200-fold difference.” In addition, “… between 1990 and 2015, 240 million children worldwide died before their fifth birthday.”

In recognizing that EPCMD is one of the overarching goals of USAID’s Global Health Bureau, USAID’s expressed goal for MCSP is to accelerate reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. MCSP is a centrally managed award that strives to deliver a full range of high-impact, evidence-based reproductive, maternal, neonatal, and child health (RMNCH) interventions. MCSP has received, as of April 2017, 77 percent through field support from Missions of its total funding to date.

As stated in the program description of the MCSP award (2014 – 2019), MCSP’s vision is of “self-reliant countries equipped with analytical tools, effective systems and technical and management capacity to eliminate preventable maternal, newborn, and child death.” In USAID maternal and child health (MCH) priority countries, MCSP works to increase efforts to achieve equitable health coverage, scale up high-impact interventions (HIIs) to address the greatest causes of maternal and child mortality, leverage

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2 Oona M R Campbell, Wendy Graham, Fernando Althabe, Marge Koblinsky, Margaret E Kruk, Suellen Miller, and Dorothy Shaw, The Lancet Maternal Health Series study group September 2016.

3 Ibid.


5 June 20, 2017, communication from USAID/Global Health/Maternal, Neonatal, and Child Health: Of the total core funding received, approximately 62% was directed to the field in support of emerging health needs, most notably Ebola and Zika.

efforts in other sectors to foster an enabling environment for improved RMNCH outcomes, and ensure mutual accountability for EPCMD.

As USAID’s flagship maternal, neonatal, and child health (MNCH) program, MCSP’s comprehensive design offers an opportunity for Missions to tap into a diverse range of technical expertise to address specific technical gaps or to offer an integrated program covering RMNCH, including malaria, HIV/AIDS, nutrition, and water, sanitation and hygiene (WASH) interventions related to RMNCH, to achieve greater efficiency and reduced management burden. MCSP’s leadership at the global level is also expected to raise global awareness, support global policy and strategy formulation through participation on global steering committees and working groups informed by past and current field experiences, and collaborate with existing alliances and partnerships to advance RMNCH programming, innovations, and learning.

Interventions supported under MCSP respond to all the MCH sub-elements from the Foreign Assistance framework, focusing on the following: birth preparedness and maternity services; treatment of obstetric complications and disabilities; newborn care and treatment; immunization; maternal and young child nutrition, including micronutrients; treatment of childhood illness; household-level WASH and environment; building host-country information capacity; and program design and learning. MCSP also contributes to several sub-elements of the family planning (FP)/reproductive health (RH), malaria, other public health threats (e.g., Zika and Ebola), and HIV/AIDS elements.

As illustrated in Figure 1, MCSP’s strategic results framework focuses on three defined result areas: sustainable and equitable high effective coverage; innovation gaps closed; and health systems strengthened.

**Figure 1. Program Conceptual Framework**

7 https://www.state.gov/f/c24132.htm.
8 Cooperative Agreement No. AID-OAA-A-14-00028 for Reproductive, Maternal, Newborn and Child Health
In the implementation of its program, MCSP brings together a partnership of organizations with demonstrated experience in maternal health, newborn health, child health, immunization, family planning, WASH, nutrition, and malaria. Each partner takes the lead in developing programs around specific technical areas. The MCSP consortium includes:

- As the prime contractor, Jhpiego leads on maternal health, reproductive health/family planning, malaria, and monitoring and evaluation (M&E).
- John Snow Incorporated (JSI) leads on child health, immunization, pediatric HIV, and health information systems.
- Save the Children leads on newborn health, WASH, adolescent health, and community mobilization.
- PATH leads on nutrition.
- International Development Consulting (ICF) leads on civil society organization (CSO) strengthening and community health.
- Results 4 Development (R4D) leads on health systems strengthening (HSS) and equity.
- Population Services International (PSI) leads on private sector and social marketing.
- CORE Group leads on nongovernmental organization (NGO)/CSO engagement, dissemination.

Of note, multiple partners support digital health efforts. In addition, MCSP has four associate partners that provide specialty expertise:

- Broad Branch Associates – performance incentives
- Avenir Health – modeling and costing
- Johns Hopkins University Bloomberg School of Public Health – implementation science and The Lives Saved Tool (LiST)
- Communications Initiative – polio outreach and networking

As illustrated in Figure 2, MCSP currently implements 44 programs in 26 countries (plus one country where work is expected to start in Program Year (PY) 3), with a focus on USAID’s EPCMD countries. Figure 3), MCSP’s Washington-based management structure, summarizes the program’s integration of three principal management and operational entities: an executive management team (EMT), a technical EMT, and country support teams for its numerous country programs.
Figure 2. MCSP Country Outreach

HIGHLIGHTS

26

MCSP countries

44

programs
(including some in planning and some in close-out)

- Afghanistan
- Bangladesh
- Burma
- Democratic Republic of Congo
- Ethiopia
- Ghana
- Haiti
- India
- Indonesia
- Kenya
- Liberia
- Madagascar
- Malawi
- Mozambique
- Mali
- Nepal
- Pakistan
- Rwanda
- Senegal
- South Sudan
- Tanzania
- Uganda
- Yemen AA
- Zambia

Other countries where MCSP/MCHIP AA works:
Egypt, Guinea, Guatemala, Laos, Namibia, South Africa, Zimbabwe

Core-Funding Only:
Benin, Burkina Faso, Chad, Cambodia, Senegal, Sierra Leone, Togo, Ukraine


Figure 3. MCSP Management Structure
2. EVALUATION DESIGN

2.1 EVALUATION QUESTIONS

As the three questions (plus one procurement-sensitive question) included in the Statement of Work (SOW) for the MCSP midterm evaluation included multiple sub-questions and notations, the following text of the final version of the SOW’s evaluation questions⁹ is included in its entirety.

1. **Country Results:** To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality RMNCH interventions?

   *Areas to consider include but are not limited to:*
   
   a. The extent and ability of MCSP to support country programs to increase coverage of appropriate interventions
   b. The strengths and limitations of MCSP-supported activities/interventions toward achieving expected program results
   c. Missed opportunities or gaps

   *Note that there is a technical and managerial aspect to answering these questions. All activities at country level should be considered (both core and field funded).*

2. **Global Leadership:** To what extent and in what ways has MCSP contributed to key programs, priorities, and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives such as Ending Preventable Maternal Mortality (EPMM); Every Newborn Action Plan (ENAP); Family Planning 2020; Roll Back Malaria (RBM); the Integrated Community Case Management (iCCM) Task Force; and APR (A Promised Renewed)?

   *Areas to consider include but are not limited to:*
   
   a. Missed opportunities or gaps in MCSP’s global leadership efforts
   b. How MCSP is linking country-level learning to inform global-level engagement and vice versa

3. **Integration and Cross-cutting areas:** To what extent and in what ways has MCSP, as an integrated flagship RMNCH project, been successful in maximizing opportunities for comprehensive RMNCH platforms at the country and global levels?

   *Areas to consider include but are not limited to:*
   
   a. Gaps or missed opportunities in integrating crosscutting themes and across technical areas
   b. Successes and challenges of MCSP in sustaining and strengthening health systems to support RMNCH programming
   c. Advancement of community and civil society engagement toward improved outcomes at the global and country levels
   d. Extent to which MCSP’s program learning agenda is on track to provide strategic learning that will foster improved RMNCH outcomes across the continuum of care

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⁹ The SOW, initially prepared on February 2, 2017, was revised on March 21, 2017, in a meeting between the evaluation team and the USAID/Global Health Bureau’s Maternal and Child Health and Nutrition Office MCSP AOR team.
Note that this question includes integration of technical areas (e.g., MNCH, family planning, nutrition, malaria, WASH) and cross-cutting topics (e.g., HSS, community health and civil society engagement, quality, equity, gender, innovation). The question has both a technical and managerial component.

2.2 EVALUATION APPROACH

As called for in the evaluation's SOW and as confirmed during initial discussions with MCSP's Agreement Officer’s Representative (AOR) team, data collection and analysis was primarily qualitative. In addition, responding to the evaluation's extensive SOW through limited quantitative analyses was facilitated by using Survey Monkey, a web-based survey development software, and through a review of program documentation to triangulate, support, and validate findings.

2.3 SOURCES OF DATA

Data were collected through initial MCSP group in-briefs, key informant interviews (KIIs), site visits to three pre-selected countries\(^\text{10}\) with MCSP field operations (Rwanda, Madagascar, Ghana), an electronic survey, and a review of relevant documents during March – April 2017. In total, primary data were collected from 85 percent (22/26) of the MCSP countries, either through face-to-face interviews or e-surveys.

**MCSP Group In-Briefs:** MCSP group in-briefs were conducted with MCSP/Washington staff and with staff representing the programs in Rwanda, Madagascar, and Ghana. As structured by the evaluation team in collaboration with MCSP staff, the briefings addressed both qualitative and quantitative issues. Twelve representatives of MCSP’s Washington technical staff provided the evaluation team with overviews of their technical areas during MCSP’s initial midterm evaluation in-brief on March 22, 2017.

**Key Informant Interviews (KIIs):** Structured qualitative interviews (see Annex V) were conducted with 166 individuals. In Washington, interviews were conducted primarily as one-on-one discussions, either face-to-face or by telephone. In three instances, Washington-based group interviews were held at the request of the interviewees. Key informants represented a broad range of stakeholders. The list of respondents from Washington included 23 USAID/Global Health staff, four USAID/Regional Bureau staff, and five senior MCSP/Washington staff. At the country level, 30 MCSP staff, eight USAID/Mission representatives, 17 health service providers, four representatives of international organizations, eight CSO representatives, and 17 Ministry of Health stakeholders were interviewed during the three-country site visits to Rwanda, Madagascar, and Ghana. Remote interviews were held with five staff from US-based health projects, two representatives of the Harvard School of Public Health, and four staff from the World Health Organization (WHO). (See Annex IV for a summary table of all evaluation respondents by organizational affiliation).

**Electronic Surveys:** Based on USAID’s selection, a structured, largely qualitative survey (see Annex VII) was sent electronically to 19 of 26 USAID Missions with buy-ins to MCSP and to 20 MCSP country program staff funded through these 19 USAID Missions. The three countries the evaluation team visited did not participate in the e-survey, as their experiences and feedback were collected during the country visits. Four countries where MCSP programs had ended or were very early in startup were excluded from the survey. Response rates of 79 percent (15/19) and 75 percent (15/20) were achieved from participating e-survey USAID Missions and MCSP country program staff, respectively (see Annex VII).

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\(^{10}\) See Annex I, “Statement of Work,” Paragraph E, for criteria USAID used to select countries for field visits.
Document Reviews: Detailed reviews were conducted on documents related to MCSP’s progress in responding to its goal, purpose, and results framework. Documents included those related to the MCSP award and subsequent contract modifications; MCSP’s global performance monitoring plan (PMP) and global and country implementation work plans (for the three countries visited); MCSP annual reports through Program Year 2 and quarterly reports through the third quarter of Program Year 2; MCSP financial reviews; MCSP internal review findings; and activity-specific documentation supplied by MCSP. (For a list of all key evaluation references, please see Annex VIII.)

2.4 DATA ANALYSIS

Following removal of identifying information, qualitative data from each KII were merged into master files organized thematically by question and informant affiliation, and analyzed for recurring responses within each of the questions. Open-ended responses collected through the e-survey were similarly grouped by question and thematically analyzed. Close-ended questions utilizing Likert scales were quantitatively analyzed.

During five day-long data analysis working sessions, the evaluation team worked together on a process focused first on identifying recurring or common responses to each of the evaluation’s questions and sub-questions. Following identification of common responses, whether positive or negative, the evaluation team reached a tentative consensus on conclusions stemming from each common theme. Next, the team turned to available quantitative and qualitative documentation to triangulate each conclusion. Conclusions that were clearly not validated through an examination of available documentation were then referred to MCSP for further comment and a request for more information or clarification. In instances where available documentation or MCSP’s responses validated a tentative conclusion, the team discussed and arrived at recommendations linked to each conclusion or, where applicable, sets of conclusions. Based on responses from MCSP, tentative conclusions that were not validated by the program were then either rejected for inclusion in the report or, based on the strength of informants’ responses to a specific question, accepted and/or modified for inclusion in the preliminary debrief with USAID and MCSP.

After completing this analytical process, the evaluation team presented its preliminary summary of principal findings, conclusions, and recommendations in two separate venues, one for USAID/Global Health stakeholders and one for MCSP/Washington staff. During these debriefs, the evaluation team noted participants’ suggestions for clarification and modification, all of which were considered during the evaluation team’s development of the first draft of the evaluation report. Finally, receiving responses to the first draft from USAID/Global Health reviewers and MCSP, the evaluation team prepared and submitted its final draft.

In addition, for each of the three countries included in the site visits, the team developed summaries of country-specific findings, conclusions, and recommendations then presented the information in separate venues to USAID/Mission staff and MCSP staff in each country. Although not intended to be a comprehensive or definitive analysis of program activities in these countries, the country-specific presentations of findings gave the team and their country hosts an opportunity to discuss each country’s

11 On May 1, 2017, the team submitted its request for additional information and clarifications to which MCSP responded on May 3, 2017.
contribution to MCSP’s global goal. The team provided USAID with copies of PowerPoint presentations used during the debriefs as a deliverable of the evaluation’s scope of work.

2.5 ETHICS

In accordance with USAID evaluation policy, the MCSP midterm evaluation team addressed applicable ethics considerations in implementing the evaluation.

Conflict of Interest: USAID evaluation policy requires members of an evaluation team to recuse themselves from interviews with individuals representing organizations with which they have a current relationship as employee, advisor, or consultant. Although two members of the evaluation team had a direct employee relationship with USAID and roles on the USAID/Global Health/MNCH MCSP executive management team, the USAID AOR determined there was no conflict of interest associated with USAID employees' being members of the evaluation team. Accordingly, the team lead accepted USAID’s determination on this issue. Signed certificates attesting to the lack of conflict of interest for the remaining two members of the team are on file with GH Pro and can be found in Annex X.

Consent and Anonymity: In a qualitative evaluation, it is essential to protect informants’ anonymity. Accordingly, the evaluation adopted the following measures to ensure anonymity for all respondents:

1. Informed consent: Prior to the initiation of each interview, each respondent was explicitly advised that all information obtained during an interview would be considered anonymous and that all quotations used in the report would be included without attribution to any individual or position. After being informed of this principle, each respondent was asked if they agreed to continue with the interview and agreed to allow the evaluation team to maintain a written record of their response to a question. Only upon agreement to both of these requests was the interview allowed to be continued. There were no dissents to either request.

2. Removal of informants' identifying information: As a first step in protecting respondents’ identities, after detailed field notes of interviews were transcribed, each electronic transcription was assigned an institutional or service identification code to assist in the transfer of information to the master files discussed earlier. As a second step, all identifying information about respondents was removed from all electronic records.

2.6 LIMITATIONS

The evaluation’s comprehensiveness was limited by the following challenges:

Time constraints: The SOW allocated the effort under this evaluation as follows:

- In-briefs, finalization of SOW, methodological approach, implementation plan, instrument development and approval, finalization of interview list: five days
- Data collection (field visits to three countries, interviews, document review): 22 days, including travel time
- Data cleaning, analysis, synthesis: five days

This ambitious timeline constrained the evaluation team’s analysis of a program of MCSP’s size and complexity. Perhaps due to the condensed schedule, a second round of data collection was not built into the SOW. Therefore, the evaluation team had limited options for addressing gaps in and unevenness of data uncovered during the data analysis. This constraint was somewhat mitigated by the high quality and detailed nature of timely e-survey responses received from the large majority of
Missions and MCSP field offices. However, the representativeness of KII was affected by the limited availability of time allocated by the SOW for KII.

**Lack of conclusive quantitative data:** Although the SOW called for the evaluation to focus on qualitative analyses, the quantitative data provided to the evaluation team provided inadequate, often selective, and occasionally contradictory information upon which to validate the evaluation’s qualitative findings.\(^1\) This was largely due to the diversity of country programs in terms of technical focus and the consequent lack of indicator comparability across MCSP’s 44 programs and 26 countries. This limitation is discussed further under Evaluation Questions 1 and 3 below.

**Gaps in qualitative data:** As noted earlier, the evaluation team interviewed or surveyed 166 key informants during the evaluation. Due to time constraints, the evaluation team was unable to conduct one-on-one interviews with all MCSP headquarters’ staff responsible for technical and country support. The evaluation team tried to address this limitation by arranging for MCSP to provide the team with an initial nine hours of presentation and document review with MCSP/Washington staff responsible for each of the program’s technical areas and country programs. In addition, only a small number of informants representing MCSP’s wide and diverse base of global partners were available for face-to-face or remote interviews within the timeframe for data collection. This gap led to a limited and potentially uneven understanding of stakeholder perspectives of MCSP.

**Inadequate time and emphasis allotted to site visits:** The breadth and depth of country visits provided only a restricted, highly curated perspective of country programs. Due to time and cost constraints, the evaluation team travelled to only three of MCSP’s 26 countries of operation. The three countries (Rwanda, Ghana, and Madagascar) were selected by USAID prior to the start of the evaluation. Visits to these countries were limited to five to six working days for data collection, interviews, and visits to program health facilities. Despite the report’s acknowledged value of responses from a significant number of e-survey informants and from the site visit informants, constraints associated with the site visits left the team with inadequate opportunities to assess first-hand and to more thoroughly validate information received through the evaluation’s e-survey and KII.

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3. EVALUATION FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

In this section, findings associated with the evaluation SOW’s three questions (plus one procurement-sensitive question) are discussed in detail and accompanied by respondents’ comments to capture themes from the interviews and e-survey. Where applicable, quantitative data from MCSP documents or other sources are discussed to enhance the evaluation’s qualitative findings. Conclusions and recommendations follow each question’s findings.

The broad scope of Question 1 led to a lengthy set of findings, conclusions, and recommendations. Given the question’s complexity, we first present the findings for each of its three sub-questions, then list all the evaluation team’s conclusions and recommendations. For Question 2, we present findings, conclusions, and recommendations sequentially for its two sub-questions. For Question 3, general findings, conclusions, and recommendations are presented first, followed by findings, conclusions, and recommendations for each of its four sub-questions. Sub-question 1 has been divided to address its two components, technical areas and crosscutting areas.

EVALUATION QUESTION 1 (EQ1): COUNTRY RESULTS

Evaluation Question 1 (EQ1): To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality RMNCH interventions?

Areas to consider include but are not limited to (Sub-questions):

1. The extent and ability of MCSP to support country programs to increase coverage of appropriate interventions
2. The strengths and limitations of MCSP-supported activities/interventions toward achieving expected program results
3. Missed opportunities or gaps

The breadth of Question 1, including its three sub-questions, necessitated a focused rather than in-depth response to any single technical area. Additionally, considering MCSP’s diverse and complex nature, the evaluation team was unable to obtain a similar level of information for all aspects of this evaluation question. In the interest of transparency, the narrative identifies this limitation in places where the evaluation team was concerned with the sparse information on which to base findings. Further analytic exercises are recommended if USAID wishes to have a deeper understanding of MCSP’s work in any one technical area.

Sub-question 1. The extent and ability of MCSP to support country programs to increase coverage of appropriate interventions.

Introduction

As the central technical focus of MCSP’s approach to accelerating reductions in maternal, newborn, and child mortality, MCSP’s identified and promoted HIIIs that held the best potential for contributing to the longer-term goal of ending preventable maternal and child deaths. As illustrated in Figure 4, the program’s strategy for identifying HIIIs incorporated five progressive steps that begin with defining a
problem and culminate in the scaling up of appropriate and evidence-based HIIs with the best potential for technically addressing each identified problem. In applying this strategy, MCSP has drawn on its experience and expertise with appropriate EPCMD interventions to introduce more than 30 HIIs (Figure 5) across 26 countries.

**Figure 4. Sustainable Impact at Scale to Achieve EPCMD**

While it was beyond the evaluation’s scope to quantitatively assess the effectiveness of MCSP’s introduction of HIIs across its many country programs, out of the 15 Missions responding to the e-survey, 10 (66 percent) agreed with the statement that MCSP has supported increased coverage of high-impact interventions. Also, among the same group of respondents, 11 Missions (73 percent) agreed with the statement that MCSP’s activities are designed to be sustainable.

In *Scaling up HIls: How is it done?* (2015), the authors discussed three HIll cases studies from the Maternal and Child Health Integrated Program (MCHIP). In conclusion to their report, the authors recommended three lessons learned for program planners to guide their efforts to scale up maternal and newborn HIls:

1. “the necessary evidence and mechanisms for local ownership for the intervention [should be] well-established”
2. “the intervention [should be] as simple and cost-effective as possible”
3. “the implementers and beneficiaries of the intervention [should be] working in tandem to build institutional capacity at all levels and in consideration of all perspectives”

Although it is too early in the program to assess if all HIls introduced under MCSP have applied all three lessons learned in their introduction of and support for the HIls in Figure 5, the evaluation’s KII and e-survey respondents frequently acknowledged the strength of MCSP’s focus on working with local governments and health service providers in their efforts to introduce HIls (Points 1 and 3 above). On these two points, of the 15 Missions responding to the e-survey, 13 (86 percent) agreed with the statement that MCSP has exhibited adaptability and/or flexibility in the local country context, and 12 (80

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percent) agreed with the statement that MCSP has worked effectively with host-country counterparts. With reference to whether the HIIs were universally “simple” and “cost-effective” (Point 2 above), Figure 5 indicates that the majority of HIIs were, indeed, simple and cost-effective, with the possible exception of HIIs introduced at the level of referral facilities.

**Measuring “Coverage”**

MCSP developed a global PMP, which was approved by USAID in December 2014. Country-level PMPs were also developed to support country work plans. As stated in the opening sentence of MCSP’s global PMP, “Accurate and timely information on health intervention coverage, quality and equity is the foundation of public health practice … and is absolutely critical to identifying strategic adjustments required to meet commitments.” The PMP further states, “In the case of national-level outcome and impact-level results, however, it will not be possible to attribute specific intervention coverage increases and mortality reductions to the Program.” MCSP did not design its M&E system to be able to measure its contribution to changes in national coverage of HIIs. However, the PMP goes on to say, “In order to systematically and prospectively study scale up, MCSP will collect robust information on several key areas: … Robust coverage information for the intervention being scaled up that is collected frequently enough to allow management of the scale process. The indicators for this are included in this PMP” [emphasis original]. The PMP specifies 26 coverage indicators (S1–S26) that the program intended to measure through population-based studies (PBS) of the funding area, “if funding is available.” Ultimately, these indicators were identified to provide the information that would effectively answer Evaluation Question 1, “To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage?”

The evaluation team has not found evidence to suggest that the global PMP’s goal to capture coverage data in a systematic way has been successful. A review of the 235 documents published to the Development Experience Clearinghouse (https://dec.usaid.gov) under MCSP’s award number returned one baseline evaluation, for Ethiopia. No baseline reports could be found on the MCSP public website or USAID’s website. Program annual reports do not report on the coverage indicators included in the global PMP. The evaluation team recognizes that there are likely many factors, namely, cost and Mission interest, that have influenced the relatively low number of baseline surveys conducted.

The absence of these coverage data makes it difficult for the evaluation team to triangulate qualitative findings that reflect key informants’ perceptions of MCSP’s success to “increase sustainable and equitable coverage” of HIIs with objective quantitative evidence. Ultimately, it makes it difficult for MCSP to demonstrate that it has effectively met its first objective. Where and when the evaluation team could use collected data to support findings, it has done so throughout this report, including for Question 1 below. However, the absence of coverage data remains a significant limitation for both the program and the evaluation team to respond to questions raised about MCSP “moving the needle” on EPCMD.

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14 In reviewing an early draft of this report, USAID reported to the evaluation team that a revised PMP had been developed and had “USAID consensus” but was not yet formally approved. This document was not provided to the evaluation team; therefore, it is not a data source for this report.
16 Ibid., p. 1.
17 Ibid., p. 4.
## Figure 5. MCSP’s High-Impact Interventions

<table>
<thead>
<tr>
<th>HII by Health Service Entry Point</th>
<th>Health System Level</th>
<th>Adolescent – Pre-Pregnancy</th>
<th>Pregnancy Antenatal Care</th>
<th>Labor &amp; Birth</th>
<th>Postnatal</th>
<th>Infancy &amp; Childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Outreach</td>
<td>FP barrier/hormonal • Nutrition/FA, STI/HIV • LLIN, ITN</td>
<td>Iron, FA, tetanus • IPTp, ITN • Malaria case mgt. • STI/HIV prevention • ART provision • Calcium • Birth planning • Advanced distribution of misoprostol • Screening for pre-eclampsia • Maternal nutrition</td>
<td>Self-administration of misoprostol • Chlorhexidine</td>
<td>Immediate Thermal Care • Exclusive &amp; early breastfeeding • Nutrition • Postpartum FP • Kangaroo Mother Care for preterm and LBW babies • LLIN, ITN</td>
<td>• Breastfeeding • Vitamin A • Infant/young child nutrition • Routine immunizations • CCM • LLIN, ITN</td>
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</tr>
<tr>
<td>Facility and Primary Care</td>
<td>FP (all appropriate methods) • Preconception care • HBV immunization</td>
<td>Post-abortion care • Syphilis screen &amp; test • Lose-dose aspirin • Mgt. of preterm labor &amp; membrane rupture • Chlorhexidine</td>
<td>AMTLS • Mgt. of PPH • Mgt. of PE/E • Respectful care at birth • Manual removal of placenta • Immediate newborn care • Neonatal resuscitation • Post-placenta IUD</td>
<td>NB infections • Kangaroo Mother Care • Treatment of Mat/NB infections • Essential newborn care &amp; selected immunizations • ARV for HIV+ women • Treatment of maternal anemia</td>
<td>• Routine immunizations • New vaccine introduction • Care of HIV+/exposed children • Mgt. of diarrhea, malaria, pneumonia &amp; malnutrition • IMCI</td>
<td></td>
</tr>
<tr>
<td>Referral Facility</td>
<td>Attention to malpresentations • Complex OB care</td>
<td>Cesarean section, incl. prophylactic antibiotics • Surgical obstetrics</td>
<td>Care of preterm NB, incl. CPAP • Mgt. of PP sepsis • TX for NB sepsis</td>
<td>Case mgt. for meningitis • Mgt. of severe malnutrition • Care of severely ill child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Review of MCSP Country Interventions**

Based on Mission buy-in specifications, MCSP has provided technical assistance directed toward one or more of the following MCSP technical areas: maternal health; newborn health; child health; family planning; immunization; malaria; nutrition; WASH; and HIV care, treatment, and prevention. To best respond to the evaluation questions, the following findings provide an assessment of MCSP’s progress in increasing coverage of appropriate HIIs with reference to the program’s defined technical areas.

**Findings**

**Maternal Health:** In response to Mission buy-ins, MCSP reports indicate that it provides technical assistance on maternal health in 19 of its 26 countries. With a strong emphasis on enhancing the continuum of care associated with antenatal care (ANC), “day of birth,” and essential newborn care (ENC), MCSP, in applying the development process illustrated in Figure 1, has worked with service providers in scaling up HIIs associated with preventing malaria in pregnancy (MIP); prevention of postpartum hemorrhage (PPH); adherence to best practices associated with basic emergency obstetric and newborn care (BEmONC); and promoting postpartum family planning (PPFP), exclusive breastfeeding (BF), and improving infant and young child feeding (IYCF). While it was not within the mandate of this evaluation to assess the technical quality of MCSP’s interventions related to maternal health, respondents frequently affirmed that MCSP’s focus on key maternal health priorities significantly increased service providers’ ability to provide high-quality maternal health services.

MCSP documentation indicates that there has been a significant emphasis on the rapid scale-up on HIIs related to maternal health. However, key informants, including MCSP personnel, expressed concern that the program has placed less emphasis on developing a process to systematically ensure that maternal health HIIs are institutionalized in MCSP countries. This raises concern about the prospects of sustainability of at-scale HIIs introduced under the program. Last, as MCSP and respondents acknowledged, the program continues to encounter difficulties with measuring the scale by which any HIIs have increased — and, therefore, whether it is “on track” in achieving its goal to accelerate the reduction in maternal and child mortality.

An illustrative example related to maternal health is in the box below. While this example is specific to a maternal health HII, the challenges are broadly applicable across technical areas and are further explored in other sections of the report.

**Newborn Health:** In response to Mission buy-ins, MCSP reports indicate that it provides technical assistance on newborn health in 11 of the program’s 26 countries. With an emphasis on the day of birth and postnatal period, MCSP supports immediate essential newborn care, including newborn resuscitation to manage asphyxia, introduction of the use of chlorhexidine for umbilical cord care, Kangaroo Mother Care (KMC) for premature and low birth weight newborns (in nine of the 26 countries), and newborn infection prevention and management. As a measurement of the impact of its

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18 MCSP midterm evaluation in-brief, March 2017.
19 Ibid.
20 “Day of birth” includes labor and delivery and early postnatal care (PNC) for mother and baby, essential newborn care, counseling, postpartum family planning method provision, early detection and management of maternal and newborn complications, and pre-discharge care.
21 MCSP communication to the evaluation team, May 3, 2017.
support for newborn health, MCSP has calculated that, “in eight of the countries that MCSP works in, we have saved over 14,000 babies who had birth asphyxia through improved actions at birth.”

Challenges in Understanding MCSP’s Contribution to Managing Postpartum Hemorrhage

The evaluation team repeatedly encountered two challenges to using program PMP data to understand program outcomes as a part of this evaluation: 1) changes in countries reporting and geographic expansion over time makes it difficult to interpret trends lines; and 2) incomplete reporting by MCSP countries makes it impossible to fully measure and understand the extent to which they are successfully increasing coverage of HIs. For example, MCSP’s Indicator 9, “Percent of women receiving a uterotonic in the third stage of labor (immediately after birth),” illustrates these dual challenges.

Figure 6. MCSP Tableau Reporting on PPH Indicator*

1. The challenge of interpreting trend lines: An average consumer of program data would look at the trend line in Figure 6 and conclude that uterotonic usage is high in MCSP countries and has remained steady or even declined slightly over time. This interpretation could lead to questions around the value of investment (e.g., Why invest in PPH management if coverage is already high? What has USAID gained for the investment in this HII?) However, when looking at country-specific data, such as in the MCSP Year 2 Annual Report, a picture emerges of sometimes significant year-over-year changes in a) the number of countries contributing to the indicator, b) the total population covered by MCSP programming in each country; and c) the number of women receiving the subject intervention in each country. All these changes are bi-directional, meaning both countries and populations are moving into and dropping out of the indicator. The presence of this dynamic movement of indicator inputs renders the trend line uninterpretable, as each moment in time is measuring a unique population.

2. The challenge of incomplete reporting: Of the 19 countries in which MCSP reports having maternal health activities, 14 are listed in its M&E system as having “active” maternal health programming, and 12 are listed as working in PPH management. In its Year 2 Annual Report, MCSP provides data on eight countries for Indicator 9 in 2016, and a total of 10 countries that have ever reported on Indicator 9 (2014 – 2016).

With official data reported for only eight of 12 countries working on PPH, the evaluation team attempted to use unofficial data provided by MCSP to gain a more complete picture of the program’s work in this area. Unofficial data included reporting from three countries that are not included in the 12 countries reported to be working on PPH, and did not include three countries of the 12 considered to be engaged in this intervention. With approximately one-third of the countries working on PPH missing from the key PMP indicator on the subject, the evaluation team could not conclude “to what extent” MCSP has increased coverage of this HII. In the data reported, coverage has appeared to increase, but it cannot reasonably be assumed that the countries that are not reporting these data are similar to those that have reported the data. Therefore, a global statement on this indicator is not possible.

* Source: MCSP communication to the evaluation team, May 3, 2017.
† Source: MCSP communication to the evaluation team, July 24, 2017. MCSP considers the annual reports to be the official mechanism for reporting PMP data.

**Child Health:** In response to Mission buy-ins, MCSP reports indicate that it provides technical assistance on child health in 10 of its 26 client countries. MCSP addresses child health issues by first assisting service providers in setting achievable child survival targets, and then working with staff to achieve these targets through a holistic health service-to-community approach to improved child health focused on enhancing staff skills in integrated management of childhood illnesses (IMCI); introducing emergency triage and treatment of children (ETAT); and in iCCM. In addition, discussions with key informants and a review of program documentation indicates that MCSP, utilizing its global platform, has played an important role in advocating for child health issues at a number of global fora. (For more information on MCSP's global focus on child health issues, see Evaluation Question 2: Global Leadership.)

Although data on country-specific scaling up of child health-related HII is available from several MCSP country programs, the data were insufficient to permit the evaluation team to comment on if MCSP, from a global perspective, is “on track” to achieve its objectives. As illustrated in Figure 7, the program has reported on the number of children treated for child pneumonia in five of the 10 countries in which it was providing technical assistance in child health. As presented, the data, even for these five countries, fails to make a conclusive case for progress in scaling up of treatment of child pneumonia, while three of the five countries (Guinea, Liberia, Mozambique) appear to have shown an increase in the number of children treated for pneumonia. In addition, in the case of Liberia, the abnormally high number of children with pneumonia reportedly treated with antibiotics may be ascribed to over-treatment with antibiotics.\(^{23}\)

**Family Planning:** MCSP provides technical assistance on family planning in 20 of the program’s 26 client countries. In family planning, MCSP provides technical assistance in PPFP, expanding method choice, and in training service providers to recognize and respond to opportunities to provide family planning information to young women of reproductive age who have not yet become mothers. In eight countries\(^ {24}\) MCSP has assisted these countries in facilitating the deliberations of technical working groups to accelerate PPFP national policies and guidelines. In addition, as discussed in this report’s response to Evaluation Question 2, MCSP’s work on the promotion of PPFP at country-level is supported by the program’s work with global fora in elevating global focus on the importance of PPFP. MCSP is recognized for its important contribution to family planning in its client countries: “[USAID’s Office of Population and Reproductive Health] requests from MCSP. [MCSP is] leading on galvanizing the PPFP global agenda to translate best practices to country action.” (USAID/Washington)

\(^{23}\) Midterm evaluation team communication with MCSP, June 2017.

\(^ {24}\) Democratic Republic of the Congo, Ethiopia, Kenya, Madagascar, Mozambique, Nigeria, Rwanda, and Tanzania
Although key informants widely recognized MCSP’s country-specific and global contribution to the promotion of PPFP, availability of data to determine the extent of scale-up of PPFP HII’s “remains a challenge for many aspects of family planning [due to] very limited routine data collection on PPFP.”

The evaluation team recognizes the inherent weaknesses of relying on Health Management Information System (HMIS) data, notably in timeliness and quality. Nonetheless, the evaluation team agrees with MCSP’s decision to use these data as a primary source for program M&E data. MCSP’s attention to strengthen country HMISs to improve the quality of its M&E data is laudable, and demonstrates a long-term approach to programming. An unfortunate reality of this approach, however, is the lack of indicator harmonization across countries. Slight definitional differences in indicators can render a country incapable of contributing to a PMP indicator. This is a possible explanation for why even relatively standard and long-standing RMNCH indicators are reported by only a fraction of MCSP countries. For example, despite reporting to work in family planning in 20 country programs, only eight countries contribute to MCSP’s PMP indicator on family planning acceptors. (See Figure 8.) In response to this challenge, MCSP has reportedly begun to introduce indicators and methods for integrating PPFP into client-country HMIS.

Figure 8. MCSP Tableau Reporting on PPH Indicator on Family Planning Acceptors

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27 Ibid.
**Immunization:** In response to Mission buy-ins, MCSP reports indicate that the program provides technical assistance in immunization in 12 of the its 26 countries. MCSP draws on its significant experience as a global leader in immunization to inform national immunization programs, strengthen routine immunization systems, and build the capacity of service providers as they work toward expanding access to and utilization of routine immunization services. MCSP’s support to strengthen routine immunization complements and leverages USAID’s large investments in Gavi to increase coverage and expand equitable access. MCSP has worked in tandem with Gavi and other partners to support the introduction of new and underutilized vaccines into routine immunization systems in 11 countries.

While countries and partners (e.g., WHO and the United Nations Children’s Fund (UNICEF) report immunization coverage estimates annually, as with the other technical elements supported by MCSP, it is difficult to determine the extent to which the program has contributed to these results and is on track to achieve its scale-up objective. MCSP uses program-generated data for planning and monitoring purposes. Data quality within official government HMISs is often an issue, with “underlying constraints ranging from false or incorrect reporting to incorrect denominators and targets which are mostly estimated [by] census data and population growth rates that are too often out of date.”28 This frank assessment by MCSP related to immunizations is reinforced by an equally frank assessment from a KII from USAID/Washington: “The problem is that they have struggled to have indicators that show us what they are doing.”

**Malaria:** MCSP provides technical assistance on malaria in 10 of its 26 countries. Depending upon the content and financing available through a Mission’s buy-in, MCSP’s assistance on malaria includes promoting the use of long-lasting insecticide-treated nets (LLINs), delivery of intermittent preventive treatment of malaria in pregnancy (IPTp) at the community and health service levels, and the management and treatment of malaria, particularly in infants and children under 5. In keeping with its focused approach to the provision of technical assistance, each of the interventions discussed above figures prominently as an HII. (See Figure 5).

While lack of quantifiable data is a recurring challenge for the evaluation’s ability to assess the scale of HIIs, the problem, in the case of malaria, is exacerbated by the fact that “not all countries are tracking the same IPTp doses in the HMIS, which makes [assessing] progress across countries challenging.”29 In addition, MCSP reports a paucity of host-country data with specific reference to case management of malaria,30 which has constrained its ability to quantify its progress in introducing this important HII in its client countries.

**Nutrition:** MCSP reports that technical assistance in nutrition has been provided to 12 its 26 countries.31 In assessing Missions’ limited buy-in support of child nutrition, the evaluation team has concluded that MCSP’s own reporting on the specific number of Missions supporting nutrition interventions may have understated the program’s depth of technical support during antenatal care. On one hand, it may be strictly correct for the program to state that only 12 Mission buy-ins specifically supported a nutrition intervention primarily for technical assistance on breastfeeding, stunting, and

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29 MCSP legacy brief, Malaria, March 2017.
30 Communication with MCSP, June 2017.
IYCF (including iron and folic acid (IFA) supplementation); on the other hand, the program’s significant support for exclusive breastfeeding and general nutrition in the 19 countries with maternal health buy-ins would indicate that its contribution to child nutrition extends far beyond its nutrition interventions in the 12 countries for which there is specific support for nutrition interventions. At the same time, as noted by MCSP in its legacy brief on the program’s contribution to improved nutrition:

“Not all countries have similar interventions or levels of support. For example, there are missed opportunities to support some MCSP countries with a range of facility- and community-level baby-friendly initiatives to improve early initiation, exclusive breastfeeding, and complementary feeding, so there is a large range in depth and breadth of activities that need to be explored in most of these countries.”

Water, Hygiene, and Sanitation: MCSP provides technical assistance in support of WASH activities in 10 of its 26 client countries. MCSP reports indicate that the importance of diarrheal case identification, treatment, and management is incorporated, under MCSP’s child health content, with reference to the enhancement of iCCM and IMCI. Limited Mission support for WASH should be viewed as a missed opportunity to holistically address the impact of WASH-related issues on the reduction of maternal, newborn, and child mortality. However, as indicated by an evaluation respondent from USAID/Washington, “We never envisioned MCSP to be scaling up WASH high-impact intervention.” Accordingly, when viewed from this perspective, it is understandable that there was limited Mission support for WASH under an MCSP buy-in. Despite this, MCSP has provided considerable attention to the issue of WASH in health care facilities as it pertains to quality of maternal neonatal health (MNH) care and behavior change through the implementation of the clean clinic approach in several key countries: Haiti, Democratic Republic of the Congo, and Mozambique.

HIV Care, Treatment, and Control: MCSP provides technical assistance in support of HIV HIIs in eight of its 26 countries. With the majority of funding concentrated in Haiti and Namibia, MCSP’s HIV-related activities focus on training in testing, treatment, and counseling; on community efforts to promote treatment compliance among HIV positive clients; and on work with the governments and health centers to ensure that testing and treatment is available to women and children accessing MCH services. As indicated in MCSP’s current PMP, reporting on the sole indicator related to the program’s HIV interventions (Number of HIV-positive pregnant women who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission) is based on HMIS/service statistics. As noted earlier, MCSP has reported that reliance on often unreliable HMIS/service statistics constrains its ability to report on progress on HIIs related to specific interventions. In addition, lack of a baseline against which to measure progress on the program’s HIV interventions has limited the evaluation’s ability to assess the extent to which MCSP is on track to achieve its objectives to increase sustainable and equitable high coverage with reference to HIV HIIs.

Sub-question 2. The Strengths and limitations of MCSP-supported activities/interventions toward achieving expected project results

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33 MCSP midterm evaluation in-brief, March 2017.
34 MCSP Year 2 Annual Report, 2017.
Finding: MCSP’s strong technical leadership and its focus on an evidence-based approach to the introduction of RMNCH HIIs was instrumental to the program’s progress in introducing ways in which to reduce maternal and child mortality.

As expressed by all of the evaluation’s respondents, MCSP’s strong and experienced technical team at the global and country levels has been the program’s greatest resource and its greatest strength in introducing HIIs in 26 countries.

MCSP’s focus on enhancing service providers’ capacity to reduce maternal and neonatal mortality was firmly grounded in the introduction and promotion of evidence-based HIIs.

MCSP’s emphasis on a “day of birth continuum” gave service providers a logical and systematic perspective on ways in which to address the challenge of reducing maternal and neonatal mortality and accelerating maternal, neonatal, and child survival.

Finding: MCSP’s lack of standard indicators across country programs constrains its ability to document progress toward achieving expected program results.

As frequently expressed by Washington respondents, MCSP has not focused sufficiently on collecting and providing cross-country quantifiable data to document if its investments in technical resources have led to progress toward expected program results. A review of the program’s global monitoring dashboards clearly demonstrates this challenge. Overall, MCSP’s global PMP indicators are collected by a small number of country programs, often representing a minority of the countries that purport to work in the technical area. For example, three of the nine countries that purport to be working on WASH in facilities report on the global indicator, “Percent of target health facilities with appropriate handwashing supplies in the delivery room,”35 Furthermore, two countries that are not reported to work on WASH in facilities have contributed to the indicator. The evaluation team was unable to further examine the reasons behind this, but this issue appeared consistently in the evaluation team’s review of quantitative data. This lack of harmonization of M&E plans across programs is a consistent finding across all technical areas. Without a standard set of indicators that are required by countries who engage in a technical area, MCSP does not have the evidence it needs to demonstrate its progress toward Objective 1 of its award.

3. Sub-question 3. Missed Opportunities or Gaps

Respondents frequently viewed MCSP’s technical approach — exemplified by its organizational structure — as one that was “siloed,” with each separate “silo” or technical area taking on its own identity with separate staff and, frequently, separate consortium partners. While MCSP has made an effort to bridge the gap between the separate technical areas and institutional entities, staff at the headquarters level continued to present themselves as being responsible for their specific technical areas rather than having a more holistic responsibility focused on reducing maternal and child mortality.

However, data collected from the three country site visits and the e-surveys shows this silo effect was less pronounced at the country level, perhaps because of the specific technical focus of Mission buy-ins.

MCSP/Washington staff suggested that a change in standard operating procedures from MCHIP to MCSP had also helped improve team cohesiveness at the country level. MCSP reports to have streamlined operational procedures in country offices so staff report through the chain of command to the chief of party regardless of partner affiliation and, where possible, employed a single office system (finance and administration), rather than multiple systems, according to which partner is responsible. As a result, country staff appeared to have a greater appreciation of the need to work together in responding to their Missions’ scopes of work.

CONCLUSIONS AND RECOMMENDATIONS FOR EVALUATION QUESTION 1

EQ1-Conclusion 1
Based on its analysis of discussions with informants, responses provided through the e-survey, and available program documentation, the evaluation team has concluded that MCSP’s assistance to country programs has been responsive to the needs and expectations of Mission buy-ins.

EQ1-Recommendation 1: During the remaining 18 months of the cooperative agreement, MCSP should maintain the reported quality of its technical assistance to ensure that, to the extent possible, continued gains in reducing maternal and child mortality are accelerated.

EQ1-Conclusion 2
Despite MCSP’s acknowledged technical excellence and the reported and directly observed strength of its country-specific interventions, the program’s limited focus on collecting a standard set of indicators and lack of coverage indicators to measure progress at a program level has limited its ability to measure progress achieved in responding to program objectives. In addition, as presented in its annual reports and documentation provided to the evaluation team, MCSP’s inconclusive use of data in summarizing its global progress on scaling up HIIIs was an issue the team encountered throughout the evaluation.

EQ1-Recommendation 2.1: There is not enough time for MCSP to address this issue during the remaining months of its award. However, for the benefit of a potential follow-on — one that would ideally begin working on maternal and child survival — MCSP and USAID/Washington should immediately begin working together on an analytical process to select indicators among its data sets that will serve as a guide for a follow-on as it establishes a program-wide approach to measuring progress achieved in responding to program objectives. This analytical process would include engaging Missions that have provided buy-ins to MCSP to arrive at a set of common indicators that could be applied to all buy-ins focused on introducing HII as a means of accelerating efforts to improve mother and child survival.

EQ1-Recommendation 2.2: As it is working on the analytical process described above, MCSP should re-examine the existing set of case studies in its legacy briefs to determine the extent to which they adequately illustrate global progress on scaling up HII for each of the program’s technical areas. If the analysis indicates that specific HII are under-represented or not represented in the case studies, it is further recommended that such case studies be developed. Once completed, the set of HII-focused case studies should form the basis for an end-of-program symposium for key national and global stakeholders.

EQ1-Conclusion 3
The evaluation team and MCSP’s ability to determine if the global program is “on track to achieve its objectives” is significantly constrained because MCSP’s 26 countries have different startup and completion dates and SOWs. In the evaluation team’s experience, MCSP should be in a consolidation and documentation phase at this point in the award cycle. The time and effort devoted to starting up
new country programs is detracting from other activities that would be taking place in a typical award related to learning, refining, consolidating, and documentation of experience.

**EQ1-Recommendation 3:** MCSP should not expand to take on any new work in the remaining 18 months of implementation. This recommendation would apply to new countries that request to buy in, as well as significant expansions within existing country programs. Currently program startup efforts should be redirected to systematic program learning; intervention refinement based on learning, lessons learned, and other forms of reflective, end-of-program documentation; high-quality and effective dissemination of the large volume of learning activities in the portfolio; and, eventually, a high-quality closeout.

**EQ1-Conclusion 4**
Due to time and resource constraints for this evaluation, it was not possible to arrive at an in-depth and conclusive understanding of the extent to which MCSP’s management structure has contributed to effective program management. However, based on the evaluation team’s experience with similarly structured global programs, MCSP/Washington’s siloed organizational structure may have constrained the program’s ability to think creatively in defining a common strategy for addressing ways in which to holistically work toward accelerating the reduction in maternal, neonatal, and child mortality.

**EQ1-Recommendation 4:** MCSP should engage an outside facilitator to promote an internal staff program appraisal process designed to determine the extent to which the program’s structure enhanced and constrained the ability to work holistically toward accelerating the reduction in maternal, neonatal, and child mortality. The results of this appraisal would be important to USAID as it deliberates on the value added to a similar structure for a potential follow-on.

**EQ1-Conclusion 5**
Weaknesses in host-country information collection systems continue to constrain governments’ abilities to identify evidence-based priorities.

**EQ1-Recommendation 5:** MCSP should continue and even more heavily emphasize program efforts to improve country-level health information systems/health information management systems and other forms of country data collection, including the harmonization of indicators in country systems. Given the time remaining in the program cycle, MCSP’s efforts to improve governments’ data collection systems may achieve only minimal immediate benefits; however, efforts to strengthen host countries’ data collection environment for the benefit of future programs are entirely within MCSP’s mandate as USAID’s flagship MNCH program.

**EVALUATION QUESTION 2 (EQ2): GLOBAL LEADERSHIP**

**Question:** To what extent and in what ways has MCSP contributed to key programs, priorities, and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives such as EPMM, ENAP, Family Planning 2020, RBM, the iCCM Task Force, and A Promised Renewed?

**Areas to consider include but are not limited to (Sub-questions):**
1. Missed opportunities or gaps in MCSP’s global leadership efforts
2. How MCSP is linking country-level learning to inform global-level engagement and vice versa

This section focuses on the extent to which MCSP has contributed to key programs, priorities, and policies to support evidence-based, high-quality RMNCH interventions across the continuum of care at
the country, regional, and global levels as part of its global leadership mandate under Program Objective 3, as stated in the MCSP program description.

Although it represents a relatively small proportion of total obligations to date, MCSP’s core-funded activities are a critical component of its design and approach to accelerating reductions in maternal, newborn, and child mortality. In Program Year 3, core-funded support directed specifically to global technical leadership varied from 14 – 38 percent across technical areas, based on specific activities outlined by MCSP and USAID/Washington teams. For purposes of the core work plan, MCSP defines global technical leadership as engagement in working groups (e.g., Roll Back Malaria – Malaria in Pregnancy Working Group), technical support to key conferences (e.g., Institutionalizing Community Health Conference), and initiatives around improving coverage, quality, and metrics related to specific technical areas (e.g., EPMM). There are other core-funded activities that support learning, service strengthening, capacity development, quality improvement, and data measurement that inform and contribute to global leadership efforts, although they are not explicitly labeled as such. The scope of this evaluation did not include analysis of MCSP’s support to the following Global Development Alliances (GDAs) and partnerships: Mobile Alliance for Maternal Action, mPowering Frontline Health Workers, Saving Mothers, Giving Life, and Survive and Thrive.

As mentioned in the discussion of limitations (see the Evaluation Design section, the short timeframe available to interview external stakeholders and MCSP technical staff resulted in sub-optimal representation of some stakeholder groups and technical areas. This limitation is reflected in the global leadership findings, in that the qualitative data used to inform the following findings do not reflect an equivalent level of understanding of all technical areas with which MCSP is engaged. Findings and conclusions may not be generalizable to all technical areas.

EQ2-Sub-question 1. Missed Opportunities or Gaps in MCSP’s Global Leadership Efforts

Finding: No evidence was found to suggest that major gaps or missed opportunities exist in MCSP’s global leadership efforts within its sphere of control or influence.

Respondents did not cite gaps or missed opportunities within MCSP’s sphere of control or influence that the program could address. Respondents frequently mentioned emerging and neglected topics and areas of work to which the global RMNCH community could apply greater focus (e.g., more emphasis on systems than interventions, urban health, and adolescent health), but qualified statements with the understanding that MCSP’s role was that of a technical implementing partner, not a donor, multilateral agency, or government organization. Respondents also recognized that MCSP’s engagement has been focused on and limited to USAID’s priorities. USAID respondents noted that in certain technical areas (e.g., malaria or family planning), MCSP’s global leadership has been focused on certain approaches and interventions, such as malaria in pregnancy and PPFP, respectively, because the Bureau for Global Health has other awards available to engage and respond to other areas of focus within those technical areas.

36 The core budget includes any funding managed out of USAID/Washington, rather than Missions. The cumulative core-funded budget as of Program Year 3 represents 26 percent of all obligations to date, 37 percent of which are Ebola funds. Although largely programmed in the field, Ebola funds are considered core because they are managed out of USAID/Washington’s core budget, and not directly by Missions.
37 Global Development Alliances will be analyzed through a separate evaluation.
(e.g., commodities, social and behavior change), and because MCSP presents a unique opportunity to integrate RMNCH interventions across its various platforms.

“Certain things are, frankly, above an implementing partner’s pay grade, so MCSP does not always have the opportunity to weigh in on key strategic decisions. This is not a gap or missed opportunity; just reality.” — Respondent, partner project

EQ2-Conclusion 1
There have been no reported missed opportunities or gaps within the program’s sphere of control or influence that have constrained MCSP’s performance in global leadership.

EQ2-Recommendation 1: Given that there were no gaps or missed opportunities identified within the scope of MCSP’s global leadership, the program should maintain its current emphasis in this area and continue to look for opportunities to document and share its lessons learned and accomplishments.

EQ2-Sub-question 2. How MCSP is linking country-level learning to inform global-level engagement and vice versa

With 44 programs in 26 countries in Africa, Asia, and Latin America, MCSP has a uniquely large geographic footprint and network of partners. MCSP leadership colloquially refers to having “a seat at the table, and a foot on the ground” and respondents generally agree that this is a major asset of the program’s design.

“It is very unique to have a program that offers support at the country level and has representation in global fora. MCSP has been an exemplar in linking country and global levels and helping the global community to bridge the policy and implementation divide.”
— External stakeholder

Sixty-six percent of Missions and 100 percent of the MCSP country offices that responded to the e-survey agreed or strongly agreed that “MCSP has been effective in linking country-level learning to inform global-level engagement.” The same ratio of respondents agreed to the converse statement, “MCSP has been effective in linking global-level learning with country-level engagement.” There was similar general agreement among USAID/Washington and MCSP/Washington staff that MCSP has been effective in this area.

Finding: MCSP’s contributions to global initiatives have been viewed as instrumental in advancing focus on specific RMNCH issues.

While the majority of external (non-USAID, non-MCSP) respondents were able to speak to only one or two global initiatives due to the specificity of their technical engagement with MCSP, there was nearly universal praise for the technical excellence of MCSP’s senior-most staff and their contributions to specific global initiatives, including EPMM; ENAP; the Quality, Equity, Dignity Network; Family Planning 2020, the iCCM Task Force; and the Roll Back Malaria–Malaria in Pregnancy Working Group. External respondents repeatedly referred to MCSP as a “collaborative,” “technically excellent,” and “impartial” partner that made important contributions to the development and revision of global and regional policies, protocols, guidelines, and tools.

Table 1 highlights ways in which MCSP has engaged in those initiatives specifically referenced in the evaluation SOW. A Promise Renewed (APR) was also among the initiatives the evaluation team was
asked to analyze, but there was little to no reference to it in MCSP literature, and the majority of respondents were unfamiliar with it or believed that it was no longer active.

Table 1. Highlights of MCSP Engagement in RMNCH Initiatives and Working Groups (specified in the Mid-Term Evaluation’s SOW)

<table>
<thead>
<tr>
<th>Global Initiative/ Working Group</th>
<th>Select MCSP Contributions</th>
</tr>
</thead>
</table>
| Ending Preventable Maternal Mortality (EPMM)                      | • Member of EPMM core Working Group  
• Co-lead (w/United Nations Fund for Family Planning Assistance) of EPMM country implementation Working Group  
• Development of EPMM indicators for global and country monitoring  
• Updates to WHO Managing Complications in Pregnancy and Childbirth manual  
• Member of WHO expert group to develop new antenatal care guidelines, WHO Perinatal Guideline Development Group Executive Committee, and Technical Working Group on Global Estimates of Preterm Birth                                                                                                                                                                                                                               |
| Every Newborn Action Plan (ENAP)                                   | • Member of ENAP country implementation group  
• Member of commodities working groups (chlorhexidine, possible severe bacterial infection)  
• Lead regional networks (LAC Neonatal Alliance, Kangaroo Mother Care Acceleration Partnership Community of Practice)  
• Support to validation of ENAP indicators to improve newborn health metrics and member of ENAP Core Metrics Working Group                                                                                                                                                                                                                                                   |
| Family Planning 2020                                              | • Co-organized Accelerating Access to PPFP Global Meeting in Chiang Mai, Thailand  
• Co-organized PPFP event at International Conference on Family Planning  
• Support to the PPFP Steering Committee  
• Developed high-impact practice brief on immediate PPFP                                                                                                                                                                                                                                                                                                                                                                                 |
| Integrated Community Case Management (iCCM) Task Force             | • Secretariat of the iCCM Task Force, coordinates partners’ efforts to influence global iCCM agenda  
• Developed indicators for routine monitoring of iCCM that have been adopted by the District Health Information Systems academy for global use  
• Facilitated mapping of global leadership in child health, used to inform WHO strategic global review of integrated management of childhood illness                                                                                                                                                                                                                                                                                  |
| Roll Back Malaria–Malaria in Pregnancy Working Group              | • Co-chair of the Working Group  
• Support to update national guidelines and strategies  
• Global promotion of intermittent preventive treatment of malaria in pregnancy and use of insecticide treated nets  
• Integration of malaria in pregnancy (MIP) and antenatal care                                                                                                                                                                                                                                                                                                                                                                        |
| Gavi, the Vaccine Alliance and Global Vaccine Action Plan (GVAP)   | • Member of Global Vaccine Action Plan Strategic Objective 2 Working Group on Vaccination Demand (WHO, United Nations Children’s Fund)  
• Member of Gavi Working Group on Measles and Rubella  
• Member of Gavi/WHO Data Management Working Group                                                                                                                                                                                                                                                                                                                                                                                   |

For the iCCM Task Force, for which MCSP serves as the secretariat, and the Roll Back Malaria–Malaria in Pregnancy Working Group, for which MCSP is the co-chair and secretariat, respondents noted the 38

38 The global iCCM Task Force is a forum for partners to coordinate advocacy efforts, share tools, develop
program’s strength as a convening partner and its exceptional ability to ground high-level discussions in reality by sharing its country-level implementation experiences. Respondents praised MCSP’s ability to focus on what is possible and realistic at the country level while maintaining an aspirational vision to accelerate reductions in maternal and child mortality.

“The [Roll Back Malaria–Malaria in Pregnancy] Working Group has been fantastic. It is hard to maintain enthusiasm for malaria because it has been around for so long. I give MCSP credit for generating excitement and breaking down our work into small, manageable, and concrete tasks that can be accomplished to really move the field forward.” — External stakeholder

“MCSP’s support to the iCCM Task Force has been excellent. [A shining star!] Their implementation platform allows them to bring their experience from the country level to the global table and help us understand the feasibility of global standards and guidelines at country level.” — Respondent, USAID/Washington

**VIGNETTE: Critical Technical Input and Advocacy: WHO Regional Office for Africa Reaching Every District Guidelines**

In 2002, WHO and its partners, including USAID’s Basic Support for Institutionalizing Child Survival (BASICS) II project, developed the Reaching Every District (RED) approach to address barriers to increasing and sustaining high levels of routine immunization coverage. It was designed as an innovative strategy to improve stagnating immunization coverage and effectiveness. Working closely with WHO, UNICEF, USAID, John Snow Incorporated (JSI), the US Centers for Disease Control and Prevention, and the Bill & Melinda Gates Foundation, MCSP has been central to the revision of the WHO Africa Regional Office’s RED guidelines. MCSP’s immunization team has played a vital coordinating role in the revision and, together with the child health team, has championed four new areas of focus in the revision of the guidelines. These include improving integration of other MNCH and nutrition interventions, addressing urbanization, supporting immunization across the lifecycle, and using an equity-based approach to go beyond geographical prioritization and help identify and address the needs of underserved and unreached individuals and communities.

The revised RED guidelines are currently at the pre-testing stage. Given its multi-country implementation experience, MCSP was called upon by partners to support it in two of the three pre-test countries: Kenya and Malawi. MSCP has also been a go-to source of tested tools and first-hand practices that have been incorporated in the revised guidelines, including experiences on infant tracking from Malawi, use of Geographic Information System (GIS) in microplanning from Nigeria, and Reaching Every Community Using Quality Improvement (REC-QI) micro-mapping tools to support routine immunization micro-planning in Uganda. Once finalized, the guidelines will provide the technical direction for routine immunization for all 47 countries in the African region. In addition, this would be the most recent update since 2008 and could serve as a catalyst for a review of the global RED approach.

**Finding:** MCSP’s senior technical staff are recognized as foremost leaders in RMNCH, particularly in the area of quality of care.
While there was general praise for MCSP as an entity, respondents, including external stakeholders and USAID/Washington, often cited individuals by name and noted the specific contributions of MCSP’s globally recognized thought leaders.

“MCSP has been an incredibly collaborative partner and the Immunization Team Lead’s technical expertise has been invaluable to the Ministerial Conference on Immunization in Africa and the development of the Roadmap. We would clone her if we could.”
— External stakeholder

“[The Maternal Health Team Lead] is a globally recognized thought leader in quality of care. MCSP has made a lot of progress in this area under her leadership.”
— Respondent, partner project

While not part of the evaluation team’s initial KII questionnaire, respondents cited MCSP’s leadership in the newly formed Quality, Equity, and Dignity Network as particularly instrumental. Under this effort, MCSP has supported the introduction and adaptation of the WHO Maternal and Newborn Health Quality of Care (QoC) framework in Nigeria, Madagascar, and Rwanda, utilizing their country platforms and global experiences to improve maternal and newborn care and outcomes. MCSP has also advocated to include a child health quality of care framework with child health-specific standards, quality statements, and measures.39 This is an example of MCSP’s ability to seize opportunities to integrate and take a more holistic approach to its work. Integration is discussed further under Evaluation Question 3.

“Over the last two years, MCSP has become one of WHO’s premier partners in maternal and newborn health. They have been especially instrumental in the new QoC initiative, and through their advocacy we have included greater focus on the child.”
— External stakeholder

**Finding:** MCSP’s network of country programs was cited as a unique asset in convening partners and drawing experiences from global and country levels.

MCSP plays a critical role in supporting USAID to carry out its own global leadership mandate within the RMNCH community, with a focus on ensuring that country implementation realities and experiences and emerging global best practices coalesce in support of EPCMD. USAID and other partners have called on MCSP to provide technical input, organize, and often co-convene a number of global and regional conferences and workshops in support of EPCMD, including the Accelerating Access to PPFP Global Meeting (Chiang Mai, Thailand, June 2015), the Global Maternal Newborn Health Conference (Mexico City, Mexico, October 2015), the Ministerial Conference on Immunization in Africa (Addis Ababa, Ethiopia, February 2016), Launch of the Network for Improving Quality of Care for Maternal, Newborn, and Child Health (Malawi, February 2017), and Institutionalizing Community Health Conference (South Africa, March 2017). Respondents frequently praised MCSP’s ability to draw from its vast network to convene critical stakeholders around a common agenda. MCSP’s capacity to lead the development of the agenda and relevant technical content, encourage and support participation from country partners and government counterparts, and provide critical follow-up to action items at country, regional, and global levels were highlighted as key strengths. MCSP’s unique ability among USAID implementing partners to provide logistical support to such large events around the world was also highlighted. While respondents recognized the importance of this support and the need for MCSP

to continue to serve in this role, several respondents also noted the significant level of effort required to support, organize, and execute large regional and global events and expressed concern that this LOE may, in some cases, detract from other important activities, without listing specific examples.

“Thanks to MCSP’s presence on the ground and understanding of local issues, they were helpful in preparing Ministers of Health and Finance for the first ever Ministerial Conference on Immunization in Africa. They also helped to convene a CSO side meeting, where we had representation from religious leaders, CSO members, and the First Lady of Ethiopia.” — External stakeholder

“The Institutionalizing Community Health Conference in South Africa represented a significant level of effort from MCSP at country and global levels, but it was a valuable contribution and will be remembered as a tipping point in community health.”
— Respondent, USAID/Washington

Another important aspect of MCSP’s global technical leadership has been carried out through support to the development of national policies. MCSP tracks the number of national policies drafted with its support in its global PMP.\textsuperscript{40} It defines national policies broadly to include national laws, policies, regulations, and strategy documents, including national service delivery guidelines and performance standards.\textsuperscript{41} By this definition, MCSP has reported support to 59 policies in 14 countries across the technical areas highlighted in Figure 9. The evaluation team could not discern the extent to which all 59 policies have been adopted, as the indicator measures “developed or revised”; the extent of MCSP’s involvement in the development or revision of these national policies is also unknown to the evaluation team.

Ministry of Health staff interviewed during the evaluation team’s country visits to Rwanda, Ghana, and Madagascar\textsuperscript{42} noted and praised MCSP’s capacity to introduce and adapt the latest policies, guidelines, and tools for use in their countries.

“We want to be at the forefront of introducing new policies, guidelines, and best practices into our programs and have benefited from MCSP’s support. When the new ANC guidelines were issued from WHO, MCSP supported us immediately to understand the revisions and the implications to our programs.” — Ministry of Health representative

\textsuperscript{40} MCSP global PMP, Indicator 37, p. 36.

\textsuperscript{41} Ibid.

\textsuperscript{42} Ministry of Health staff in other MCSP countries were not interviewed or surveyed.
Figure 9. MCSP’s Contribution to National Policies

- **Nigeria**: Task shifting—Use of Amoxicillin DT and Chlorhexidine at community level.
- **Haiti**: National WASH Policy
- **Tanzania**: One plan, new National CHW policy, strategy and RMNCH training curriculum will create Tanzania’s paid cadre of CHWs.
- **DRC**: New National Health Plan 2016-2020 will guide GFF Investment Case and national RMNCAH programs; updated IMCI and FP policies.
- **Ghana**: CHPs National Implementation Guidance
- **India**: Expansion of the FP basket: i.e. Centchroman, Injectable and Progestin-only Pill approved and included in the national FP basket.
- **Haiti**: National WASH Policy


**EQ2-Conclusion 2**
MCSP’s contributions to the development and revision of national policies are broadly defined and the program’s role in the policy development and revision process are not well captured in the global PMP.

**EQ2-Recommendation 2**: To facilitate greater understanding of MCSP’s contribution to the development and revision of national policies, the program should consider adding an indicator to measure the number of supported policies that have been adopted or utilized in the global PMP for Program Years 4 and 5. It should also look for opportunities to clearly and succinctly communicate its role in the development and revision of national policies.

**Finding**: Respondents had mixed perceptions of short-term technical assistance, but there is general agreement that Washington-based staff are “overworked.”

The evaluation team did not independently assess workflow and staff utilization patterns as a part of this SOW. However, four respondents from USAID/Washington, two external stakeholders, and one respondent from MCSP/Washington expressed concern that MCSP’s senior-most technical staff were “overworked” and that MCSP did not have a sufficient number of technical staff to respond appropriately to all technical needs, particularly at global and regional levels. The frequency of unsolicited comments of this nature from diverse sources led the evaluation team to investigate the issue further. When the evaluation team shared this finding with MCSP senior staff, it indicated that mid-level personnel had equally high workloads.
“Our budget is small from the MCSP perspective, but a big part of our budget. Our buy-in ends up being of individuals. When individuals aren’t available our work doesn’t move forward. The project should be able to respond if their individual staff member can’t for one reason or another.” — Respondent, USAID/Washington

In discussions with MCSP/Washington staff, it was clear they view MCSP county staff as an extension of the expertise at the global level, and they “consider the technical expertise within the project to be based in several places — not exclusively in Washington, D.C.” However, this understanding was not universal among respondents outside of MCSP. In one country the evaluation team visited, the Mission expressed concern about the use of MCSP country personnel to serve program needs in other countries, as it was perceived to deprioritize their own program’s work. The capacity of in-country technical staff was recognized as exceptional during the evaluation team’s country visits and evident in the review of the e-surveys from 15 additional countries. However, the evaluation team was unable to determine the extent to which country staff are providing South-to-South or regional technical assistance, even though this was a stated measure of cost containment in the initial program description.43

In addition to the perception of USAID/Washington respondents that Washington-based MCSP technical staff spend too much time focused on field activities, there were expressions of concern from Mission respondents about the high number of short-term technical assistance (STTA) visits to their countries, particularly when they felt local staff were more than capable of meeting their demands. This is not a unique or uncommon sentiment expressed by Missions buying into global awards; however, the clear tension in the perspectives of Missions and Washington/global levels suggests that the deployment of STTA could be more strategic to better meet the priorities and preferences of USAID stakeholders.

“The local staff are exceptional, yet we receive what seems like weekly notices of [short-term technical assistance] travel from Washington. It seems excessive and unnecessary.”
— Respondent, USAID Mission

EQ2-Conclusion 3
Global partners value and rely on MCSP’s ability to bridge the gap between global policy and best practice development and country-level advocacy, adaptation, and implementation; however, stakeholders express concern with the program’s bandwidth to manage all the demands on Washington-based staff.

EQ2-Recommendation 3: To enhance and harmonize its use of high-demand but limited Washington-based technical advisers, MCSP should increase and institutionalize regional or country-to-country models of support to meet technical assistance needs, where and when appropriate. Care should be taken to acknowledge and assuage concerns of Missions when drawing upon in-country staff in this way.

43 From program description, p. 58: “Maximize use of regional and local expertise to reduce costly travel from the U.S.”
EVALUATION QUESTION 3 (EQ-3): INTEGRATION AND CROSS-CUTTING AREAS

Evaluation Question: To what extent and in what ways has MCSP, as an integrated flagship RMNCH project, been successful in maximizing opportunities for comprehensive RMNCH platforms at the country and global levels?

Areas to consider include but are not limited to (Sub-questions):

1. Gaps or missed opportunities in integrating cross-cutting themes and across technical areas. (To improve the flow and organization of findings, we have broken this sub-question into two parts in the findings section below: EQ3.1a, “Gaps or missed opportunities in integrating across technical areas,” and EQ3.1b, “Gaps or missed opportunities in integrating cross-cutting areas.”)

2. Successes and challenges of MCSP in sustaining and strengthening health systems to support RMNCH programming

3. Advancement of community health and civil society engagement toward improved outcomes at the global and country levels

4. Extent to which MCSP’s program learning agenda is on track to provide strategic learning that will foster improved RMNCH outcomes across the continuum of care

Note that this question includes integration both of technical areas (e.g., MNCH, family planning, nutrition, malaria, WASH) and of cross-cutting topics (e.g., health system strengthening, community health and civil society engagement, quality, equity, gender, innovation). The question has both a technical and managerial component.

Introduction

This question, including its four sub-questions, is complex and multi-faceted. The eight “technical areas” within the MCSP context appear to align with the USAID Program Elements or defined Congressional earmarks; the seven “cross-cutting areas” appear a bit more fluid, depending on the document referenced. As such, USAID requested that the evaluation team consider the “cross-cutting” areas listed in Figure 10.

Figure 10. MCSP Technical and Cross-cutting Areas (15)

<table>
<thead>
<tr>
<th>Technical Areas</th>
<th>Crosscutting Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternal Health</td>
<td>1. Gender</td>
</tr>
<tr>
<td>2. Newborn Health</td>
<td>2. Equity</td>
</tr>
<tr>
<td>3. Child Health</td>
<td>3. Innovation</td>
</tr>
<tr>
<td>4. Immunization</td>
<td>4. Quality of Care</td>
</tr>
<tr>
<td>5. Family Planning</td>
<td>5. HSS</td>
</tr>
<tr>
<td>6. WASH</td>
<td>6. Civil Society Engagement</td>
</tr>
<tr>
<td>7. Nutrition</td>
<td>7. Community Health</td>
</tr>
<tr>
<td>8. Malaria</td>
<td></td>
</tr>
</tbody>
</table>

MCSP annual reports for Program Years 1 and 2 mention six additional technical and cross-cutting areas: private sector; social and behavioral change; eHealth/digital health; Global Development Alliances; strategic communications; and Zika. To manage the broad scope of this evaluation question, the evaluation team did not include these areas of work explicitly in the key informant line of inquiry related to this question. USAID specifically directed the evaluation team not to evaluate the GDA activities,
citing the desire to avoid overloading an already complex evaluation and noting that these activities are being evaluated through other means.\textsuperscript{44}

For the 15 technical and crosscutting areas identified, the team assessed MCSP’s efforts to maximize opportunities for comprehensive RMNCH platforms in the following ways:

1. Integrated and/or comprehensive approaches
2. Country and/or global level
3. Technical and/or managerial effort

**General Findings and Observations**

The broad scope of this evaluation question leads to a lengthy set of findings, conclusions, and recommendations, which are described below. Given the length and complexity of this evaluation question, conclusions and recommendations are consolidated by sub-question and can be found following the full set of findings for that sub-question. In many ways, this evaluation question overlaps with Evaluation Questions 1 and 2. To avoid redundancy, findings that are discussed in other sections of the report are not repeated here.

The breadth of Evaluation Question 3 and its four sub-questions did not permit the time for the evaluation team did not have sufficient time to delve deeply into any single technical area as a part of this evaluation. Additionally, with the diversity and complexity of MCSP, the evaluation team was not able to obtain a similar level of information about all aspects of this evaluation question (i.e., technical areas, cross-cutting areas, in addition to the six lenses through which USAID requested the 15 technical areas be assessed). To ensure full transparency, the narrative clearly identifies this limitation in places where the evaluation team was concerned about the limited information on which it had to base findings. Further analytic exercises are recommended if USAID wishes to have a deeper understanding of MCSP’s work in any one of the 15 technical and cross-cutting areas.

The methodological approach of this evaluation is qualitative, and the evaluation team was instructed to put little effort into quantitative data analysis. The team was asked, however, to use existing quantitative data when possible to triangulate and reinforce findings. When reviewing the program quantitative data for this evaluation, the team found much of the available data to be of little assistance for this purpose. The evaluation team has provided illustrative examples of why this was the case throughout Question 3, but notes that it was a general limitation applicable across all the evaluation questions.

**Finding:** There is not consensus as to whether MCSP has a mandate or an obligation to integrate RMNCH services.

Despite the repeated references to “integration” in the evaluation SOW, USAID/Washington and MCSP/Washington agreed during the March 21, 2017, midterm evaluation in-brief that the program was designed to be “comprehensive,” without an explicit requirement to integrate services. For the purpose of this evaluation, “integrated” and “comprehensive” are defined in the text box below.

\textsuperscript{44} Written correspondence between the evaluation team and the USAID evaluation manager, June 20, 2017.
Definitions

Comprehensive: The full set of interventions that should be available at the facility level, as defined by the Ministry of Health*.

Integrated: The combination of some services which were previously separate – for example the integration of HIV/AIDS and sexual/reproductive health activities†.

* Definition provided by USAID during evaluation in-brief, March 21, 2017

Key informants were asked whether they would describe the program as integrated or comprehensive. Results were mixed. Respondents closer to the design and management of the program (specifically, the USAID AOR Team and the MCSP Senior Management Team) felt that MCSP was comprehensive, and offered the capacity to work in all technical areas, without the mandate to integrate them.

“The project is not integrated, it is comprehensive. You want to achieve a top line goal. This project is the complete tool box needed to get to that goal. Not everything is needed everywhere, but every tool needs to be there to be flexible about the way that we problem solve.” — Respondent, USAID/Washington

Outside of this senior-level of management, however, respondents did not question the program’s mandate to support integrated RMNCH services. Respondents most frequently expressed that MCSP was somewhat integrated, citing both successes and missed opportunities to maximize opportunities for integration.

This lack of clarity about something so fundamental to the design of the program is likely driven by the way that country activities are funded. As described by respondents at all levels of USAID and MCSP, when a Mission decides to use MCSP, it provides the AOR Team with a project description (PD) that outlines the work it desires from MCSP. The program uses this PD as a blueprint for their activity design. For this reason, the degree of integration in a country program is largely driven by a Mission’s decision to buy into MCSP for comprehensive RMNCH programming, or more specific technical assistance, as well its level of focus and interest on integration.

“Requests from Missions is sometimes for an integrated platform, other times not. When Missions request integration [MCSP] provides it.” — Respondent, USAID/Washington

EQ3-Conclusion 1
The MCSP award does not mandate integration in all activities; however, de facto USAID stakeholders expect MCSP to integrate at every reasonable opportunity, and most operation-level key informants did not question the need to work toward integration. The conversation over comprehensiveness versus integration is largely between USAID and MCSP management teams, and is related to what the program should be held accountable for. It does not appear to be affecting the quality of programming, integrated or otherwise.

EQ3-Recommendation 1: MCSP should reconsider and carefully word any public statements to indicate that it is not “integrated” and does not have a mandate to be “integrated.” The discussion around this issue does not add value to USAID’s or MCSP’s communication about the good work that the program is doing to support the essential service package in RMNCH to the maximum extent possible.
EQ3-Sub-question 1, part a. Gaps or missed opportunities in integrating across technical areas

Finding: Generally, MCSP supports the provision of integrated services to the maximum extent permitted. Where there are gaps or missed opportunities, they tend to be due to external factors beyond the control of MCSP.

Despite MCSP management’s concerns about being held accountable for integration, there was consistent evidence that the program was maximizing opportunities to integrate services in the core technical areas of RMNCH. MCSP does not make a concerted effort to track integration as an outcome of interest; as such, the evaluation team did not make a significant effort to look into program data to ascertain the extent to which integration had been achieved. However, respondents consistently praised MCSP for integration efforts in RMNCH.

“[MCSP] is a leader in MNH integration. Integration is hard, they are making a valiant effort.” — External stakeholder

Question 1 provides additional details on successful scale-up of RMNCH interventions, including by definition integrated service provision.

Respondents familiar with MCSP’s nutrition activities cited a limited SOW for nutrition, related to facility-based services around pregnancy and delivery (e.g., supplementation, counseling, early and exclusive breastfeeding). Although USAID did not characterize nutrition as a gap or a missed opportunity, it cited its preference for the use of other “flagship nutrition” awards to meet community-based nutrition interventions and other aspects of IYCF practice promotion. This highlights a general finding of the evaluation team that is echoed elsewhere in this report: MCSP is not positioned to implement every type of intervention with the eight technical areas in its PD. Rather, its strategy is to focus on the 30 HIIs across the eight technical areas. Therefore, the absence of an intervention is not necessarily a gap or a missed opportunity — it could represent an activity that MCSP or a Mission does not consider to be within its mandate.

WASH was consistently cited as a technical area where MCSP’s work was limited. MCSP reports to have current or planned WASH programming in eight of 26 countries. All eight countries had facility-based WASH interventions, and three had community or household WASH interventions. Respondents recognized that the absence of good WASH impacts health outcomes. However, respondents also recognized the limitations of asking MCSP to expand its work in this area.

“We [included WASH in MCSP because we] wanted to make sure that WASH wasn’t forgotten about in MCH. In reality, it hasn’t been totally clear how to integrate it.”
— Respondent, USAID/Washington

Respondents cited two external reasons driving missed opportunities to integrate services within country programs: the verticality of ministries of health and Mission directives. MCSP’s ability to integrate RMNCH services is limited by the types of funding Missions provide and by each Mission’s focus. MCSP cannot support prevention of mother to child transmission of HIV (PMTCT) unless it has access to funds from, for example, the United States President’s Emergency Plan for AIDS Relief.

(PEPFAR), or support post-partum family planning without family planning funds. Similarly, in countries in which MCSP supports the health system by strengthening service delivery, national protocols, policies, and guidelines direct the level of integration of services and, therefore, the degree to which MCSP can support integrated service delivery. To a great extent, these drivers of programming are beyond MCSP’s control, and can result in missed opportunities to support integration and comprehensive service provision.

**EQ3-Conclusion 2**
Except for its limited focus on promoting WASH interventions, MCSP is maximizing opportunities for comprehensive RMNCH platforms that incorporate HIIs related to its technical mandate.

**EQ3-Recommendation 2:** MCSP should maintain the focus on preventing “missed opportunities” to provide mothers and children with care by supporting the most comprehensive service provision allowable within funding constraints.

**EQ3-Sub-question 1, part b. Gaps or missed opportunities in integrating crosscutting areas**
The response to this evaluation sub-question will also cover successes in integrating the crosscutting themes of equity, gender, and innovation. HSS as a cross-cutting area is addressed in Evaluation Sub-question 2. Community health and civil society engagement as cross-cutting areas are addressed in evaluation Sub-question 3.

| Finding: | Global and country-level management efforts to integrate programming have improved integration of the consortium partners; however, stovepiping is cited as inhibiting effective integration of cross-cutting areas. |

The MCSP management structure was revealed to be a contentious area of inquiry. The evaluation team presents its findings here, but recognizes that the issue would benefit from more probing and analysis than was possible under this evaluation. This is elaborated upon in the recommendations.

During KIIs for this evaluation, respondents from USAID and MCSP frequently sought the opportunity to offer their impressions of the award’s management structure. Very few KIs were in a position to view the program holistically. As such, they reflected on the management structure from their view of the program and interaction with it. However, taken together, the comments form a picture of tension and complicated organizational dynamics throughout the MCSP structure, but most acute at the central level.

The method by which work was assigned to a consortium partner was described several times to the evaluation team. The allocation process appears to involve a complex algorithm comprising four components: the lead partner in a country; the technical areas in the country project description (PDs); the lead partner for the technical area; and an “X factor,” such as pragmatism, Mission preference, or in a less congenial sense, competition between partners. Consequently, the “technical lead” consortium member, named in the award, retains a certain overall responsibility for MCSP’s work in that technical area, but at the country level the work is performed by a constellation of partners over which the lead partner has varying levels of control. Though the evaluation team found this complicated and fraught with a high potential for tension in the consortium, respondents at the country level and in Washington level felt this “matrix style” of work allocation and management was going well overall, and that consortium-related management tensions had declined, but were not absent.
“It takes time for the project to develop a consensus because of tension between the partners. This slows down implementation.” — Respondent, USAID Mission

In what seems to be an outcome of this matrix style, several themes emerged. First, in some cross-cutting areas there was a sense that the Washington-based teams were disconnected from the country work, and focused on implementing their own work plan. Examples respondents gave included the HSS and community health/CSO teams. The evaluation team noted that the focus of significant activities in these teams’ core work plans differed from the country programming, which could be driving this perception. Examples include the HSS team’s highly technical health financing work and the planning for the Institutionalizing Community Health Conference 2017 (ICHC). While these were clearly tied to the MCSP goal and country programming, the evaluation team can understand why respondents perceived this work to be distinct from more conventional country support work.

A second theme from interviews was that separate teams at the global level for crosscutting areas appear to make them function as separate technical areas instead of being truly integrated across and within programs. As an example, USAID/Washington technical respondents in many technical areas questioned if having a stand-alone gender team enhanced support to programming or created barriers to integration.

“I don’t see the MCSP as working on Gender. I don’t see the newborn team reaching out to gender folks. I don’t see it being mainstreamed. It seems like separate, stove-piped teams.”
— Respondent, USAID/Washington

“Having HSS as a stand-alone team undermines the desire to strengthen HSS in everything that they do. It is not [the HSS team’s] fault, the structure is the problem, not the tech ability of the partner.” — Respondent, USAID/Washington

The third theme that emerged was the idea that the agendas were being set by Washington-based technical teams, who were then trying to generate buy-in from Missions.

“The Community Health team at global level have struggled to have Missions buy in to their program” [emphasis added]. — Respondent, USAID/Washington

USAID Missions also described frustration with the “pushing” of ideas that were not of interest to them.

“They bring in lots of [temporary duty travelers – TDYers], who all bring in their pet projects. The Mission doesn’t appreciate that. HQ pushes specific things. The team on the ground gets distracted by ‘shiny new’ ideas from Washington.” — Respondent, USAID Mission

Finding: Quality of care is prominent across and within RMNCH programming.

Due to the near total integration of quality of care into the MCSP approach, the evaluation team’s comments on this area are integrated into Evaluation Question 1.

Finding: At the global level, MCSP has contributed to an elevated focus on equity in RMNCH. In country programs, equity integration is uneven.
MCSP was designed to have the principle of equity underlie all programming, as described in the PD and MCSP’s Year 1 Annual Report. As noted in its equity brief, the program proposed to incorporate equity into designs in three primary ways: 1) delivering RMNCH interventions in ways that improve equity and reach the underserved, 2); introducing and/or scaling up pro-equity interventions; and 3) providing data on the economic status of beneficiaries … enabling program managers to improve targeting of the underserved. In its Program Year 2 final report, MCSP identified four areas of intervention it considered to be equity approaches (Figure 11).

**Figure 11. Equity Approaches of MCSP**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaching Every District/Reaching Every Community (RED/REC)</td>
<td>Uganda, Kenya, Malawi, Nigeria, Tanzania, Zimbabwe, Madagascar, Liberia, India, Pakistan, Haiti</td>
</tr>
<tr>
<td>Advance Distribution of Misoprostol for Self-Administration</td>
<td>Mozambique, Haiti</td>
</tr>
<tr>
<td>Community use of chlorhexidine</td>
<td>Ethiopia, Mozambique</td>
</tr>
<tr>
<td>Integrated Community Case Management (iCCM)</td>
<td>Democratic Republic of the Congo, Rwanda, Mozambique, Zimbabwe, Kenya, Nigeria, Haiti, Burma</td>
</tr>
</tbody>
</table>

Sixty-seven percent of e-survey respondents (n=30) agreed or strongly agreed with the statement, “MCSP has advanced RMNCH equity towards improved outcomes at country level.” Respondents most frequently cited MCSP’s immunization support as an example of successful integration of equity into programming. MCSP reports to support Expanded Program on Immunization (EPI) activities in 12 countries. All respondents who discussed RED/REC agreed that by supporting scale-up of the RED/REC approach, MCSP was promoting equitable access to vaccination services. From the third quarter of 2014 to the fourth quarter of 2016, MCSP reported vaccination coverage in program-supported areas increased from 90 percent to 102 percent, which indicates substantial progress in coverage of this HII.

In its Year 2 Annual Report, MCSP reported that it supported iCCM, an equity-driven approach, in eight countries; as of May 2017, it reported supporting iCCM in four countries. Respondents cited MCSP’s activities to support efforts globally through the iCCM Task Force as an influential accelerator of that intervention. (See Question 2 for details.) However, at the country level, it was mentioned only in relation to activities in Nigeria, and does not play a prominent role in programming for the majority of the MCSP portfolio. Advance distribution of misoprostol for self-administration (ADMSA) and community-based use of chlorhexidine are reported to be implemented on a small scale through pilot

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46 “Equity in all aspects of design: All project design under RMNCH will be rooted in understanding who is and who is not accessing services, identifying barriers to access, targeting those least served.” MCSP award, p. 10.


49 Due primarily to poor estimations of eligible population, it is relatively common for Ministry of Health information systems to report immunization coverage of over 100 percent.

activities, and were not mentioned by respondents as dominant equity approaches promoted by the program.

Beyond immunization activities, respondents at all levels cited a lack of satisfaction with the level to which MCSP was addressing equity as a principle of programming. Two broad themes emerged that were perceived to drive this weakness: Mission preference and facility-based approaches.

“[MCSP] has struggled to address equity. They are not able to work with the most vulnerable because the Mission dictates where they work. But the project didn’t think through how to address equity within the parameters they were given. They’ve focused on financial equity, less on vulnerable groups.” — Respondent, USAID/Washington

“Access to hospitals is not equitable. Many things keep people from coming to hospital. But we can’t work in communities to improve equity and access because we don’t have a mandate from the Mission to work at that level.” — MCSP country staff

A significant missed opportunity emerged related to equity, but is applicable more broadly to intervention design. Key informants questioned why MCSP, with a clear mandate to improve equitable coverage of HII, focused on rural areas with low population density instead of underserved urban populations. Respondents cited USAID’s preference for rural-focused programming as the reason for this missed opportunity. Nonetheless, when prompted to discuss equity, a theme emerged suggesting that MCSP and USAID should consider the “value for money” in equity programming — that is to say, where can dollars invested result in the greatest equity gains?

“[MCSP] needs to focus on how best to reach out to the poorest of the poor. You can use $1 million to reach kids on the farthest mountain top, or you can use $1 million to reach more kids in a densely populated area. I think they have taken an equity approach in some areas, but need to look at efficiency/effectiveness measures on the equity approach.” — Respondent, USAID/Washington

**Finding:** Gender is reported by country programs to be mainstreamed as a guiding principle in MCSP approaches. However, this cannot be confirmed by project data, and missed opportunities exist. MCSP’s thought leadership in respectful maternity care (RMC), gender-based violence (GBV) and male engagement are recognized as strong and influential.

USAID’s defines gender terms in its 2012 Gender Equality and Female Empowerment Policy⁵¹ (see text box below). MCSP defines gender mainstreaming as “promotion of women’s empowerment and male involvement through civil society and community engagement [that] will help ensure robust, multi-layered integration of gender into all aspects of the program.”⁵²

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⁵² MCSP award, p. 10.
USAID’s policy clearly defines the roles and responsibilities of different actors in its programming environment toward meeting policy expectations for accountability. Of particular relevance to this finding is the expectation that USAID Missions “be accountable, through the Mission Director, for implementation of the Gender Equality and Female Empowerment policy in mission portfolios” and that Missions “hold implementing partners responsible for integrating gender into programming, developing indicators that measure specific gender equality goals for each activity, and consistently reporting to USAID on results related to gender equality and female empowerment.”

**Gender Definitions from USAID’s 2012 Gender Equality and Female Empowerment Policy**

**Gender equality** concerns women and men, and it involves working with men and boys, women and girls to bring about changes in attitudes, behaviors, roles, and responsibilities at home, in the workplace, and in the community. Genuine equality means more than parity in numbers or laws on the books; it means expanding freedoms and improving overall quality of life so that equality is achieved without sacrificing gains for males or females.

**Female empowerment** is achieved when women and girls acquire the power to act freely, exercise their rights, and fulfill their potential as full and equal members of society. While empowerment often comes from within, and individuals empower themselves, cultures, societies, and institutions create conditions that facilitate or undermine the possibilities for empowerment.

**Gender integration** involves identifying, and then addressing, gender inequalities during strategy and project design, implementation, and M&E. Since the roles and power relations between men and women affect how an activity is implemented, it is essential that project managers address these issues on an ongoing basis.

All of the 18 MCSP country programs that provided input to the evaluation team (15 through the e-survey and three through field visits) clearly articulated ways in which gender was embedded and mainstreamed in program activities. Country programs reported that gender sensitivity in pre- and in-service training of health care providers and community health workers (CHWs) was standard across their programming. MCSP’s global efforts to advance RMC, GBV, and male engagement is significant and appreciated by stakeholders.

In countries where MCSP is working as a comprehensive RMNCH implementer, country programs report success influencing and promoting gender-sensitive health service delivery throughout the system. However, the evaluation team found it difficult to objectively verify these claims with program data. MCSP identifies a country program as including a gender-specific activity if the work plan includes one of six interventions: GBV, gender policy, gender-sensitive services, gender studies/assessments, male engagement, and promoting gender equity/women’s empowerment. Twelve of 26 MCSP countries report working in one of these areas, but information on scale or depth of the work within a country was not available at an aggregate level.

MCSP’s global PMP includes three indicators to track gender. Anywhere from three to six program countries reported on any one indicator. The lack of data on gender activities at an aggregate level

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54 Number of people completing an intervention pertaining to gender norms that meets minimum criteria; number of countries where MCSP supported a gender analysis; number of countries that have integrated GBV screening
rendered the evaluation team unable to assess the extent to which MCSP has maximized opportunities for integrating gender into RMNCH platforms.

For gender, there are several missed opportunities that, if acted upon, could build on MCSP’s current programming. MCSP does not report working on gender in 14 of its 26 countries. This represents a missed opportunity, and would suggest that MCSP has not successfully integrated gender into more than half of its programming. Madagascar respondents felt that the program did not sufficiently engage men in family and reproductive health issues, which is also likely true in other country programs, as male engagement was reported to be an active component of programming in only seven of 26 countries. The lack of referral facilities for GBV was seen as a constraint to operationalizing GBV training the program was providing. In the e-survey of 19 programs in 18 countries, respondents were split on the question of whether “The MCSP has incorporated principles of gender equality and empowerment in the design and implementation of activities.” Approximately one-third “strongly agreed,” one-third “agreed,” and one-third were neutral or disagreed.

**Finding:** The innovation agenda for MCSP at the global level has been defined as advancing seven prioritized interventions in RMNCH, and has encountered challenges that have impacted the ability of these innovations to be scaled up on comprehensive platforms. However, country programs are viewed as very **innovative** in their introduction of RMNCH best practices on comprehensive country platforms.

MCSP adopted USAID’s definition of innovation, and USAID/Washington and MCSP/Washington selected seven “priority innovations.” MCSP’s mandate is to accelerate progress for these innovations along the pathway from conceptualization to scale. Key informants expressed frustration with both the limited scope of the innovation agenda and the innovations selected, suggesting that they created gaps and missed opportunities in programming.

“Too many of the innovations are solutions looking for problems. Also, they don’t seem ready for prime time. Innovations [have] been a problem around here. It is hard to work on. We were excited at first, but too many products were not ready.”
— Respondent, MCSP/Washington

“All we have done on this project is to track the seven innovations and observe how they have been implemented. We haven’t been able to expand beyond these seven. This is a missed opportunity for the project.” — Respondent, MCSP/Washington

“[MCSP] has tried very hard to roll out innovations, but it has been a struggle. We identified bubble cPAP [continuous positive airway pressure] as the next innovation to roll into ANC services with MCSP support. Source: MCSP global PMP.

55 “Novel business or organizational models, operational or production processes, or products or services that lead to substantial improvements in executing against development challenges. Innovations are not limited to products, drugs, or diagnostics, but could also include a novel approach or application of a technology, service or intervention.” [http://www.mcsprogram.org/our-work/innovations/](http://www.mcsprogram.org/our-work/innovations/).

56 Uterine balloon tamponade (UBT), bubble continuous positive airway pressure (bCPAP), pneumonia diagnostic, Reaching Every Community / Quality Improvement (REC/QI), possible serious bacterial infections (PSBI) guidelines, first time/young parents (FTP), gestational age estimation (GA).

57 MCSP legacy brief, “Innovation to Close Key Gaps in Coverage, Quality, or Equity.”
out. But it has been very difficult because of system constraints. There are lots of barriers to rolling out these innovations.” — Respondent, USAID/Washington

Of the seven priority innovations, uterine balloon tamponade (UBT) appears to have progressed the most along the scale pathway. The program reports to be working in Liberia, Laos, Nigeria, and Madagascar on introduction at scale, and reports plans to integrate it into standard PPH management across its priority countries.58 MCSP has introduced bubble continuous positive airway pressure (bCPAP) in select facilities in two countries (Zimbabwe and Nigeria), and plans to assess market potential in other MCSP countries.59 The five remaining innovations are reported to be in pre-introduction phases or early, small-scale pilot phases. The program does not expect these remaining innovations to move substantially past these phases within the remaining eighteen months of the award.60

Respondents viewed MCSP as extremely innovative at the country level, and praised it for bringing appropriate innovation to countries. Sixty-five percent of e-survey respondents,61 all of whom were based in the field, agreed that “MCSP has advanced RMNCH innovation towards improved outcomes at country level.” The interventions country-based key informants cited as innovative include post-partum family planning; newborn resuscitation; community-based distribution of misoprostol; low density/high frequency training; clinical governance; integration around the day of birth; and chlorhexidine for cord care. The seven “priority innovations” discussed above were not known to stakeholders outside of the few countries in which they were being studied or piloted.

“The program is always trying new things and if they work it scales up: the program is working within the departmental health offices with embedded staff, innovative pilots (misoprostol, model referral network, Zika ultrasound, HIV self-testing), Zika prevention, etc.).” — MCSP Country staff

“It is important to have core funding to test innovation solutions to MNCH programming. Field support funding should continue to target country specific solutions.” — MCSP country staff

EQ3-Conclusion 3
Gender and equity are partially integrated in MCSP’s programming, but missed opportunities exist.

EQ3-Recommendation 3: To ensure that the principles and equity are fully integrated into its technical interventions, MCSP should seek to apply a gender and equity lens to all future work planning. With regard to gender and gender drivers of inequity, the USAID AOR Team and MCSP should follow USAID’s Gender and Female Empowerment Policy62 to facilitate this process. Per this guidance, USAID Missions and implementing partners should support efforts to thoughtfully respond to gender and gender equity within country programs. With regard to other drivers of health inequity, USAID sub-sector strategies63 provide guidance on the equity principles Missions and implementing partners should

58 Legacy brief, “Innovation to Close Key Gaps in Coverage, Quality, and Equity.” March 2017. p. 3.
59 Ibid.
60 Ibid.
61 Total respondents n=30.
63 For example, the Maternal Health Vision for Action, p. 11; USAID Multi-Sectoral Nutrition Strategy, p. 16.
be considering when programming funding. These principles can similarly be used to facilitate greater integration of equity principles into program designs. Gender and equity should not be viewed as distinct technical interventions that require their own set aside funds. Rather, to best align with USAID policy and guidance, they should be included as a lens that is applied to all MCSP programming.

**EQ3-Conclusion 4**
A narrow definition of “innovation” constrains the program’s ability to fully convey its scope and success in this area.

**EQ3-Recommendation 4**: MCSP should continue to support USAID’s innovation agenda at the global level with USAID core funds. For country-level programming, innovation should continue to be defined by the country context, and remain focused on scaling up interventions (new or old) that will result in the greatest reduction of preventable maternal and child death per dollar invested. MCSP should broaden its innovation messaging to include the “context-appropriate innovation” that is being done at the country level, which is considered a hallmark of the program and fundamental to its success at the country level.

**EQ3-Sub-question 2. Successes and challenges of MCSP in sustaining and strengthening health systems to support RMNCH programming**

**Finding**: MCSP has experienced challenges in defining its HSS role and mandate.

The evaluation team collected significant primary data on HSS from field visits and KIIIs, and used it to arrive at this set of findings. It also held group meetings with MCSP, and reviewed documents and data. However, the evaluation team did not conduct individual interviews with USAID’s Office of Health Systems (OHS) or the HSS/Equity team at MCSP/Washington during the primary data collection, and acknowledges this as a significant shortcoming to the data collected.

Stakeholders at different levels described MCSP’s HSS work in two distinct ways. The majority of country-level respondents, including Missions, perceived MCSP’s role in HSS as focusing on filling gaps and strengthening three of the six WHO HSS building blocks: health workforce, health information systems, and leadership and governance. In a subset of country programs and at the Washington level, MCSP’s HSS work was recognized for taking a “systems approach,” understanding the interconnectedness between HSS functions that drives system performance and establishing mechanisms to identify and address bottlenecks to improve RMNCH outcomes. The latter work is led by the HSS/Equity team in MCSP/Washington. A general theme that emerged from key informants who understood MCSP’s work in both of these areas was that the program had struggled since inception from a lack of clarity as to where USAID wanted it to focus within the broad range of activities that are considered HSS. Consequently, respondents held views of the HSS work of MCSP that were largely dependent on their relationship with the program (field-based or Washington-based).

“There are different degrees of understanding [about HSS work]. USAID vision and expectations are not clear.” — Respondent, MCSP/Washington

**Finding**: MCSP’s health systems support for RMNCH service delivery is mainstreamed and highly regarded.
Supporting health workforce development (under HSS Dashboard columns “Human Cap Development-in-Service,” “Human Cap Development-Mentoring/Coaching,” and “Human Cap Development-Preservice”) and health information systems (under column “HMIS/HIS”) are core principles to MCSP’s approach and are found in 19 of 26 country programs. Seventy-three percent of e-survey respondents agree or strongly agree with the statement, “MCSP has advanced health systems strengthening towards improved RMNCH outcomes at country level.” MCSP’s comfort working within health systems to support service delivery and information management is clear in respondents’ descriptions of country-level work.

“We are working with the national [Ministry of Health] M&E team to pool and analyze data and report on PMP, followed by quarterly Action Plans at the National and District levels down to the facility level to ensure data quality and strengthen their capacity.”

— MCSP country staff

Respondents view MCSP’s position as a source of health systems support and HSS expertise that works at the sub-national level as a strength, and state that the program fills a need that is not addressed by other USAID global programs that work on HSS. MCSP’s HSS Dashboard reports working on sub-national planning and management in nine countries, with plans to expand to another five countries. MCSP’s HSS legacy brief, dated March 2017, states active programming in this area in seven countries.

“They have been effective in HSS and [quality of care] because they understand the health systems challenges in different settings very well.” — External stakeholder

“At district level and below, we are the only ones there. USAID’s big HSS projects don’t get to that level.” — Respondent, MCSP/Washington

**Finding:** MCSP’s systems approach to address system performance drivers is perceived to be of high quality, but underutilized.

USAID and MCSP respondents in Washington report that MCSP’s mandate to work on health system performance drivers related to finance and management originated from the request for applications and was based upon a request from OHS to build such capacity into the award. However, informants at USAID/Washington and MCSP/Washington report limited engagement OHS to date. MCSP expressed a desire to better manage its work in complementarity with other OHS efforts, and welcomed greater engagement from the office. OHS has other centrally funded awards that specialize in providing HSS technical assistance to governments. Several Missions said USAID’s Health Finance and Governance project was operating alongside MCSP to support HSS functions in the USAID portfolio in their countries. Feedback from Missions suggests that they prefer these OHS mechanisms to the MCSP for HSS work. OHS’ lack of engagement with MCSP since its inception, along with the fact that it manages its own awards that provide the same function, made the evaluation team wonder if HSS requests from Missions are being met through buy-in to OHS awards instead of MCSP. OHS was not interviewed for this evaluation, so the evaluation team could not confirm this hypothesis. However, this would explain...

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64 MCSP HSS Dashboard.

why MCSP, which is reported to do good work in this technical area, has not garnered much interest from Missions to undertake this type of work.

“If you are really trying to do [an] HSS activity, you are going to go with OHS award.”
— Respondent, USAID/Washington

With MCH funding, MCSP has developed two tools to identify and address health system bottlenecks: the Rapid Health Systems Assessment (RHSA) tool, which has been used in four countries, and the Comprehensive Approach to Health Systems Management tool, which has been used in two countries. MCSP has also conducted financial and costing analysis to inform country decision-making on the scale-up of HIIs in three countries. The feedback has been positive where MCSP has applied these skills; in Rwanda and Ghana, ministry officials felt the costing analysis was instrumental in helping the country understand the full implications of taking interventions to scale and allowed the government to plan for sustainability from the beginning. This clearly supports MCSP’s mandate to increase coverage of HIIs in a sustainable way. The limited scale of these activities, however, and lack of indicators on this work, makes it difficult for the evaluation team to make any conclusive statements on how and to what extent this work has contributed to maximizing opportunities for comprehensive RMNCH platforms or increased coverage of HII.

**Finding:** MCSP’s 11 HSS indicators in the global PMP have significant limitations and do not clearly or fully capture the HSS work described in country.

When reviewing the indicators for HSS, evaluation team identified several issues that made it difficult to triangulate the qualitative findings with quantitative data. First, the 11 HSS indicators, when taken in aggregate, do not provide significant understanding of how the health systems in which MCSP is working are functioning or improving over time with program assistance. Indicators are input- or output-based, emphasize the management of health information systems (four of 11 indicators) and civil society engagement (two of 11 indicators), and did not include any indicators related to addressing bottlenecks, health financing, or health workforce development.

The second concern the evaluation team identified was related to data quality. As shown in Figure 12, the data collected for and reported through these two HSS indicators fluctuated significantly from period to period. Under MCSP’s Indicator #24, for example, “Number of MCSP-supported health facilities actively implementing a QI [quality improvement] approach, by type of approach,” reporting from program countries varies between almost zero and nearly 6,000, with no clear trend line over time. This confusing picture is further complicated as MCSP reports 17,110 facilities “actively implementing a [quality improvement] approach” when the trend line never exceeds 6,000, and reports 744 facilities as of the fourth quarter of fiscal year 2016. Similar issues with erratic trend lines and conflicting results are seen in Indicator 44, “Percentage of MCSP target districts with regular feedback mechanisms supported by the program to share information on progress toward RMNCH health targets with community members and/or CSOs.” In the trend line, it varies from 100 percent to 58 percent between the fourth quarter of fiscal year 2013 and the third quarter of fiscal year 2016, though the program reports 44 percent. More questions arise when these figures are cross-referenced with MCSP’s Year 2 Annual Report (Figure 13), as the program reported 119 of 124 districts meeting this indicator across the seven countries reporting, which is equivalent to 96 percent compliance.
EQ3-Conclusion 5
The evaluation team recognizes that it is a difficult task to identify a reasonable and manageable number of high-quality indicators for a program of this size and scope, and MCSP has made a strong effort to set up good M&E systems. However, the HSS indicators do not provide the program with a sufficient program of how the health systems in which it is working are functioning or improving over time with MCSP's assistance.

EQ3-Recommendation 5: The evaluation team recommends adding indicators to the global PMP to capture MCSP’s “system drivers” work, which is led by Results for Development.

EQ3-Conclusion 6
The evaluation team’s ability to use program-derived quantitative data in this evaluation was limited due to concerns about data consistency and precision. These concerns were underscored by the variability in reporting by program source. This issue was widespread and not limited to only HSS data.

EQ3-Recommendation 6: MCSP should continue to refine M&E reporting systems to make publicly reported data more consistent. User-friendly “dashboards” and other attempts to increase transparency of program data should be reviewed to ensure that the take-away message understood by stakeholders is consistent and accurate.

EQ3-Conclusion 7
The role of HSS in MCSP remains unclear, largely due to an unclear mandate from USAID. Based on available information, HSS activities to date appear to have made important contributions to the
program goal despite the nebulous mandate. MCSP is positioned to contribute more in this area if provided the opportunity.

**EQ3-Recommendation 7:** To enhance MCSP’s understanding of its responsibility for integrating HSS into its technical initiatives, the USAID AOR Team should continue to try to clarify the program’s role in meeting broader Agency goals in HSS through dialogue with OHS and Missions. USAID should provide MCSP with a clear understanding of how its HSS capacity will be used in its remaining 18 months, and the approximate funding level for which it should plan. Despite MCSP’s current position to contribute to HSS needs in EPCMD in priority countries, if USAID does not intend to use the program for this purpose, then MCSP should consider how to be commensurate with the anticipated level of effort. Given the evaluation team’s understanding of the current budget environment, it is possible that this could mean a downward revision of HSS activities or the staff devoted to this work.

**EQ3-Sub-question 3. Advancement of community health and civil society engagement toward improved outcomes at the global and country levels**

**Finding:** Community health and civil society engagement is an approach that is broadly applied across country programs. Where it is not a component of the approach, its absence may limit the effectiveness of MCSP programming.

During the data analysis phase of this evaluation, it became clear to the evaluation team that this technical area was underrepresented in the primary data collection. The evaluation team did not see community health activities in site visits, and interviewed only two key informants with significant knowledge of this area of work. The timeline for the evaluation did not permit a second round of data collection. As such, this finding relies heavily on document review and other secondary sources.

MCSP’s goal in community health is “to accelerate the institutionalization of community health as a central component of country health strategies.” Community health and civil society engagement is an approach to improving RMNCH outcomes, rather than a technical intervention. In this way, its integration into programming is through designing programs that use a community health/engagement approach to deliver or stimulate demand for HIIs. MCSP uses a systems perspective to look at how to integrate child health/CSO engagement into programming, as depicted in Figure 14.

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In its legacy brief on community health and civil society engagement, MCSP describes activities in this area to work toward the following outcomes:

- At the global level, to influence policy-makers and donors regarding the importance of both community health and civil society engagement for strengthening national health systems, EPCMD, and achieving universal health care, especially among marginalized populations, in the context of the Sustainable Development Goals and targets.

- At the national level, to integrate community health and civil society engagement into national health programs and policies and build capacity for their implementation.

- At the district and community levels, to include civil society in local health resource allocation decisions, in mobilizing for improved health service use, in health service monitoring and accountability, and in directly engaging communities in the prevention and treatment of common illnesses and health risks.

The evaluation team identified community health/CSO engagement activities in 20 of MCSP’s 26 countries, indicating that this platform was broadly used in MCSP programs. Specific areas of engagement and promotion were cited in policy and advocacy, community health worker/CSO capacity building, and community mobilization. Figure 15 shows distribution of these activities across countries.

67 Ibid.
68 Bangladesh, Democratic Republic of the Congo, Egypt, Ethiopia, Ghana, Guinea, Haiti, India, Kenya, Malawi, Mali, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Rwanda, Tanzania, Sierra Leone, and Zimbabwe.
Figure 15. Distribution of Community Health Engagement/CSO Activities in MCSP Programming, by Type

<table>
<thead>
<tr>
<th>Activity Category</th>
<th>Countries Reported Working in These Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalization of community health in national policies and strategies</td>
<td>7 countries: Egypt, Ethiopia, Guinea, Mozambique, Rwanda, Sierra Leone, Tanzania</td>
</tr>
<tr>
<td>Capacity building of community health workers and community groups</td>
<td>17 countries: Bangladesh, Democratic Republic of the Congo, Egypt, Ethiopia, Ghana, Guinea, Haiti, Kenya, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Rwanda, Tanzania, Zimbabwe</td>
</tr>
<tr>
<td>Community engagement approaches to improve access, use and quality of RMNCH services</td>
<td>7 countries: Ethiopia, Guinea, Haiti, Mozambique, Rwanda, Tanzania, Uganda</td>
</tr>
</tbody>
</table>

While the breadth of programming using community platforms is captured in available data (with some degree of variation by source), the evaluation team found it difficult to determine the extent to which MCSP has used community health and civil society engagement platforms to maximize opportunities or advance comprehensive RMNCH platforms. Of the 20 MCSP countries working on these types of activities, only between two to 11 reported data on the six global indicators that capture data related to this area of work.

From the data available, a range of scale and coverage was observed among MCSP countries working in community health. For example, for MCSP PMP Indicator 36, “Percentage of MCSP target districts that have engaged CSOs to develop community health strategies that include institutionalization of CSO involvement,” coverage data from the eight countries that reported into this indicator ranged from 38 percent (Kenya) to 100 percent (Guinea, Malawi, and Rwanda). The evaluation team’s data collection process was not extensive enough to independently evaluate how many countries are implementing an activity that would qualify for reporting into this indicator, so the evaluation team was unable to determine how many countries were missing from the data reported.

Furthermore, as Figures 16 and 17 illustrate, similar findings regarding the few countries reporting and a wide variation in coverage were seen across indicators related to community health/CSO engagement. The evaluation team cannot draw generalizable conclusions from these data to inform the response to the evaluation question because of the lack of representativeness.

Figure 16. MCSP Tableau Reporting on the PPH Indicator on Community Health/CSO Involvement
MCSP country program staff from Egypt, Mozambique, Ghana, and Nigeria provided illustrative examples of how the program was working in communities, which helped to confirm information reported in MCSP’s annual reports. CSO engagement in the roll-out of RED/REC was repeatedly acknowledged as a strong and positive illustration of MCSP’s work to advance civil society engagement for improved health outcomes. Few USAID/Washington and Mission respondents commented on country-level community health work. This is perhaps due to a feeling among those who did discuss community health work that it has been difficult to interest Missions to use MCSP for community health work. This perception from USAID informants is at odds with the significant level of community health programming in which MCSP reports being engaged.69

When and where MCSP is not provided with the mandate to incorporate community work in its technical approach, its ability to increase coverage of HIIs can be hampered. In the circumstance directly observed by the evaluation team during field visits, MCSP’s mandate to increase coverage of HIIs was highly dependent on an increase in demand for services over which the program had little control. Without a demand generation and/or community mobilization activity to increase patient flow at MCSP-supported facilities, its ability to effectively increase coverage of HIIs is limited. The reason for this programmatic gap could be related to Mission directive, the presence of another USAID program with a community mandate, or other reasons related to national policies or priorities. In these cases, the lack of a community health component to stimulate demand and utilization of services makes it is difficult for MCSP to achieve its objectives or goal.

**Finding:** MCSP’s global-level community health/CSO engagement work has primarily focused on a large, global community health conference, at the request of USAID.

Respondents familiar with the MCSP/Washington community health global efforts reinforced extremely high-quality efforts to facilitate the planning of the Institutionalizing Community Health Conference, which took place in South Africa in March 2017. MCSP’s global leadership efforts in support of global and regional conferences and events are further discussed in Evaluation Question 2.

**EQ3-Conclusion 8**

There is evidence of a lack of clarity and understanding among USAID personnel in other technical areas as to the importance and role of community health in the EPCMD agenda. This may result in insufficient emphasis on community health in USAID requests for buy-in (e.g., in project descriptions).

**EQ3-Recommendation 8:** USAID should look for ways to increase understanding of community health in EPCMD programming among those primarily responsible for developing PDs and negotiating work plans with MCSP at the Washington and Mission levels. Possible avenues include webinars, state-of-the-art meetings, and Continuing Learning Points for AOR certification.

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EQ3-Conclusion 9
In a complex USAID portfolio in country, community health may be the mandate of another award. In these cases, MCSP does not necessarily need to take on the community health work, but the work must be well-coordinated to maximize effectiveness and impact.

EQ3-Recommendation 9: During scoping visits and work plan development, MCSP should review the community health landscape and identify needs and gaps in programming that must be addressed for its technical approach to be successful. Where the community health work is led by another award, careful consideration should be given to how the coordination function between the two programs will be handled. The USAID AOR should support MCSP to advocate to Missions when needed to ensure that the necessary coordination mechanisms are in place. (Note: The evaluation team recognizes that this is true in all technical areas. However, because the landscape of development actors at the community level can be very crowded, this recommendation is particularly important for community-level activities.)

EQ3-Sub-question 4. Extent to which MCSP’s program learning agenda is on track to provide strategic learning that will foster improved RMNCH outcomes across the continuum of care

The scope of this evaluation sub-question is narrowly focused on the “learning agenda” without reference to other program M&E activities. MCSP defines the “learning agenda” as 99 activities that include different types of research (e.g., process documentation, human subject research, and observational studies).70 However, the evaluation team offers one additional finding relevant to MCSP M&E and learning outside of the formal learning agenda at the end of this sub-question.

Finding: The learning agenda role and linkage with MCSP activities is not clearly understood by external stakeholders, nor by some within USAID.

All key informants interviewed by the evaluation team were asked about the learning agenda. No stakeholders interviewed external to the program or USAID provided comment on what the learning agenda was or how it was proceeding. Within USAID, some respondents indicated that they did not know what it was or that the learning agenda was not a part of their engagement with MCSP. The learning agenda is not perceived by most respondents to be well integrated into program activities.

“I have never heard of the global learning agenda.” — Respondent, USAID Mission

Finding: The majority of the studies in the learning agenda will not be completed in time to be used by the program to improve RMNCH outcomes.

During the evaluation team’s in-brief, USAID expressed a desire for the evaluation team to determine if the learning agenda was on track to produce results that could be used by MCSP to inform program activities and improve overall program impact.71 MCSP reports72 that 13 of the 99 learning activities in the learning agenda have been completed (Figure 18). Respondents reported that the time between study conception and start inhibited the timeliness of research, noting this delay was due to many layers of review and long turnaround times at many levels. This is a common weakness in research that

70 MCSP Year 2 Annual Report, p. 91.
72 MCSP Year 2 Annual Report, p. 91.
represents an ever-present tension between quality control and timeliness. Similarly, USAID said its formal USAID review process was put in place under MCSP as a quality control measure, based on experiences and concerns under MCHIP. However, it appears to have impacted the ability to complete the research-to-action cycle within the award’s life span.

“The proposal process takes a long time for approval so we only had one year to complete the research.” — External stakeholder, field

**Figure 18. Studies Reported to Be Completed by MCSP at the End of Program Year 2**

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of Studies</th>
<th>Title</th>
</tr>
</thead>
</table>
| Ethiopia (Basic Emergency Obstetric and Newborn Care) | 2 | • Assessment of Respectful Maternity Care Practice in Public Health Facilities of Ethiopia  
• The Effectiveness of a Blended Learning Approach for Basic Emergency Obstetric and Newborn Care Training in Ethiopia |
| Madagascar | 1 | The Status of MNH Services Delivery at Public Health Facilities in 15 Regions of Madagascar |
| Mali | 2 | • Seasonal Malaria Chemo Prevention Intervention  
• Introduce Chlorhexidine for Umbilical Cord Care |
| Mozambique (Bridge) | 1 | Process Documentation of the Helping Babies Breathe Approach and KMC Needs Assessment in Mozambique |
| Nigeria (MNCH) | 2 | Facility Assessment and Quality of Care Study in Ebonyi and Kogi States |
| Nigeria (Routine Immunization) | 3 | • Sokoto – Training Needs Assessment (Technical Report)  
• RI Diagnostic Study  
• Bauchi Community Partnership Assessment |
| Rwanda (EPCMD) | 1 | Health Facility Baseline Assessment |
| Tanzania | 1 | Knowledge, Practice, and Coverage Survey |

It was not within the evaluation team’s scope to determine the utility of each study undertaken as a part of the learning agenda. However, the completed studies appear largely relevant to local country programming, with limited utility to inform global policy or influence RMNCH outcomes at the global level. As such, the ability of these studies to contribute to improved RMNCH outcomes appears limited to their country context. Allowing time for program closeout, MCSP has 18 months of activity implementation. At this point in the award, it is difficult for the evaluation team to foresee how findings from the additional 86 studies underway could be used to substantially inform or alter MCSP activities in a way that would significantly contribute to improved RMNCH outcomes attributable to the program’s intervention and within its life cycle.

**Finding:** There is not consensus as to the goal of the learning agenda and whether MCSP has taken the “right” approach to systematic learning or struck the appropriate balance between learning and implementation.

Stakeholders who were involved in the design and/or request for an increased focus on learning in MCSP, including a formal learning agenda, articulated different visions for the purpose, utility, and function of the learning agenda. Respondents differed in their views on the balance between an agenda

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73 USAID AOR Team written correspondence, June 20, 2017.
that informs global thought leadership versus one that is country-owned and led. There was general agreement among stakeholders involved in the learning agenda that there is a need to balance implementation with the type of learning that contributes to global thought leadership in RMNCH. There was not agreement within USAID as to what the appropriate balance was for a program like MCSP. Therefore, it was difficult, if not impossible, for MCSP to understand, reconcile, and meet the varying expectations. Consequently, there appears to be a general level of dissatisfaction with the balance that has been struck in MCSP to date.

“They are repeating the same mistake under MCHIP in terms of managing their learning agenda. They should have found the handful of things (issues) that are going to change the landscape — the ‘seminal’ things. They should be able, at the end of the project, to say that, had the project not existed, advancements on these issues would not have occurred.”
— Respondent, USAID/Washington

“We are the ones who insisted on global learning agenda topics. When are we going to scale this up? When are we going to apply what we have learned? Maybe there are too many research questions. I want them to roll out things. I get a sense that there are too many studies.”
— Respondent, USAID/Washington

By contrast, another respondent noted,

“The real place for them to make an impact is on field support. I think it needs to be the country’s learning agenda, and then we follow. Helping countries be able to own, learn from, and use their learning is more important and more valuable than arriving at particular global questions to be answered regardless of whether or not it is important for those countries.”
— Respondent, USAID/Washington

**Finding:** Some learning agenda questions have the potential to result in groundbreaking evidence to improve RMNCH outcomes.

The evaluation team was very impressed with some of the innovative learning being done under the learning agenda. Examples include the testing of an indicator monitoring stillbirth and very early newborn death in Tanzania to address a major gap in identifying a correct indicator for quality of intrapartum care; a study on the impact of integrated ENC and BEmOC training on provider competence in newborn care in Ethiopia and Nepal; and maternal perinatal death surveillance and response and other forms of audit in Zimbabwe, Rwanda, Nigeria, and Tanzania. Respondents who had some understanding of studies included in the learning agenda felt that those studies were relevant and meeting an expressed need of the stakeholders.

**Finding:** MCSP’s ongoing vertical and horizontal information sharing is an example of real time project learning and is well-regarded by stakeholders at all levels.

As discussed in Evaluation Question 2, MCSP’s ability to share learning in real time from the global to country level and vice-versa was heralded as unique and irreplaceable. Ministry of Health officials and USAID Missions greatly appreciated the program’s ability to quickly bring global best practices to country settings. Similarly, global stakeholders greatly appreciated the perspective that MCSP can bring to global meetings, reminding people who operate far away from field realities just how complicated it can be to roll out best practices in country contexts.
“Having a country level reality check at the global level is really important. It is easy to sit in a capital city in the north and forget how hard it is to do things in these countries. They bring that point of view.” — External stakeholder

Similarly, MCSP country programs appear to be engaged with one another, sharing lessons and problem-solving in real time in an effort to maximize results across the program. Webinars and regional meetings, as well as informal connections between country programs, were provided as examples of how country programs share relevant information in timely ways.

“MCSP has provided forums where country teams share experiences and learn from each other. There are also new approaches infused to country work plans … providing the country with learning opportunities as well.” — Respondent, USAID Mission

Additionally, the evaluation team saw clear examples of other donors and/or programs adopting MCSP materials to harmonize and ensure international standards of practice in the countries visited. This represents a third type of real time learning that is not well documented by the program.

“We need to do a better job of documenting these things that we see happening in the field where other projects are taking up work based on our learning.”
— Respondent, MCSP/Washington

**EQ3-Conclusion 10**

Much of MCSP’s formal learning agenda will benefit future programming, not programming within the MCSP lifespan.

**EQ3-Recommendation 10**: To enhance the learning agenda’s potential benefit to RMNCH priorities within the life of the program, MCSP should begin planning now for how it will document and robustly disseminate findings and manage the knowledge from the significant number of studies that will conclude near closeout. Dissemination should not be truncated due to time constraints. This should be managed as a priority of the final year work plan, with measures of accountability in place and an agreed-upon a priori definition of what would constitute a successful dissemination process.

**EQ3-Conclusion 11**

Significant, high-quality, real time learning is taking place within the program and between MCSP and other development partners in country, but documentation on this is limited.

**EQ3-Recommendation 11**: MCSP should develop a clear plan to document its lessons learned and best practices for real time learning in programs of a similar size, and include this in its dissemination plan (mentioned above). This is an important component of the program’s knowledge management, and future programs should be able to learn from and build on this experience.
For more information, please visit

http://ghpro.dexisonline.com/reports-publications
ANNEX I. STATEMENT OF WORK

Assignment #: 341 [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: December 12, 2016
Last update: February 14, 2017
Amendment #1: August 14, 2017

I. TITLE: Mid-term Evaluation of the Maternal and Child Survival Program

II. Requester / Client
USAID/Washington Office/Division: GH / MCHN

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): March 10, 2017
Anticipated End Date (on or about): September 8, 2017

VI. Location(s) of Assignment: (Indicate where work will be performed)
Washington DC; 4 countries selected depending on Mission interest and feasibility - Madagascar, Ghana, Rwanda

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)

- Baseline
- Midterm
- Endline
- Other (specify):

  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)

<table>
<thead>
<tr>
<th>PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> If PEPFA-funded, check the box for type of evaluation</td>
</tr>
</tbody>
</table>

- **Process Evaluation** (Check timing of data collection)

  - Midterm
  - Endline
  - Other (specify):

  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)

  - Baseline
  - Midterm
  - Endline
  - Other (specify):

  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:

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Maternal and Child Survival Program (MCSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Number:</td>
<td>AID-OAA-A-14-00028</td>
</tr>
<tr>
<td>Award Dates:</td>
<td>March 17, 2014 to March 16, 2019</td>
</tr>
<tr>
<td>Project Funding:</td>
<td>$560,000,000 ceiling</td>
</tr>
<tr>
<td>Implementing</td>
<td>Jhpiego (prime), consortium members include JSI, Save the Children, PATH, ICF, R4D, PSI, Core Group; associate partners include Broad Branch Associates, Avenir Health, JHU BSPH, and Communications Initiative</td>
</tr>
<tr>
<td>Organization(s):</td>
<td>Nahed Matta</td>
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</tbody>
</table>

#### Background of project/program/intervention:

**Background**

With 210 million women becoming pregnant each year, and 140 million newborns delivered, maternal and child health is an imperative concern for global development. In 2015, the UN estimates that 303,000 maternal deaths occurred around the world, which represents an over 40% fall in maternal mortality over the last 25 years. Since the 1980s, the annual number of under-five deaths has declined from an estimated 13.5-15 million (levels that would be higher now, taking into account the increased numbers of births each year) to about 5.9 million. Of these, 44% died in the neonatal period and 51.8% died of infectious causes. This progress, however, has been uneven. Least progress has been made in sub-Saharan Africa, where some countries have actually seen worsening of maternal and child mortality. Many countries of southern Asia also continue to have large numbers of newborn, infant, and child deaths. In all regions, inequity in access and use of essential health services is a major issue, with poor and marginalized segments of the population significantly underserved. The causes of mortality and morbidity are increasingly diverse and require a range of healthcare services, including addressing unmet need for family planning, to match needs with quality care.

**USAID programming**

One of the overarching goals of USAID/GH is on Ending Preventable Child and Maternal Deaths (EPCMD). USAID maternal and child programming focuses geographically on 25 countries where 70% of maternal and child deaths occur; however, there are a number of additional countries which receive MCH funds. The USAID Bureau for Global Health (USAID/GH) has been funding maternal health operations research and programs since the 1980s. In 2008, USAID/GH funded the flagship Maternal and Child Health Integrated Program (MCHIP) which worked in more than 50 developing countries to improve maternal, newborn, child health, immunization, family planning, nutrition, malaria, and HIV/AIDS. MCHIP focused on addressing the barriers to accessing and using key evidence-based interventions across the life stages—from pre-pregnancy to age 5—by linking communities, primary health facilities and hospitals. MCHIP supported countries to identify and focus on the delivery of evidence-based interventions through strengthening government health systems, nongovernmental organizations and other local partners. MCHIP’s successor project is MCSP, launched in 2014. MCSP is a centrally-managed project that strives to deliver a full range of high-impact, evidence-based reproductive, maternal, neonatal, and child health (RMNCH) and nutrition interventions through an integrated approach as appropriate. The ceiling is $560M; majority of these funds are field support from Mission buy-ins for one or more of the technical elements. The goal of MCSP is to accelerate intensive reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. As stated in the Program Description of the MCSP award, MCSP’s vision is of “self-reliant countries equipped with analytical tools, effective systems and technical and management capacity.
“to eliminate preventable maternal, newborn, and child death.” Beyond a commitment to focus geographically on the USAID MCH priority countries, MCSP works to increase efforts to achieve equitable health coverage for high-burden populations, apply high-impact solutions to the most important causes of maternal mortality and under-five deaths, exploit efforts in other sectors to foster an enabling environment for improved RMNCH outcomes, and ensure mutual accountability for ending preventable child and maternal deaths.

MCSP will contribute to reduction in maternal, neonatal, and child mortality with a focus on USAID’s 25 MCH priority countries by:

<table>
<thead>
<tr>
<th>MCSP Program Objectives, as stated in MCSP Program Description</th>
</tr>
</thead>
</table>
| **OBJECTIVE 1:** Support countries to increase coverage and utilization of evidence-based, high-quality RMNCH interventions at the household, community and health facility levels | 1.1 Country programs are empowered with the analytical information needed to identify and implement the most effective and appropriate interventions to reduce MNC mortality rates  
1.2 High-impact RMNCH interventions—integrated with nutrition, malaria, HIV/AIDS and water, sanitation and hygiene (WASH) as appropriate—are effectively scaled up through the public and private sector health system in priority countries  
1.3 RMNCH outcomes are improved through a focus on quality in facility and community-based service delivery  
1.4 RMNCH programs within the health system are effectively reinforced by behavior change interventions that increase essential RMNCH behaviors  
1.5 The objectives of USAID’s Public-Private Partnerships for RMNCH (including but not limited to Mobile Alliance for Maternal Action, Helping Babies Breathe, Saving Mothers, Giving Life, Survive and Thrive, and mPowering Frontline Health Workers) are supported |
| **OBJECTIVE 2:** Close innovation gaps to improve health outcomes among high-burden and vulnerable populations through engagement with a broad range of partners | 2.1 Innovative technologies and equity-focused approaches are applied at scale to improve RMNCH service availability, access, quality, demand, cost-effectiveness and utilization  
2.2 eHealth solutions for improved equity in RMNCH programs are incorporated in a systematic way to country health systems |
| **OBJECTIVE 3:** Foster effective policy, program learning, and accountability for improved RMNCH outcomes across the continuum of care | 3.1 USAID’s leadership role in global RMNCH dialogue is supported and reinforced  
3.2 Knowledge generation, management and use strategies are implemented to support global, regional, national and local learning and decision-making needs and to advance RMNCH priorities  
3.3 Civil society, local institutions and communities are strengthened and engaged at the global, regional, national and local levels to improve accountability and enhance responsiveness of health systems to local and community health needs |
As USAID's flagship MNCH project, MCSP's platform strives to support countries to increase coverage and utilization of high quality interventions. MCSP's integrated design offers an opportunity for Missions to tap into a diverse range of technical expertise from one project to address specific technical gaps or to offer an integrated program covering RMNCH, as well as malaria and HIV/AIDS to achieve greater efficiency and reduced management burden. MCSP's leadership at the global level is also expected to raise global interest, support global policy and strategy formulation through participation on global steering committees and working groups informed by past and current field experience, collaborate with existing alliances and partnership to advance RMNCH programming, innovations and learning.

MCSP brings together a partnership of organizations with demonstrated experience in addressing maternal, newborn, child health, nutrition, malaria and HIV/AIDS issues. Each partner takes the lead in developing programs around specific technical areas. The MCSP consortium includes:

- As the prime, Jhpiego leads on maternal health, RH/FP, elimination of mother-to-child transmission of HIV (EMTCT), Malaria
- JSI leads on child health, immunization, pediatric HIV, and health information systems
- Save the Children leads on newborn health, WASH, adolescent health and community mobilization
- PATH leads on nutrition
- ICF leads on CSO strengthening and community health
- R4D leads on health systems strengthening and equity
- PSI leads on private sector and social marketing
- Core Group - NGO/CSO engagement, dissemination

Of note, multiple partners support digital health efforts. In addition, MCSP has four associate partners who provide specialty expertise:

- Broad Branch Associates - performance incentives,
- Avenir Health - modeling and costing,
- JHU BSPH - implementation science and LiST
- Communications Initiative – polio outreach and networking

Interventions supported under MCSP respond to all the MCH sub-elements from the Foreign Assistance program structure hierarchy, focusing on the following: Birth Preparedness and Maternity Services; Treatment of obstetric complications and disabilities; Newborn care and treatment; Immunization; Maternal and young child nutrition, including micronutrients; Treatment of child illness; Household level water, sanitation, hygiene and environment; Building host-country information capacity; Program design and learning. MCSP also contributes to several sub-elements of the Family Planning/Reproductive Health, Malaria, Other Public Health Threats (Zika, Ebola), and HIV/AIDS Elements.

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

If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

From the MCSP Program Description:
What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

MCSP currently implements 44 programs in 26 countries (plus one country where work is expected to be starting up), with a focus on EPCMD priority countries. Currently MCSP works in Burma, DRC, Egypt, Ethiopia, Ghana, Guatemala, Guinea, Haiti, India, Kenya, Laos, Liberia, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Pakistan, Rwanda, South Africa, Tanzania, Uganda and coordinates with three active Associate Awards under the MCHIP project in Bangladesh, Pakistan, and Zimbabwe.

IX. Purpose, Audience & Application

A. Purpose: Why is this evaluation or analysis being conducted (purpose of analytic activity)?

Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this activity is to provide the United States Agency for International Development’s (USAID) Bureau for Global Health Maternal and Child Health and Nutrition Office (MCHN) with an independent mid-term performance evaluation of the Maternal and Child Survival Project (MCSP). MCSP is a five-year global project that began on March 17, 2014 and will end on March 16, 2019. As the project is half-way through implementation, the GH/MCHN office is commissioning this mid-term evaluation to examine the project’s progress towards achieving planned results and lessons learned to date. The evaluation team will identify MCSP activities that may warrant continued future investment, as well as other RMNCH interventions and activities that would likely contribute to improvement of the project. Through analysis of MCSP’s progress and achievements at the mid-point of the project, this performance evaluation will make recommendations to improve implementation during the Years 4 and 5 of the project and will be used to guide USAID on the design of follow-on awards beyond the MCSP life of project. The evaluation will address whether the program is in fact achieving its objectives as
stated in the original award and contributing to the GH’s and Mission’s needs for a wide range of technical areas.

The overall goals of this evaluation are to:

1. **Assess whether MCSP is achieving its objectives and planned outputs as stated in the MCSP agreement’s program description and in approved implementation plans.** The evaluation will determine qualitatively whether MCSP is on target to achieve the goal of the project: to accelerate reductions in maternal, newborn and child mortality with increased equity to end preventable maternal and child deaths, as well as 3 objectives:
   a. Objective 1: Support countries to increase coverage and utilization of evidence-based, high-quality RMNCH interventions at the household, community, and health facility levels
   b. Objective 2: Close innovation gaps to improve health outcomes among high-burden and vulnerable populations through engagement with a broad range of partners
   c. Objective 3: Foster effective policy and program learning and accountability for improved RMNCH outcomes across the continuum of care

2. **Make recommendations to improve implementation of the current program and to inform follow-on projects.**
   a. The evaluation will assess whether MCSP is supporting USAID’s objective to equitably scale up and sustain coverage and utilization of evidence-based high-quality RMNCH interventions and if so, offer recommendations to improve implementation of the current program. It will also identify opportunities for MCSP to better align with key priorities of EPCMD and global initiatives such as the SDGs and UNSG Global Strategy for Women’s, Children’s, and Adolescent’s Health, and promote the most recent advances in RMNCH interventions during the remaining period of the project.
   b. For internal use: the evaluation will make recommendations on the project design that USAID will consider for follow-on awards.

**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 USAID AOR team, and USAID MCHN staff and MCSP staff and partners will be the primary users of this report. Mission Health teams, host country governments, in-country beneficiaries of MCSP activities, and other offices in the USAID Global Health and Regional Bureaus are also target audiences of the larger public report.

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

The evaluation report will be available publicly in the Development Experience Clearinghouse (DEC) and will be shared with participants in the evaluation and other missions who are currently buying into the MCSP project. The recommendations from this evaluation will be used to inform implementation plans for Years 4 and 5 of the MCSP project and the design of follow on project(s) to end preventable maternal and child death (EPCMD). Any lessons learned or best practices in support of EPCMD may be shared with other offices in USAID’s Global Health Bureau, Regional Bureaus, and Mission Health Teams for possible adoption or adaptation to other health programming. Mission teams will be encouraged to share lessons learned and best practices with their in country partners and governments. USAID may also use the report to demonstrate and advocate for best practices with other donors, US and UN sister agencies, and other international stakeholders.

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74 Not all objectives are weighted and funded equally. Objective 1 receives the greatest amount of attention and funds
### X. Evaluation/Analytic Questions & Matrix:

a) Questions should be: a) aligned with the evaluation/analytic 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/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Suggested methods for answering this question</th>
<th>Sampling Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What data sources and data collection and analysis methods will be used to produce the evidence for answering this question?</td>
<td>Who is the best source for this information? What is the sampling criteria?</td>
</tr>
</tbody>
</table>

To the extent it is meaningful to do so, the team should specifically consider each of the program’s main technical areas—maternal health, newborn health, child health, immunization, family planning, nutrition, and malaria—as they address the questions below; and tailored to country context where possible.

#### 1 Country Results

To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality RMNCH interventions?

**Areas to consider include but are not limited to:**

a. The extent and ability of MCSP to support country programs to increase coverage of appropriate interventions

b. The strengths and limitations of MCSP-supported activities/interventions towards achieving expected project results

c. Missed opportunities or gaps

**Note that there is a technical and managerial aspect to answering these questions. All activities at country level should be considered (both core and field funded).**

<table>
<thead>
<tr>
<th>Main data sources:</th>
<th>WHO, UNICEF, UNFPA and other UN staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>- key informant interviews</td>
<td>- individuals working on global initiatives</td>
</tr>
<tr>
<td>- group interviews/ focus group discussions</td>
<td>- MCSP staff</td>
</tr>
<tr>
<td>- surveys</td>
<td>- USAID staff</td>
</tr>
<tr>
<td>- project documents</td>
<td>- USAID staff in Missions and in DC</td>
</tr>
<tr>
<td>- field visits including service delivery record reviews</td>
<td>- Key stakeholders such as NGO and public and private sector</td>
</tr>
<tr>
<td>- review of program and country-level data as appropriate/ feasible</td>
<td></td>
</tr>
</tbody>
</table>

#### 2 Global Leadership

To what extent and in what ways has MCSP contributed to key programs, priorities and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives (such as EPMM, ENAP, GAVI, GFF)?

<table>
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</tr>
<tr>
<td>- field visits</td>
<td>- USAID staff in Missions and in DC</td>
</tr>
<tr>
<td>- MCSP published reports and articles</td>
<td>- Key stakeholders such as NGO and public and private sector</td>
</tr>
</tbody>
</table>
### Areas to consider include but are not limited to:

| a. Missed opportunities or gaps in MCSP’s global leadership efforts |
| b. How MCSP is linking country-level learning to inform global-level engagement and vice versa |

- Review of global initiative documents and reports
- Review of WHO policies and guidelines where MCSP has contributed
- Review of MOH policies related to MCH in which MCSP has contributed

#### Main data sources:
- key stakeholders

### Integration and Cross-cutting Areas

3 **Integration and Cross-cutting areas**

To what extent and in what ways has MCSP, as an integrated flagship RMNCH project, been successful in maximizing opportunities for comprehensive RMNCH platforms at the country and global levels?

**Areas to consider include but are not limited to:**

| a. Gaps or missed opportunities in integrating cross-cutting themes and across technical areas |
| b. Successes and challenges of MCSP in sustaining and strengthening health systems to support RMNCH programming |
| c. Advancement of community and civil society engagement towards improved outcomes at the global and country levels |
| d. Extent to which MCSP’s program learning agenda is on track to provide strategic learning that will foster improved RMNCH outcomes across the continuum of care |

**Note that this question includes integration both of technical areas (MNCH, family planning, nutrition, malaria, WASH, etc.), and of cross-cutting topics (health system strengthening, community and civil society engagement, quality, equity, gender, innovation, etc). There is both a technical and managerial component to this question.**

**Main data sources:**
- key informant interviews
- group interviews/ focus group discussions
- project documents
- surveys
- field visits

### Future Mechanisms (for internal use):

4 **Future Mechanisms (for internal use):**

How could follow-on global project(s) be structured differently to better support Agency needs? This could include technical content, USAID’s and/or MCSP’s management approach, defining targets and expected results, etc.

**Areas to consider include but are not limited to:**

| a. How synergies and coordination could be enhanced in the design of future mechanisms |

**Main data sources:**
- key informant interviews
- focus group discussions with USAID Mission and DC-based staff
- survey to USAID staff
- project documents
- field visits

**Main data sources:**
- Ministry of Health officials
- healthcare providers
- MCSP staff
- USAID staff
- key stakeholders such as local and international NGOs and private sector organizations
- between core and field investments of MCSP and;
- between MCSP investments (core and field funded) and other USAID projects

b. Components of the MCSP project design should be reconsidered by USAID in future iterations because they did not flourish under MCSP (based on lack of buy-in or substantial challenges in implementation)
c. The potential role of the private sector engagement

### XI. Methods

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

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

The focus of this evaluation will be on countries where there is a field visit and countries for which in-depth phone interviews occur. However, this evaluation is not limited to only these countries. To the extent that it will help answer questions, the evaluation team will review program data and consider results of a survey sent out to all MCSP countries which will provide a snapshot of performance across all MCSP countries, and possibly select key informant interviews.

**Field Visits:** Prior to convening the evaluation team, USAID/AOR team, in consultation with MCSP Executive Management Team (EMT), will agree on a list of countries for site visits. The evaluation team is expected to travel together to four countries. The evaluation team is expected to split into two sub-teams so that each pair travels to two countries. The four countries were selected based on the following criteria:

- At least one country with a significant amount of field support funding (between $20M-$30M for life of program budget) invested in MCSP and one or two countries of medium-level field support funding investment (between $5M-$15M), countries that had at least 2 years of implementation Countries which work across two or more technical areas (MNH, CH, Imm, FP, Nut, Malaria, HIV)
- At least one country which had previously bought into the precursor, MCHIP, for technical assistance.
- At least one country where MCSP is functioning as the mission’s primary health bilateral
- Appropriate country and program diversity
- Countries in which missions have reported challenges to the MCSP AOR.
The countries recommended for site visits and confirmed by the respective USAID Missions include Madagascar, Nigeria, Rwanda, Ghana. The full team (of which, two will be GH Pro consultants and two USAID staff) will split into two teams and each team will visit two countries.

The evaluation team is expected to interview project staff, USAID/W (AOR and extended technical teams) and Mission Health Office staff, other implementing organizations, Ministry of Health staff, and MCSP partners (including local NGOs, public sector representatives, private sector representatives, etc., and other key stakeholders in visited countries, in addition to reviewing project reports and documents. Points of contact for each country will be identified by USAID and MCSP staff. The three to four missions will be notified of the planned evaluations by USAID.

Additional countries identified for phone interviews include: Kenya, DRC, Ghana, Burma, Malawi, Uganda, Mozambique, and Tanzania. Other countries may be considered for a phone interview.

Data collection and analysis should be primarily qualitative. The evaluation team should consider qualitative analysis of the timeliness, quality, and completion of MCSP’s technical assistance to USAID Missions, host governments, and other partners compared with missions’ expectations, disaggregated by program size and other relevant factors. Limited quantitative analysis to add value to qualitative results may include an aggregation of survey monkey interview data (if appropriate) or a review of available HMIS data and comparisons of achievements against targets for key output indicators to date using global and country PMPs.

USAID country mission staff and MCSP country teams will provide guidance and assistance in the following areas to facilitate and ensure timely completion of the site visits:

- Arrange in-briefing and debriefing at the USAID country mission
- Identify in-country key informants and relevant contact information
- Introduce consultant team to project partners, local government and other stakeholders, as appropriate
- Arrange appointments with relevant government officials and accompany the consultant team on these interviews, as appropriate.

Beyond countries selected for field visits and phone interviews, the evaluation team will incorporate data from a wider range of MCSP countries (including an example of a country which did not select to buy-into MCSP) via document review, surveys, and interviews as needed.

### Document and Data Review

This desk review will be used to provide background information on the program, and will provide data for analysis for this evaluation. GH/MCHN and/or MCSP will provide the evaluation team with a package of briefing materials related to the MCSP mid-term evaluation. Documents and data to be reviewed include, but not limited to:

- The USAID Request for Applications (RFA)
- MCSP Award (including program description) and relevant Modifications
- MCSP global and country-level Performance Management Plans (PMP)
- MCSP management reviews
- MCSP Facility Assessments, particularly for any facility the Evaluation Team is to visit
- MCSP global and country implementation work plans for Years 1-3;
- MCSP Annual and Quarterly Reports to date;
- MCSP website (as an example of dissemination of learning, leadership, advocacy, etc)
- MCSP technical briefs and documents, research reports, advocacy documents, and publications;
- Other MCSP project documents and materials, including global and country-level PMPs;
- Where appropriate, financial reviews and reports;
- USAID reports: Acting on the Call reports; Maternal Health Vision for Action; draft Child Health Strategy; and others
Global Initiative strategies, such as Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030); Every Newborn Action Plan; Ending Preventable Maternal Mortality; WHO MNCH Quality Network initiative; RBM Malaria in Pregnancy, FP2020, etc

- An updated table of the countries in which MCSP is working including the amount of money expended (disaggregated by field support and central funding) and if possible, activities carried out;
- List of resources (e.g. financial, goods, and services) leveraged from non-MCSP sources;
- Tools, implementation guidelines, policies, and/or training curricula developed;
- Country reports, where possible; and
- USAID Evaluation Policy.

The team is also expected to review the MCSP website for resources: [http://www.mcsprogram.org/](http://www.mcsprogram.org/)

### 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. 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/skype interviews should be conducted. MCSP and USAID staff will give advance notice to key informants, and then the evaluation team will follow-up to schedule the interviews in coordination with MCSP and USAID staff.

Key informants should include, but not be limited to:

- MCSP/Jhpiego project staff
- MCSP partner staff at consortium members - JSI, Save the Children, PATH, ICF, R4D, PSI, Core Group; associate partners include Broad Branch Associates, Avenir Health, JHU BSPH, and Communications Initiative
- USAID/Washington (GH/MCHN) MCSP project management staff and other USAID/W staff involved with MCSP
- USAID missions, in countries which MCSP works or collects data
- One USAID mission where the mission decided not to work with MCSP (e.g. Senegal)
- MCSP in-country partners, including NGO/FBO entities and public and private sector organizations
- Ministry of Health officials
- Representative healthcare workers
- Global and country-level experts on maternal and child health programming, including from the WHO, UNICEF, UNFPA, GAVI, CDC, World Bank/ GFF, international and national professional associations, leading global advocates

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

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

Optional: Key informants can be grouped and interviewed together, as long as the respondents feel free to express their opinions openly. Depending on time and available stakeholders, the evaluation team may wish to host group interviews with certain groups, particularly during in-country visits. For instance, discussions can be with groups of MCSP staff, USAID Mission health team staff, and NGO partners working in country.

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

### Survey (describe content of the survey and target responders, and purpose of inquiry)
The evaluation team should design and implement a web-based survey (i.e., Survey Monkey) of USAID Washington D.C.-based staff and/or regional and country Missions that have bought into or worked with MCSP regarding their level of satisfaction and experiences with the project.

The evaluation team should also design and implement a web-based survey to poll outside organizations that have partnered with MCSP (such as UNICEF, GAVI, UNFPA, WHO, and FIGO) regarding their level of satisfaction and experiences with the project. In addition, surveys may also be implemented amongst other sub-groups whose input is valuable, but for whom interviews or focus group discussions are not feasible.

Both survey questionnaires will be reviewed and approved by GH/AOR team before the surveys are implemented.

- **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 may decide to visit MCSP-supported facilities and communities to conduct semi-structured observations, interviews, and focus groups.

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

- **Data Abstraction** *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

- **Case Study** *(describe the case, and issue of interest to be explored)*
  
  To the extent that a case study methodology could address one of sub-question, the evaluation team may consider this approach in consultation with USAID staff.

- **Verbal Autopsy** *(list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)*

- **Rapid Appraisal Methods** *(ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)*

- **Other** *(list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)*

  As a part of document review, the Evaluation team should also review:
  
  - The MCSP management structure including the roles of partners and the extent to which coordination is occurring among partners.
  - Achievements to date
  - As available and only as it supports qualitative findings and offers a new and added-value, quantitative comparison of achievements against targets for key output or outcome indicators to date, such as number of countries demonstrating greater equity in coverage of MNCH services, and review of HMIS data or household survey data to understand how MCSP influences improvement of coverage and equity.
The evaluation team will consider an assessment of specific tools being introduced (such as the rapid health system assessment tool) and its utility on improved quality MNH services and health outcomes at the facilities where it is implemented.

If **impact evaluation**

- Is technical assistance needed to develop full protocol and/or IRB submission?
  - ☐ Yes  ☐ No

List or describe case and counterfactual:

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
</table>

### XII. HUMAN SUBJECT PROTECTION

Once the methods to answer each question have been clearly defined, and only if needed, the evaluation 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)

### XIII. 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. The evaluation will assess whether MCSP is achieving its objectives and planned outputs as stated in the MCSP agreement’s project description and approved implementation plans. The evaluation will determine qualitatively whether MCSP is on track and will make recommendations to improve implementation of the current project and to inform follow-on projects. The evaluation will review qualitative data related to the project’s achievements. Only as it is readily available, presents new and value-added information, and supports qualitative findings, the evaluation will include a review of quantitative data. No statistical tests will be run; however descriptive data may be included if it supports a response to the evaluation questions.
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. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist. Use of multiple methods, as well as existing data (e.g., project/program performance indicator data, DHS, MICS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results. The Evaluation Report will describe analytic methods employed in this evaluation.

**XIV. 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 the MCSP proposal, annual work plans, M&E plans, semi-annual progress reports, and routine reports of project 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 two or three-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- 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 the all Evaluation Team experts, but will be determined in consultation with the Mission and USAID/Washington. 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 MCSP** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

● **In-brief and debrief with each USAID Mission**, at the start and end of each country field visit

● The Team Lead (TL) will brief the 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.

● A final debrief between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting 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 finding may change.)*

● If deemed critical, a Stakeholders’ debrief/workshop will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Missions, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

**Evaluation Workplan:** The evaluation team shall prepare a workplan, including milestones and deliverables with due dates clearly established during the Team Planning meeting, to be provided to USAID for approval. This plan will include, but not be limited to, the following items:

● Key evaluation questions

● Evaluation protocols, including methods, and for each method:
  o data collection procedures
  o sample
  o limitations

● Data collection tools

● Timeline for key activities, including product due dates

● Schedule of interviews, both internal and external

● Schedule of informal and final debriefing presentations to USAID and MCSP

● Schedule of field visits

This work plan (including questionnaires, etc.) will be approved prior to initiation of key informant interviews and site visits.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits to four countries for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. After USAID facilitates initial introduction with USAID Mission staff and MCSP staff, the evaluation team will outline and schedule key meetings and site visits prior to departing to the field. USAID staff will join the evaluation team for these country visits and assist with data collection.

**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. Prior to submitting the report, the Team Lead will clarify any questions with USAID and MCSP/HQ

2. Team Lead will submit draft evaluation report to GH Pro for review and formatting

3. GH Pro will submit the draft report to USAID

4. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro

5. 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

6. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo 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.

XV. 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>March 10, 2017</td>
</tr>
<tr>
<td>In-brief with USAID</td>
<td>March 20, 2017</td>
</tr>
<tr>
<td>Workplan and methodology review briefing</td>
<td>March 24, 2017</td>
</tr>
<tr>
<td>Workplan (must include questions, methods, timeline, data analysis plan, and instruments)</td>
<td>March 27, 2017</td>
</tr>
<tr>
<td>In-brief with MCSP IP</td>
<td>March 27, 2017</td>
</tr>
<tr>
<td>Field visits to 3 African countries, including in/out-briefs with Missions</td>
<td>April 1-16, 2017</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>Out-brief with USAID with Power Point presentation</td>
<td>May 3, 2017</td>
</tr>
<tr>
<td>Findings review workshop with MCSP and stakeholders with Power Point presentation</td>
<td>May 4, 2017</td>
</tr>
<tr>
<td>Draft report</td>
<td>Submit to GH Pro: May 26, 2017</td>
</tr>
<tr>
<td></td>
<td>GH Pro submits to USAID: May 31, 2017</td>
</tr>
<tr>
<td>Draft 2</td>
<td>Submit to GH Pro: July 10, 2017</td>
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<tr>
<td></td>
<td>GH Pro submits to USAID: July 17, 2017</td>
</tr>
<tr>
<td>Final report</td>
<td>Submit to GH Pro: August 4, 2017</td>
</tr>
<tr>
<td></td>
<td>GH Pro submits to USAID: August 8, 2017</td>
</tr>
<tr>
<td>Raw data (cleaned datasets in CSV or XML with data dictionary)</td>
<td>August 3, 2017</td>
</tr>
<tr>
<td>Report Posted to the DEC</td>
<td>September 8, 2017</td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
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</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? ________ 15 ________ Business days
XVI. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic 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/analytics must be an external expert with appropriate skills and experience.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this 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:
GH Pro will recruit two external team members. Between them, the team members should have substantial and demonstrated knowledge of maternal and child health issues. At least one of the evaluation team members should be an evaluation expert. Additionally, at least one evaluation team member should speak French or Portuguese.

In addition to the team members recruited by GH Pro, one or two staff members from USAID will act as full team members (full time during team planning meetings and country visits) to facilitate introductions with key informants, participate in field visits and contribute knowledge of USAID policies and procedures and of maternal, newborn, child health, FP, immunizations, malaria, nutrition, and HIV/AIDS. USAID staff will contribute to the report writing. They will coordinate their own travel plans, country clearances, other logistics, and expenses will be provided separately by the GH/MCHN office.

The evaluation team will be composed of three or four individuals, two of these individuals will be consultants. All team members should have the following characteristics:

- Master’s degree or higher level of education in a relevant technical area;
- Knowledge, skills, and experience with USAID contracting and reporting requirements; policies and initiatives; and tools, such as performance monitoring plans (PMPs) and results frameworks;
- Advanced written and oral communication skills in English, French or Portuguese language is a plus;
- Expertise working in developing countries;
- Experience working in the international donor environment especially with other development agencies (e.g. UN agencies, GAVI, WHO, or other USG agency);
- Strong qualitative analytical skills.

Additionally, the team members should together include the following individual levels of expertise:

- At least one person with strong knowledge, skills, and minimum of 8 years of experience in evaluation tools and methods;
- At least two people with minimum of 12 years of experience in public health with extensive technical knowledge and experience with interventions, policies and programs in maternal health, newborn health, child health, and family planning;
At least one person with a minimum of 4 years' experience in organizational management;
At least two people with 10 years of experience in designing, implementing, managing, and evaluating international health programs;

Team Lead: This person will be selected from among the key staff, approved by USAID, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

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.

Qualifications:
- Minimum of 10 years of experience in public health, which included experience in implementation of maternal and child health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- 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
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in one or more of the Sub-Saharan African site visits countries is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: MNCH Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in MNCH. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:
- Master’s degree or higher level of education in a relevant technical area
- At least 8 years’ experience with MNCH projects; USAID project implementation experience preferred
- Expertise in supply and demand for MNCH services at the community and clinical level
- Familiarity with FP, immunizations, malaria, nutrition, and HIV/AIDS projects is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Advanced written and oral communication skills in English, French or Portuguese language is a plus
- Expertise working in developing countries
- Experience working in the international donor environment especially with other development agencies (e.g. UN agencies, WHO, or other USG agency)
- Experience in RMNCH program implementation and M&E, including design and implementation of evaluations
- Good presentation and writing skills, including report writing experience
Experience in conducting USAID evaluations of health programs/activities

Key Staff 2 Title: Evaluation Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues. S/He will have knowledge, skills in evaluation tools and methods. S/he will also have experience in public health and particularly in RMNCH interventions. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:
- Master’s degree or higher level of education in a relevant technical area
- Knowledge, skills, and experience with USAID designs and projects; policies and initiatives; and tools
- Advanced written and oral communication skills in English, French or Portuguese language is a plus
- Expertise working in developing countries
- Experience working in the international donor environment especially with other development agencies (e.g. UN agencies, WHO, or other USG agency)
- Experience in RMNCH program implementation and M&E, including design and implementation of evaluations
- Strong qualitative evaluation and analytical skills
- Good presentation and writing skills, including report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID M&E policies and practices
- Evaluation policies
- Results frameworks
- Performance monitoring plans

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

In addition to the team members recruited by GH Pro, two staff members from USAID will act as full team members. USAID staff will have knowledge and skills in reproductive, maternal, and child health and some evaluation experience. USAID staff will facilitate introductions with key informants, participate in field visits and contribute knowledge of USAID policies and procedures and of maternal, newborn, child health, FP, immunizations, malaria, nutrition, and HIV/AIDS. USAID staff will contribute to sections of the report writing. They will coordinate their own travel plans, country clearances, other logistics, and expenses will be provided separately by the GH/MCHN office.

MCSP staff in DC and in country will help with logistics and facilitating introductions, and conduct other programmatic and support tasks.

GH Pro may provide a Program Assistant who will provide logistics and administrative support for this evaluation, for a minimal number of days. Working under the guidance of the Team Lead, she will arrange meetings and appointments, assist with managing with web-based survey, and other tasks as assigned and ensure the processes moves forward smoothly.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.
- Yes – If yes, specify who: one or two staff members from USAID’s MCHN Offices will act as full team members (full time during team planning meetings and country visits)
- Significant Involvement anticipated – If yes, specify who:
No

**Staffing Level of Effort (LOE) Matrix:**
This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

1. For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
2. Immediately below each staff title enter the anticipated number of people for each titled position.
3. Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
4. Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
5. At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

**Level of Effort in days for each Evaluation/Analytic Team member**
*(The following is an Illustrative LOE Chart. Please edit to meet the requirements of this activity.)*

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Team Lead / Evaluation Specialist</th>
<th>MNCH Specialist</th>
<th>GH Pro Program Assistant</th>
<th>USAID MCHN staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch Briefing</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HTSOS Training</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk review</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel to and from DC</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Planning Meeting</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>In-brief with USAID/Washington to discuss workplan and methodology</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Briefing with MCSP in Washington DC</td>
<td>0.5</td>
<td>0.5</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Finalize Eval planning deliverables: 1) workplan with timeline analytic protocol (methods, sampling &amp; analytic plan); 2) data collection tools</td>
<td>2</td>
<td>1</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Data Collection DQA Workshop (protocol orientation/training for all data collectors)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Prep / Logistics for Data Collection and Site Visits</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Data Collection, including Travel and field visits to 2-3 countries (per person)-- activities include in- and debrief with Mission staff, data collection, site visits, country prelim analysis</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Data cleaning and analysis (US and field)</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Debrief with presentation with USAID/GH/MCHN to present preliminary findings (US and field), with prep</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>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>8.5</td>
<td>5</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>GH Pro Report QC Review &amp; Formatting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission of draft report(s) to Mission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
USAID Report Review

Revise report(s) per USAID comments

Finalize and submit report to USAID

USAID approves report

Final copy editing and formatting

508 Compliance editing

Eval Report(s) to the DEC

<table>
<thead>
<tr>
<th></th>
<th>19</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

Total LOE per person 72.5 50 9 80

Total LOE 72.5 50 9 80

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

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

Washington DC, and 4 countries: Ghana, Madagascar, Rwanda, Nigeria

XVII. LOGISTICS

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

GHPro will work with consultants to determine necessary visa requirements.

List recommended/required type of Visa for entry into countries where consultant(s) will work

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Tourist</th>
<th>Business</th>
<th>No preference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></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, GHPro can submit an application for it on the consultant’s behalf.

GH Pro can obtain Secret Security Clearances and Facility Access (FA) for our consultants, but please note these requests processed through USAID/GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking approximately 6 months to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA 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) TBD based on Mission request

☐ 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: ________________________________

☐ Travel - other than posting (specify): GH Pro will arrange travel to all work locations for two consultants.

☐ Other (specify): ________________________________

XVIII. GH PRO ROLES AND RESPONSIBILITIES
GH Pro will coordinate and manage the evaluation/analytic 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/analytic 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.

XIX. 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>
<tr>
<td><strong>Before Field Work</strong></td>
</tr>
<tr>
<td>- SOW.</td>
</tr>
<tr>
<td>o Develop SOW.</td>
</tr>
<tr>
<td>o Peer Review SOW.</td>
</tr>
<tr>
<td>o Respond to queries about the SOW and/or the assignment at large.</td>
</tr>
<tr>
<td>- 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.</td>
</tr>
</tbody>
</table>
● **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.

### XX. 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 be **30-40 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/analytic 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/analytic 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:
- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages)
- Table of Contents (1 page)
- Acknowledgements
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Introduction (1-3 pages)
- Purpose
- Project Background
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions)
- Conclusions
- Lessons Learned
- Prioritized Recommendations
- Future Directions
- Annexes
- Annex I: Evaluation/Analytic Statement of Work
- Annex II: Evaluation/Analytic Methods and Limitations
- Annex III: Data Collection Instruments
- Annex IV: Sources of Information
  - List of Persons Interviews
  - Bibliography of Documents Reviewed
  - Databases
  - [etc.]
- Annex V: Disclosure of Any Conflicts of Interest
- Annex VI: Statement of Differences (if applicable)
- 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 for others 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.

XXI. USAID CONTACTS

<table>
<thead>
<tr>
<th>Primary Contact</th>
<th>Alternate Contact 1</th>
<th>Alternate Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Nahed Matta</td>
<td>Emily Hillman</td>
<td>Kim Garcia</td>
</tr>
<tr>
<td>Title: Maternal and Child Survival Project (MCSP) AOR</td>
<td>Public Health Advisor</td>
<td>Program Assistant</td>
</tr>
<tr>
<td>Email: <a href="mailto:nmatta@usaid.gov">nmatta@usaid.gov</a></td>
<td><a href="mailto:ehillman@usaid.gov">ehillman@usaid.gov</a></td>
<td><a href="mailto:kigarcia@usaid.gov">kigarcia@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone: 202-679-7301</td>
<td>571-551-7374</td>
<td>571-551-7391</td>
</tr>
<tr>
<td>Cell Phone: 703-625-9791</td>
<td>202-412-5431</td>
<td>703-314-2672</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)

<table>
<thead>
<tr>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Carmen Tull</td>
<td>Malia Boggs</td>
</tr>
<tr>
<td>Title: Maternal and Newborn Health Division Chief (Acting)</td>
<td>Senior Child Health Technical Advisor, MCSP Alt. AOR</td>
</tr>
<tr>
<td>USAID Office: Maternal and Child Health and Nutrition Office/ Maternal and Newborn Health Division in Washington DC</td>
<td>GH/MCHN, Child Health and Immunization Division in Washington DC</td>
</tr>
<tr>
<td>Email: <a href="mailto:ctull@usaid.gov">ctull@usaid.gov</a></td>
<td><a href="mailto:mboggs@usaid.gov">mboggs@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone: 571-551-7066</td>
<td>571-551-7386</td>
</tr>
<tr>
<td>Cell Phone: 202-679-7208</td>
<td></td>
</tr>
</tbody>
</table>

XXII. OTHER REFERENCE MATERIALS

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

List of Key Stakeholders, Partners & USAID Contacts in Annex 1
XXIII. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)

KII, Question 4.1 Question 2 was modified with approval from USAID:

Original: To what extent and in what ways has MCSP contributed to key programs, priorities and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives (such as EPMM, ENAP, GAVI, GFF)?

Revised: To what extent and in what ways has MCSP contributed to key programs, priorities and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives (such as EPMM: Ending Preventable Maternal Mortality; ENAP: Every Newborn Action Plan; FP2020: Family Planning 2020; RBM (Roll back malaria); ICCM (Integrated Community Case Management) Task Force; APR (A Promised Renewed).

The countries to be included in the original e-survey were: Nigeria, Tanzania, Burma, DRC, Mozambique, Uganda, Malawi, Liberia, Namibia, Guatemala, Egypt, Guinea, Kenya, India, Pakistan, Zambia, Ethiopia, Haiti and South Africa. The e-survey was expanded to include all MCSP countries with the survey sent to the USAID Country Mission and Country MCSP office.

In-country visits were reduced from four countries to three with Nigeria being removed due to the closure of the Abuja airport.

Timelines & Deadlines: Dates for the final deliverable have shifted throughout the period of performance with agreement from USAID Washington during the final technical report review process.

LOE Original: Report Drafting Team Development of 1st Draft (6 days); Team Development of Final draft in response to USAID Review (3 days)

Adjusted LOE: Report Drafting Team Development of 1st Draft (13.5 days); Team Development of 2nd draft in response to USAID Review (6 days); Team Development of Final draft in response to USAID Review (5 days)

ANNEX 1: USAID/Washington and MCSP/HQ CONTACTS: The original list of contacts was updated with the help of USAID/Washington to reflect an accurate list of stakeholders and job descriptions. Interviewees who were not contacted were removed.
ANNEX 1: USAID/Washington and MCSP/HQ CONTACTS

The evaluation team should add to this preliminary list of stakeholders and partners as necessary.

**USAID/Washington Maternal and Child Health and Nutrition Office (MCHN) / MCSP**

**AOR Team**
- Nahed Matta (AOR) - Senior Maternal and Newborn Health Advisor
- Malia Boggs (Alt. AOR) – Senior Child Health Advisor
- Karen Fogg- Senior Maternal Health Advisor
- Kerry Ross- Child Health Advisor

**Maternal and Child Health and Nutrition Office (MCHN)**
- Barbara Hughes – Maternal, Child Health, and Nutrition (MCHN) Office Director
- John Borrazzo - Maternal, Child Health, and Nutrition (MCHN) Deputy Director
- Carmen Tull – Acting Child Health and Immunization Division Chief
- Mary Ellen Stanton – Senior Maternal Health Advisor
- Lily Kak - Senior Advisor for Global Partnerships & Newborn Health
- Debbie Armbruster - Senior Maternal and Newborn Health Advisor
- Endale Beyene - Immunization Technical Advisor
- Susan Ross - Digital Health Advisor
- Nazo Kuresshy - Team Leader- Community Health
- Troy Jacob – Senior Medical Advisor
- Anne Peniston – Nutrition and Environmental Health Division Chief
- Jeneice Alvey – Nutrition Advisor
- Jesse Shapiro – WASH Advisor
- Supria Madhavan - Senior Implementation Research Advisor

**Infectious Diseases Office (ID)**
- Susan Youll - Public Health Advisor

**Population and Reproductive Health Office (PRH)**
- Patricia MacDonald - Senior FP/RH Technical Advisor

**USAID Africa Bureau**
- Sylvia Alford - Health Program Advisor
- Sara Zizzo – Health Program Advisor

**USAID Asia Bureau**
- Micaela Arthur - Special Populations Health Advisor – Asia

**OAA**
- Boryana Boncheva (Agreement Officer)
- Joseph Hamilton (Portfolio manager)

**Maternal and Child Survival Program Staff, Washington DC**
- Koki Agarwal, Project Director
- Anita Gibson, Deputy Project Director
- Neena Khadka (Newborn Health)
- Kathleen Hill (Maternal Health)
- Anne Pfitzer (Family Planning)
- Michel Pacque (Child Health)
Elaine Roman (Malaria)
Folake Olaykina (Immunization)
Pat Taylor (Country Programs)
Jim Ricca (Learning)
Grace Chee (Health systems and equity)
Barbara Rawlins (M&E)
Melanie Morrow (Community Health/CSE)
Justine Kavle (Nutrition)
Laura Skolnick (Country Support Manager)
Rachel Taylor (Country Support Manager)
Kate Onyejekwe (Country Support Manager)
Mieko McKay (Country Support Manager)
ANNEX II. EVALUATION/ANALYTICAL METHODS AND LIMITATIONS

EVALUATION/ANALYTICAL METHODS

In consultation with the USAID/AOR team, the Maternal and Child Survival Program (MCSP), the evaluation team implemented the following 10-step methodology with reference to the MCSP Mid-term Qualitative Evaluation’s scope of work:

1. Document Review (3/15/17 and onwards): The evaluation team reviewed all relevant documents associated with the MCSP. Documents were made available by MCSP’s USAID/GH/MCHN Agreement Officer’s Representative (AOR) team and by the MCSP. Documents reviewed in detail included, inter alia, those related to the MCSP Award and subsequent contract modifications, MCSP’s global Performance Monitoring Plan (PMP) and MCSP global and country implementation work plans (for the three countries visited), MCSP Annual Reports through Project Year 2 and Quarterly Reports through Project Year 2 – Third Quarter, MCSP Financial Reviews, MCSP Internal Review Findings, and activity-specific documentation supplied by MCSP.

2. Team Planning (3/20-3/24/17): Once assembled in Washington, DC, the evaluation team was engaged over 4 days in a series of team planning and briefing sessions. As its first step, the mid-term evaluation team (MTET) met internally for an in-depth examination of the evaluation’s SOW. As its second step, the MTET met with the AOR to receive an in-briefing on the scope of work during which the two entities reached consensus on SOW issues. During this initial meeting with the AOR, the MTET also received guidance on the selection of the three MCSP country programs (Rwanda, Ghana, and Madagascar) to be included in site visits, on the list of potential informants to be included in key informant interviews (KII), and the list of MCSP collaborating country Missions and MCSP country programs to be included in the evaluation’s electronic survey (e-survey). The MTET then received a full-day in-briefing from MCSP/W staff. Following on the in-briefings from both entities, the evaluation team meet internally to develop key informant and e-survey templates. As a final step, the MTET met again with the AOR to discuss and receive final approval for all evaluation aspects including the structure and implementation of KII and e-surveys. Final approval from the AOR was received on 3/27/17.

3. Data Collection: Key informant interviews, e-surveys and field visits (Dates: 3/27-4/25): In the course of the data collection phase, the MTET interviewed 155 key informants using the agreed-upon structured KII. In addition, using the agreed-upon e-survey format, the MTET received responses from 19 USAID Missions and from 20 MCSP country programs supported by the 19 Missions. As specified by the SOW, the content and structure of the KII and of the e-survey focused principally on the collection of qualitative data with reference to the extent to which MCSP had achieved progress toward meeting its goals and objectives. As a final component of the evaluation’s focus on data collection, during the MTET brief 5-day visits to the three selected MCSP country projects, the MTET, operating under a restricted time schedule,
completed group KIs with MCSP program staff, Mission representatives, and representatives of the three countries’ ministries of health. In each country, the team was able to visit and interview staff at 1-2 health facilities at which MCSP had provided technical assistance. As agreed-upon by the AOR team, each of the country site visits was focused on providing the MTET with an appreciation, however limited in scope, of the MCSP’s global approach to providing participating countries with technical assistance.

4. **Data Analysis:** (Dates 4/28-5/5): During the 6 days provided by the SOW for data analysis, the MTET, after removing all personal identification data from all KII, consolidated the identity-masked KIs into seven thematically-organized master files with each file including a responses of a specific stakeholder group (i.e. USAID/W staff, USAID Mission staff, Washington implementing partners, MCSP/W staff, MCSP country staff, health service staff, senior country stakeholders, field implementing partners, and global stakeholders). In addition, using analytical features provided through Survey Monkey, all e-survey responses were similarly summarized by Mission and country program informants’ responses to each e-survey question. Once the responses were organized thematically, the MTET, in a series of four day-long data analysis working sessions, one for each scope of work question and its sub-questions, the evaluation team worked together on a process focused first on identifying recurring or common responses to each of the evaluation questions and sub-questions. Following identification of common responses, whether positive or negative, the evaluation team then reached a tentative consensus on conclusions stemming from each identified common theme. After identifying tentative conclusions, the team then turned to available documentation to validate each conclusion. On two occasions, the team submitted requests for information on issues requiring clarification. Once these issues were clarified, the team then arrived at a final list of conclusions for inclusion in the preliminary de-brief with USAID and MCSP.

5. **Presentation and discussion of preliminary findings** (Date 5/8-5/9/17): Following its completion of the above analytical process, the evaluation team prepared and presented its preliminary summary of principal findings, conclusions and recommendations in two separate venues, one for USAID/GH stakeholders and a second to MCSP/Washington staff. During these de-briefings, the evaluation team noted participants’ suggestions for clarification and modification, all of which were taken into consideration during the evaluation team’s development of the evaluation’s 1st draft.

6. **Preparation and submission of 1st Draft** (Dates: 5/10-5/31//2017): Based on clarifications and modifications suggested by the USAID and MCSP review, the evaluation team prepared and submitted its 1st draft to USAID. The 1st draft, submitted on 5/31/2017 to USAID after a 3-day review by GH/Pro, was prepared in two versions, one for general review by both USAID and MCSP and a second, containing procurement-sensitive information for review by USAID.

7. **USAID and MCSP review of the 1st Draft** (Dates 6/1 – 6/20/2017): During this period, USAID and MCSP reviewed their separate versions of the final 1st draft of the evaluation report with comments and requests for modifications and clarifications submitted to the evaluation team on June 20th.

8. **Preparation of the Evaluation Team’s 2nd Draft** (June 21 – July 10/2017): During this period, the MTET prepared its second draft of the evaluation report incorporating modifications
and clarifications proposed by USAID and MCSP. The second draft was submitted on July 10th to GH Pro for review and submission on July 14 for final comments from USAID and MCSP.

9. **USAID/W Review of Evaluation MTET’s 2nd Draft** (July 17 – 22/2017): Following its submission to USAID, the 2nd draft was reviewed by USAID with its final comments forwarded to the MTET on July 21st.

10. **Preparation of the Evaluation Team’s Final Draft** (July 25 – August 4, 2017): During this period, the MTET prepared its final draft of the evaluation report incorporating modifications and clarifications proposed by USAID and MCSP. The final draft was submitted to GH Pro on July 28th for final editing and formatting prior to submission on August 4, 2017 to USAID for final approval.

**LIMITATIONS**

The evaluation’s comprehensiveness was limited by the following challenges:

- **Time constraints**: The scope of work’s allocation of: five days (March 20-24) for team review (including briefings and discussions with the AOR and the development of the KIs and the e-survey); 22 days for data collection and interviews (including travel to and data collection in three countries, and Washington-based and remote interviews); and five days for data analysis prior to USAID and MCSP debriefings significantly constrained the evaluation team’s analysis of a program of MCSP’s size and complexity. In addition, while the team recognized during the five days allocated for data analysis that there were gaps in the depth of information provided through the KIs, a second round of data collection and analysis was not built into the scope of work. Nevertheless, this constraint was somewhat mitigated by the high quality and detailed nature of timely e-survey responses received from the large majority of Missions and MCSP field offices.

- **Lack of conclusive quantitative data**: Although the scope of work called for the evaluation to focus on qualitative analyses, the quantitative data provided to the evaluation team provided inadequate, often selective and occasionally contradictory information upon which to validate the evaluation’s qualitative findings on the extent to which the Global program was “...on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality RMNCH interventions.”

- **Gaps in qualitative data**: As noted earlier, the evaluation interviewed or surveyed 155 KIs and representatives in 19 MCSP-supported Missions and 20 country programs. Nevertheless, because of the scope of work’s time limitations, the evaluation team was unable to personally interview an adequate number of MCSP headquarters’ staff responsible for technical and country support. While the gap associated with a limited number of face-to-face interviews with key program staff was partially mitigated by a detailed nine hour series of presentations and by documents on each technical area’s anticipated legacies, opportunities for additional KIs would have added additional depth to the evaluation’s findings. In addition, only a small number of

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Informants representing MCSP’s wide and diverse base of global partners were available for face-to-face or remote interviews. This gap led to a limited and potentially biased understanding of global stakeholders’ perspectives of MCSP.

- **Inadequate time and emphasis allotted to site visits:** The breadth and depth of country visits was insufficient to gain more than a restricted on-site perspective on the program’s global outreach. Due to time and cost constraints, the evaluation team travelled to only three of MCSP’s 26 countries of operation. The three countries (Rwanda, Ghana, and Madagascar) were selected by USAID prior to the start of the evaluation based on country program representatives’ availability during the evaluation’s narrow timeframe. Visits to these countries were limited to five to six working days for data collection, interviews, and visits to program health facilities. Despite the report’s acknowledged value of responses from a significant number of electronic survey informants and from the site visit informants, constraints associated with the evaluation team’s site visits left the team with inadequate opportunities to personally assess and more thoroughly validate information received through the evaluation’s electronic survey and through key informant interviews.

**Evaluation Matrix (Page 1)**

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Data Source/Collection Methods</th>
<th>Data Analysis Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country Results</strong></td>
<td>• Project documents provided by MCSP/W</td>
<td>• Master file with KII responses organized by question and theme and triangulated with data from project documents</td>
</tr>
<tr>
<td>To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality RMNCH interventions?</td>
<td>• Key informant interviews with USAID/GH/MCHN managers</td>
<td>• Survey Monkey analysis of quantitative and qualitative responses associated with e-survey</td>
</tr>
<tr>
<td>Sub-questions:</td>
<td>• Key informant interviews with MCSP managers</td>
<td></td>
</tr>
<tr>
<td>a. What is the extent and ability of MCSP to support country programs to increase coverage of appropriate interventions?</td>
<td>Technical presentations by MCSP/W staff</td>
<td></td>
</tr>
<tr>
<td>b. What are the strengths and limitations of MCSP-supported activities/interventions towards achieving expected project results?</td>
<td>KIIs with implementing partners</td>
<td></td>
</tr>
<tr>
<td>c. What are the missed opportunities or gaps?</td>
<td>Field visits to three country programs (Rwanda, Ghana and Madagascar) selected by USAID /GH/ MCHN. Agenda included KIIs with MCSP Program staff, USAID Mission staff, and key government and CSO stakeholders, review of country-specific documents and observational visit and KIIs with staff in one health center per country.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• e-survey of USAID selected Missions not included in field visits*</td>
<td></td>
</tr>
</tbody>
</table>

- Countries included in e-survey: Nigeria, Tanzania, Burma, DRC, Mozambique, Uganda, Malawi, Liberia, Namibia, Guatemala, Egypt, Guinea, Kenya, India, Pakistan, Zambia, Ethiopia, Haiti and South Africa.

| **Global Leadership**                                                                | • Project documents provided by MCSP/W                                                      | • Master file with responses organized by question and theme and triangulated with data from project documents |
| To what extent and in what ways has MCSP contributed to key programs, priorities and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives | • Key informant interviews with USAID/GH/MCHN managers                                   | • Survey Monkey analysis of                                                                |
|                                                                                      | • Key informant interviews with MCSP managers                                               |                                                                                     |
|                                                                                      | Technical presentations by MCSP/W staff                                                   |                                                                                     |
|                                                                                      | Remote interviews with national and international partners                                |                                                                                     |
### Evaluation Questions

**Sub-questions:**

| a. | What are the missed opportunities or gaps in MCSP’s global leadership efforts? |
| b. | How does MCSP link country-level learning to inform global-level engagement and vice versa? |

**Data Source/Collection Methods**

- e-survey of USAID selected Missions not included in field visits* (see * above)

**Data Analysis Method**

- quantitative and qualitative responses associated with e-survey

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### Evaluation Matrix (Page 2)

**Evaluation Questions**

**Integration and Cross cutting areas**

To what extent and in what ways has MCSP, as a flagship RMNCH project, been successful in maximizing opportunities for comprehensive RMNCH platforms at the country and global levels?

**Sub-questions:**

| e. | What are the gaps or missed opportunities in integrating crosscutting themes and across technical areas? |
| f. | What are the successes and challenges of MCSP in sustaining and strengthening health systems to support RMNCH programming |
| g. | What has MCSP accomplished to advance community and civil society engagement towards improved outcomes at the global and country levels? |
| h. | To what extent is MCSP’s program learning agenda on track to provide strategic learning that will foster improved RMNCH outcomes across the continuum of care? |

**Data Source/Collection Methods**

- Project documents provided by MCSP/W |
- Key informant interviews with USAID/GH/MCHN managers |
- Key informant interviews with MCSP managers |
- Technical presentations by MCSP/W staff |
- KIIs with implementing partners |
- Field visits to three country programs (Rwanda, Ghana and Madagascar) selected by USAID /GH/ MCHN. Agenda included KIIs with MCSP Program staff, USAID Mission staff, and key government and CSO stakeholders, review of country-specific documents and observational visit and KIIs with staff in one health center per country. |
- e-survey of USAID selected Missions not included in field visits* (see * above)

**Data Analysis Method**

- Master file with responses organized by question and theme and triangulated with data from project documents |
- Survey Monkey analysis of quantitative and qualitative responses associated with e-survey

*Note that the response to this question will include consideration of the extent to which integration both of technical areas (MNCH, family planning, nutrition, malaria, WASH, etc.), and of crosscutting topics (health system strengthening, community and civil society engagement, quality, equity, gender, and innovation, has occurred from both a technical and managerial perspective.)*
## ANNEX III. EVALUATION TIMELINE

**March 2017 - MCSP Evaluation Timeline**

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<th>Sunday</th>
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<tr>
<td>12</td>
<td>13</td>
<td>14 Desk Review</td>
<td>15 Desk Review</td>
<td>16 Desk Review</td>
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<tr>
<td>19 Travel to DC</td>
<td>20 Team Planning Meeting (TPM) Focus: Team building and SOW review: Led by Emmet – Team Lead (TL)</td>
<td>21 AM: In-brief w/USAID – 9:00-12:00 PM: TPM Focus: Preparation of survey instruments 16h00-17h00 – Nahed interview</td>
<td>22 9h00 – 16h30 In-brief with MCSP</td>
<td>23 TPM Focus: Finalize instruments and Preparation of PPT for USAID</td>
<td>24 AM: Work plan and protocol briefing with USAID 9:00-12:00 PM: TPM: Focus: Final preparation of documents for Team A country visits and travel</td>
<td>25 Team A (Putney and Noonan) travel to Rwanda Team B (Emmet and Bear) Work on email survey</td>
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<tr>
<td>End March Schedule for Team A in Rwanda</td>
<td>26 Team A arrives in Rwanda</td>
<td>27 TEAM A: AM: In-brief with USAID Rwanda Mission; PM: In-brief with MCSP</td>
<td>28 TEAM A: Data collection</td>
<td>29 TEAM A: Data collection One-on-one or focus group interviews with MCSP staff</td>
<td>30 TEAM A: Data collection</td>
<td>31 TEAM A: Data collection TEAM A check-in with Team B</td>
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<tr>
<td>Sunday</td>
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<tr>
<td><strong>End March Schedule for Team B in Washington</strong></td>
<td>26 Team B finalize email survey and methodology</td>
<td>27 Team B: Submit work plan, methodology &amp; data collection tools to USAID-COB</td>
<td>28 Team B: DC-based interviews</td>
<td>29 DC-based interviews</td>
<td>30 DC-based interviews e-surveys sent</td>
<td>31 AM: DC-based interviews; PM: TL goes home</td>
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### April 2017 - MCSP Evaluation Timeline

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</thead>
<tbody>
<tr>
<td>2 Team Lead (TL) follow-up on e-survey countries</td>
<td>3 TEAM A: Outbrief with Rwanda Mission</td>
<td>4 Team A travel to Ghana</td>
<td>5 Team A arrives in Ghana</td>
<td>6 AM: Team A: In-brief with Ghana Mission</td>
<td>7 Team A: One-on-one or focus group interviews with MCSP staff</td>
<td>8 Teams A&amp;B: Document analysis</td>
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<td>Sunday</td>
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</tr>
<tr>
<td>9</td>
<td>Team Lead (TL) follow-up on e-survey countries</td>
<td>10 Teams A&amp;B: Data collection 3-6 PM Team B: One-on-one or focus group interviews with MCSP Tana staff</td>
<td>11 Teams A&amp;B: Data collection including meetings with MCSP staff and partners</td>
<td>12 Teams A&amp;B: Summary of findings Teams A and B Preparation of PPT for Missions</td>
<td>13 Teams A&amp;B: Outbrief with Missions Team Lead (TL) final follow-up on e-survey countries</td>
<td>14 Good Friday Teams A and B send weekly report to GH Pro</td>
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<tr>
<td>16 Easter Sunday</td>
<td>17 Easter Monday Remote interviews</td>
<td>18 Remote interviews</td>
<td>19 Remote interviews</td>
<td>20 Remote interviews</td>
<td>21 Remote interviews</td>
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<td>23</td>
<td>24 Remote interviews</td>
<td>25 Remote interviews</td>
<td>26 Travel to DC</td>
<td>27 Additional interviews</td>
<td>28 TPM: Data cleaning and analysis</td>
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May 2017 - MCSP Evaluation Timeline

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<tbody>
<tr>
<td>1</td>
<td>TPM: Data cleaning and analysis</td>
<td>2 TPM: Data cleaning and analysis</td>
<td>3 TPM: Data cleaning and analysis</td>
<td>4 TPM: Prepare de-brief presentations</td>
<td>5 AM: Finalize de-brief and send to USAID/GH</td>
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<tr>
<td>7</td>
<td>8 AM: De-brief with USAID PM: TPM: Revision of MCSP debrief based on USAID discussion</td>
<td>9 AM: MCSP Debrief PM: Final TPM PM: Travel Home</td>
<td>10 Evaluation team writes 1st draft report</td>
<td>11 Evaluation team writes 1st draft report</td>
<td>12 Evaluation team writes 1st draft report</td>
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<td>14</td>
<td>15 Evaluation team writes 1st draft report</td>
<td>16 Evaluation team writes 1st draft report</td>
<td>17 Evaluation team writes 1st draft report</td>
<td>18 Evaluation team writes 1st draft report</td>
<td>19 Evaluation team writes 1st draft report</td>
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### June 2017 - MCSP Evaluation Timeline

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<td></td>
<td>Evaluation team writes 1st draft report</td>
<td>Evaluation team writes 1st draft report</td>
<td>Evaluation team submits 1st draft to GH Pro</td>
<td>GH Pro reviews 1st draft</td>
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<td>28</td>
<td>29 Memorial Day</td>
<td>30 GH Pro reviews 1st draft</td>
<td>31 GH Pro submits 1st draft to USAID</td>
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July 2017 - MCSP Evaluation Timeline

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<td>Evaluation team revises report per USAID comments on 1st draft</td>
<td>Independence Day</td>
<td>Evaluation team revises report per USAID comments on 1st draft</td>
<td>Evaluation team revises report per USAID comments on 1st draft</td>
<td>Evaluation team revises report per USAID comments on 1st draft</td>
<td>8</td>
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<td>12</td>
<td>13</td>
<td>14</td>
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<td>Evaluation team submits 2nd draft to GH Pro for editing/formatting of report</td>
<td>GH Pro edits and formats 2nd draft</td>
<td>GH Pro edits and formats 2nd draft</td>
<td>GH Pro edits and formats 2nd draft</td>
<td>GH Pro edits and formats 2nd draft and submits to USAID for final comments</td>
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<td>USAID reviews 2nd Draft</td>
<td>USAID reviews 2nd Draft</td>
<td>USAID reviews 2nd Draft</td>
<td>USAID reviews 2nd Draft</td>
<td>USAID reviews 2nd Draft and submits to Evaluation Team for final edit</td>
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<td>Evaluation Team makes final edits</td>
<td>Evaluation Team makes final edits</td>
<td>Evaluation Team makes final edits</td>
<td>Evaluation Team makes final edits</td>
<td>Evaluation Team submits final draft and data sets to GH Pro</td>
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<td>GH Pro edits and formats final draft</td>
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### August 2017 - MCSP Evaluation Timeline

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<td>GH Pro edits and formats final draft</td>
<td>GH Pro edits and formats final draft</td>
<td>GH Pro edits and formats final draft</td>
<td>Final draft edited by GH Pro and sent to USAID for approval</td>
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<tr>
<td></td>
<td>USAID reviews final draft and works with GH Pro on final revisions</td>
<td>USAID reviews final draft and works with GH Pro on final revisions</td>
<td>USAID reviews final draft and works with GH Pro on final revisions</td>
<td>USAID reviews final draft and works with GH Pro on final revisions</td>
<td>USAID approves final formatted report</td>
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<td>GH Pro uploads data to DDL</td>
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## ANNEX IV. MCSP EVALUATION
### RESPONDENT AFFILIATIONS AND TOTALS

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<th>Washington DC</th>
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<tbody>
<tr>
<td><strong>Affiliation</strong></td>
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<tr>
<td>MCSP/W Management</td>
<td>5</td>
</tr>
<tr>
<td>MCSP/W Technical*</td>
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<tr>
<td>USAID/Washington Staff</td>
<td>27</td>
</tr>
<tr>
<td>Representatives of allied health projects</td>
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<td><strong>TOTAL</strong></td>
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*Includes Briefing Presenters (3-22-17)

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<tr>
<th>Site Visits (3 Countries)</th>
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<tbody>
<tr>
<td><strong>Affiliation</strong></td>
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<td>Ministry of Health Staff</td>
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<td>MCSP Country Program</td>
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<td>USAID Mission Staff</td>
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<td>Community Service Org.</td>
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<td>Service Providers</td>
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<td>International Agencies</td>
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<td><strong>TOTAL</strong></td>
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<tr>
<th>International Agencies and Academic Organizations</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td><strong>Affiliation</strong></td>
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<tr>
<td>World Health Organization</td>
<td>4</td>
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<tr>
<td>Harvard School of Public Health</td>
<td>2</td>
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<td><strong>TOTAL</strong></td>
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<tr>
<th>E-Survey</th>
<th>Number</th>
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<tr>
<td><strong>Affiliation</strong></td>
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<tr>
<td>USAID Missions</td>
<td>19</td>
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<tr>
<td>MCSP Country Programs</td>
<td>20</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>39</strong></td>
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**TOTAL RESPONDENTS (including MCSP in-brief presenters)** | **178**
ANNEX V. KEY INFORMANT INTERVIEW GUIDELINES

Maternal and Child Survival Program
USAID/GH/MCHN
Mid-Term Evaluation
March 10 – August 23, 2017

Managed by Global Health Program Cycle Improvement Project (GH Pro)

Key Informant Interview Guidelines

Background for Moderator’s Reference

Instructions to Moderator: Familiarize yourself with the following background information that can be used to respond to informant’s questions about the MCSP and the evaluation’s background.

The Maternal and Child Survival Program (MCSP) is a centrally-managed project under the United States Agency for International Development’s (USAID) Bureau for Global Health Maternal and Child Health and Nutrition Office (MCHN) that strives to deliver a full range of high-impact, evidence-based reproductive, maternal, neonatal, and child health and nutrition (RMNCH) interventions through an integrated approach as appropriate. With a ceiling of $560M, the majority of funds available to the MCSP are provided through field support from Mission buy-ins for one or more of the programs eight technical elements: maternal, newborn, child health, immunization, family planning, nutrition, malaria, and HIV/AIDS. The goal of MCSP is to accelerate intensive reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. As stated in the Program Description of the MCSP award, MCSP’s vision is of “self-reliant countries equipped with analytical tools, effective systems and technical and management capacity to eliminate preventable maternal, newborn, and child death.” Beyond a commitment to focus geographically on the USAID MCH priority countries, MCSP works to increase efforts to achieve equitable health coverage for high-burden populations, apply high-impact solutions to the most important causes of maternal mortality and under-five deaths, exploit efforts in other sectors to foster an enabling environment for improved RMNCH outcomes, and ensure mutual accountability for ending preventable child and maternal deaths.

Commissioned by USAID/MCHN, the Global Health Program Cycle Improvement Project (GH Pro) has formed a four-person evaluation team to undertake a mid-term evaluation of the MCSP. The purpose of this evaluation is to examine the project’s progress towards achieving planned results and lessons learned to date. The evaluation team will identify MCSP activities that may warrant continued future investment, as well as other RMNCH interventions and activities that would likely contribute to improvement of the project. Through analysis of MCSP’s progress and achievements at the mid-point of the project, this performance evaluation will make recommendations to improve implementation during the Years 4 and 5 of the project and will be used to guide USAID on the design of follow-on awards beyond the MCSP life of project.
As part of the MCSP evaluative process, interviews with key informants, all of whom have been selected based on their knowledge and involvement with the MCSP, will establish a knowledge base critical to the evaluation team’s ability to respond to the evaluation’s established purpose. Accordingly, the following questions are designed to promote the development of a dialogue between key informants and the evaluation team. The objective of the dialogue is to enhance the capacity of the evaluation team to reliably document whether the program is in fact achieving its objectives as stated in the original award’s focus on contributing to the GH/MCHN and Missions’ needs quality technical assistance across a wide range of technical areas.
Instructions to Moderator: Fill out the following information before meeting with informant

Respondent Name:
Respondent Position:
Respondent Sex: Male / Female
Date of Interview:
Moderator(s):
Location of interview:

Instructions to Moderator: Use the following to the respondents.

Good day. My name is ___________________, and we are conducting a performance evaluation of USAID/Global Health’s Maternal and Child Survival Program (MCSP). The overall objective of the evaluation is to document the extent to which the MCSP has accelerated intensive reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. MCSP is a follow-on to MCHIP and is being implemented by JHPIEGO and sub-partners on behalf of USAID.

You have been selected as a Key Informant to provide information that will establish a knowledge base critical to the evaluation team’s ability to respond to the evaluation’s objective. The information collected will only be used for the above purpose. All information you provide will be considered strictly confidential.

I would also like to clarify that this interview is entirely voluntary and that you have the right to withdraw from interview at any point without consequence.

At this time, do you have any questions? (Instructions to Moderator: If required, reference the above background information to respond to questions from the informant).

Are you willing to participate in this interview and to allow me to take notes?

Yes 1) Instructions to Moderator: Proceed
No 2) Instructions to Moderator: Thank the KI and STOP HERE

May I begin the discussion now?

Yes 1) Instructions to Moderator: Thank the KI and continue with the Key Informant Interview
No 2) Instructions to Moderator: Thank the KI and STOP HERE

Start Time: ____:____ Time of conclusion: ____:____
Key Informant Interview

Question Guidelines

Instructions to Moderator:

A. Use the following questions to guide the flow of the interview;

B. Give the informant sufficient time to respond to each question;

C. If indicated, allow the discussion to expand to issues introduced by the informant;

D. If the respondent does not seem to have an answer to a question, record no response and move on to the next question;

E. When taking notes, maintain eye contact with the respondent as much as possible. Ideally, it would be best to have two persons conduct the interview with one person taking the lead in asking the questions and the other person taking notes.

Instructions to Moderator: The informant’s answer to the following question will help you determine the extent to which you can proceed with subsequent questions. For example, if the informant should indicate that s (he) has limited knowledge of the MCSP, you will need to find a way to politely end the interview.

1. How would you describe your experience working with the MCSP program and your knowledge of the MCSP? □ Administrative □ Technical □ External

2. With which of the following MCSP technical areas are you familiar?

□ Maternal Health □ Newborn Health □ Child health

□ Immunizations □ Family planning □ Nutrition

□ Malaria □ HIV/AIDS □ Water and Sanitation □ HSS

□ Community Health and Civil Society Engagement

Instructions to Moderator: Based on the respondent’s experience, knowledge and engagement with the MCSP, proceed with the following questions.

3. Moderator’s introduction to the questions in this section: The evaluation team is being asked to document the MCSP’s progress on promoting an increase in the coverage of high quality, evidence-based Reproductive, Maternal, Newborn and Child Health (RMNCH) interventions that are equitable and sustainable. Your response to the following questions will contribute to the evaluation team’s ability to assist USAID in accurately and reliably evaluating the extent to which the MCSP is on track to promote high-quality RMNCH interventions. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the program.

[Note to the moderator: The exact wording of the SOW question is as follows: To what extent and in what ways is MCSP on track to achieve its objectives to increase sustainable and equitable high coverage and use of evidence-based, high-quality RMNCH interventions?]
3.1 From your perspective, has the MCSP been effective in supporting high-quality interventions in technical areas with which you are familiar?

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
<th>Not sure</th>
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</thead>
<tbody>
<tr>
<td>Maternal Health</td>
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<td>Newborn Health</td>
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<td>Child Health</td>
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<td>Immunizations</td>
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<td>Family Planning</td>
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<td>Nutrition</td>
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<td>Malaria</td>
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<td>HIV/AIDS</td>
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<td>Water and Sanitation</td>
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<td>HSS</td>
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<td>CSO/Community</td>
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[Note to the moderator: The informant’s knowledge and grading of the above nine intervention areas will serve as a guide for your facilitation of the following open-ended questions. In guiding the informant through the following questions, you should focus on the respondent’s perception on managerial and technical aspects of interventions with which s/he is familiar.]

3.1.1 For those interventions that have been effective, in what ways has the MCSP been effective?

3.1.2 For those interventions that have been not been effective, why have they not been effective?

3.3.3 For all interventions with which you are familiar, could you describe any missed opportunities to promote a sustainable increase in high quality interventions?

3.1.4 For all interventions with which you are familiar, could you describe any gaps that you have noted in the provision of technical assistance?

3.1.5 Based on lessons learned, what actions or interventions would you recommend for the remaining two years of the project and beyond?

4. Moderator’s introduction to questions in this section: The evaluation team is being asked to document the MCSP’s progress in contributing to the promotion of priorities and policies associated with evidence-based, high-quality RMNCH initiatives within countries and at regional and global levels. Your response to the following questions will assist the evaluation team in assisting USAID in accurately and reliably evaluating the extent to which the MCSP has strengthened global health RMNCH priorities and policies. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.
**Note to the moderator:** The exact wording of the SOW question is as follows: To what extent and in what ways has MCSP contributed to key programs, priorities and policy on evidence-based, high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives (such as EPMM: Ending Preventable Maternal Mortality; ENAP: Every Newborn Action Plan; FP2020: Family Planning 2020, RBM (Roll back malaria); ICCM (Integrated Community Case Management) Task Force; APR (A Promised Renewed).

4.1 From your perspective, has the MCSP been effective in the global promotion of RMNCH priorities and policies for the following initiatives?

- EPMM
- ENAP
- FP 2020
- RBM
- ICCM Task Force
- APR
- Other

4.2 For those priorities and policies associated with global health initiatives in support of which you believe the MCSP has been effective, in what ways has the MCSP been effective?

4.3 For those priorities and policies associated with global health initiatives in support of which you believe the MCSP has not been effective, why has the program not been effective?

4.4 For those global health initiatives with which you are familiar, where has the MCSP missed opportunities to promote associated priorities and policies?

4.5 For those global health initiatives with which you are familiar, what gaps in promotion of priorities and policies have you noted?

4.6 For those global health initiatives with which you are familiar, to what extent has MCSP applied or linked its country-level learning toward informing or strengthening the priorities and policies of these global health initiatives?

4.7 For those country-level MCSP programs with which you are familiar, to what extent has MCSP applied or linked global health initiatives’ priorities and policies toward informing or strengthening MCSP-supported country programs?

4.8 Based on lessons learned, what actions or interventions would you recommend for the remaining two years of the project and beyond?

5. **Moderator’s introduction to questions in this section:** The evaluation team is being asked to document the MCSP’s progress in promoting the integration of RMNCH platforms at country and global levels. Your response to the following questions will assist the evaluation team in assisting
USAID in accurately and reliably evaluating the extent to which the MCSP has strengthened integration of RMNCH programs at country and global levels. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.

[Note to the moderator: The exact wording of the SOW question is as follows: Integration and Cross cutting areas: To what extent and in what ways has MCSP, as an integrated flagship RMNCH project, been successful in maximizing opportunities for comprehensive RMNCH platforms at the country and global levels?]

5.1 Do you consider that the MCSP is an integrated RMNCH program?
5.2 Could you provide a few examples of instances that illustrate your position?
5.3 For all interventions with which you are familiar, where has the MCSP missed opportunities within its sphere of influence or control to promote integration across RMNCH initiatives?

[Note to moderator: The following questions address MCSP successes and challenges associated with the MCSP’s execution. The moderator should encourage/guide informants to consider both technical and managerial successes (especially those that the informant considers are innovative) and challenges for which the MCSP’s response was innovative.]

5.4 For all RMNCH country programs with which you are familiar, what have been the successes and challenges associated with sustaining and strengthening elements of health systems to support RMNCH services:

   5.4.1 Successes
   5.4.2 Challenges
   5.4.2.1 How has the MCSP responded to these challenges?

5.5 At the global and country level for all RMNCH initiatives with which you are familiar, what have been the successes and associated with advancing community and civil society engagement toward sustaining and strengthening health systems to support RMNCH services:

   5.5.1 Successes – Global
   5.5.2 Challenges – Global
   5.5.2.1 How has the MCSP responded to these challenges?
   5.5.3 Successes – Country-level
   5.5.4 Challenges – Country-level
   5.5.4.1 How has the MCSP responded to these challenges?

5.6 For the following crosscutting themes, has the MCSP been effective in incorporating the following principles in the design and implementation of activities with which you are familiar?

- Gender
  - Yes
  - Somewhat
  - No
  - Not sure
- HSS
  - Yes
  - Somewhat
  - No
  - Not sure
5.6.1 For those cross cutting themes with which you believe the MCSP has been effective, in what ways has the MCSP been effective?

5.6.2 For those cross cutting themes with which you believe the MCSP has not been effective, why has the program not been effective?

5.7 From your perspective with reference to your knowledge of the MCSP’s global learning agenda and of specific countries (or evidence-based information generation or research agenda), what have been the successes and challenges in supporting learning and decision making needs to advance RMNCH priorities?

5.7.1 Successes

5.7.2 Challenges

5.7.2.1 How has the MCSP responded to these challenges?

5.8 Based on lessons learned on cross-cutting topics, what actions or interventions would you recommend for the remaining two years of the project and beyond?

6. Moderator’s introduction to questions in this section: Finally, the evaluation team is being asked to document lessons learned that can inform project management for the remainder of the project life and future potential follow-on designs? Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.

[Note to the moderator: The exact wording of the SOW question is as follows: How could follow-on global project(s) be structured differently to better support Agency needs? This could include technical content, USAID’s and/or MCSP’s management approach, defining targets and expected results, etc.]

6.1 Looking back at the MCSP’s first three years of project implementation:

6.1.1 What lessons have been learned that will help inform project administrative management for the remainder of the project’s life?

6.2 Based on lessons learned and if you were to be involved in the design of a project to continue after the MCSP is completed in March 2019:

6.2.1 For the future project:

6.2.1.1 What elements should be added?

6.2.1.2 What elements should be removed?
From your perspective, what is the potential role (if any) for the private sector in a follow-on to the MCSP?

(To moderator: The final question is designed to give the key informant an opportunity to address additional points of importance that were not covered during the interview. Care should be taken to encourage the respondent to respond as openly and as frankly as possible in providing this additional input).

As stated in the introduction to this interview, the overall objective of the evaluation is to document the extent to which the MCSP has accelerated intensive reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. The evaluation is also expected to provide recommendations for the design of a possible successor to the MCSP project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?

(To moderator: At the completion of this final question, please thank the respondent(s) for their cooperation. Please be sure to record the starting and ending time of this focus group discussion.)
Key Informant Interview Consent Agreement
Mid-Term Evaluation of the Maternal and Child Survival Program (MCSP)

INFORMED CONSENT STATEMENT

Instructions to Moderator: Read the following to the respondents.

Good day. My name is ___________________, and we are conducting a performance evaluation of USAID/Global Health’s Maternal and Child Survival Program (MCSP). The overall objective of the evaluation is to document the extent to which the MCSP has accelerated intensive reductions in maternal, newborn, and child mortality, with increased equity to end preventable maternal and child death. MCSP is a follow-on to MCHIP and is being implemented by JHPIEGO and sub-partners on behalf of USAID.

You have been selected as a Key Informant to provide information that will establish a knowledge base critical to the evaluation team’s ability to respond to the evaluation’s objective. The information collected will only be used for the above purpose. All information you provide will be considered strictly confidential.

I would also like to clarify that this interview is entirely voluntary and that you have the right to withdraw from interview at any point without consequence.

At this time, do you have any questions? (Instructions to Moderator: If required, reference the above background information to respond to questions from the informant).

Are you willing to participate in this interview and to allow me to take notes?

Yes 1) Instructions to Moderator: Proceed
No 2) Instructions to Moderator: Thank the KI and STOP HERE

May I begin the discussion now?

Yes 1) Instructions to Moderator: Thank the KI and continue with the Key Informant Interview
No 2) Instructions to Moderator: Thank the KI and STOP HERE

E-Survey Consent Agreement Statement (Included with each survey to potential respondents)

The following questions are designed to solicit information that will strengthen the GH-Pro evaluation team's ability to objectively evaluate the MCSP's progress toward defined contractual objectives. Your participation in the e-survey is entirely voluntary. All responses provided in this survey will be confidential with the identification of all respondents masked for purposes of anonymity. Your willingness to respond to this survey by returning a completed e-survey to ghpro341@gmail.com, will confirm your agreement for the evaluation team to integrate your responses into the analyses associated with the final evaluation report.
ANNEX VII. E-SURVEY TEMPLATE

Mid-term Evaluation of the Maternal and Child Survival Program (MCSP)

USAID Priority Country Electronic Survey (e-Survey)

Managed by Global Health Program Cycle Improvement Project (GH Pro)

Commissioned by USAID/GH/MCHN, the Global Health Program Cycle Improvement Project (GH Pro) and USAID/GH/MCHN have formed a four-person evaluation team to undertake a mid-term evaluation of the MCSP. The purpose of this evaluation is to examine the project’s progress towards achieving planned results and lessons learned to date. The evaluation team will identify MCSP activities that may warrant continued future investment, as well as other RMNCH interventions and activities that would likely contribute to improvement of the project. Through analysis of MCSP’s progress and achievements at the mid-point of the project, this performance evaluation will make recommendations to improve implementation during the Years 4 and 5 of the project and will be used to guide USAID on the design of follow-on awards beyond the life of MCSP.

The following questions are designed to solicit information that will strengthen the GH-Pro evaluation team’s ability to objectively evaluate the MCSP's progress toward defined contractual objectives. Your participation in the e-survey is entirely voluntary. All responses provided in this survey will be confidential with the identification of all respondents masked for purposes of anonymity. Your willingness to respond to this survey by returning a completed e-survey to ghpro341@gmail.com, will confirm your agreement for the evaluation team to integrate your responses into the analyses associated with the final evaluation report. Accordingly, if you should agree to respond to this e-survey, the evaluation team would appreciate receiving your response no later than April 10, 2017. Thank you, in advance, for your consideration and cooperation.

Evaluation Code (For internal GH Pro Use)

Country: ____________________

Check one: ☐ Mission ☐ MCSP Project

Respondent Name(s): 1. ______________________ Position: ________________________

2. ______________________ Position: ________________________

3. ______________________ Position: ________________________

4. ______________________ Position: ________________________

Country Experience with the MCSP

1.1. With which of the following MCSP technical areas have you been involved:

☐ Maternal Health ☐ Newborn Health ☐ Child health ☐ Immunizations ☐ Family planning ☐ Nutrition ☐ Malaria ☐ HIV/AIDS ☐ Water and Sanitation ☐ HSS ☐ Community Health/Civil Society Engagement
1.2 *(For Mission Response Only)* Why did the Mission select MCSP to implement activities in your country?

1.3 Below are a number of statements regarding your experience with the MCSP’s technical and administrative execution of the program in your country. Please indicate with an “X” the extent to which you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
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<tbody>
<tr>
<td>a. The MCSP has met the Mission’s expectations</td>
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<td>b. MCSP has supported increased coverage of high impact interventions</td>
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<td>c. The MCSP’s technical approach is innovative</td>
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<td>d. The MCSP has exhibited adaptability and/or flexibility in the local country context.</td>
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<td>e. The MCSP’s activities are designed to enhance sustainability</td>
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<td>f. The MCSP has worked effectively with host-country counterparts</td>
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<td>g. The MCSP is responsive to the Mission’s reporting requirements</td>
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<td>h. The qualifications of MCSP’s technical staff meet the needs of the program</td>
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<td>i. The MCSP is effectively managed by MCSP leadership team in-country</td>
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<tr>
<td>Statements</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<tr>
<td>j. The MCSP is effectively managed by the USAID Mission</td>
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<td>k. The MCSP’s use of available resources is cost-effective</td>
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<td>l. The MCSP’s headquarters management is responsive to the needs of the country program</td>
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1.4 For those statements above (1.3) with which you agreed, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

1.5 For those statements above (1.3) with which you did not agree, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

1.6 What are the greatest strengths of MCSP’s approach towards achieving expected project results?

1.7 What are the greatest challenges associated with MCSP’s approach?
1.8 How is MCSP responding to these challenges?

1.9 What are the missed opportunities or gaps associated with the MCSP’s approach?

1.10 Additional comments on country experience with the MCSP:

2. **MCSP’s Global Leadership**: Given its significant outreach to USAID priority RMNCH countries, MCSP, through its available resources, has an opportunity to significantly contribute to key programs, priorities and policies on evidence-based high-quality RMNCH interventions across the continuum of care at the country, regional, and/or global level to support initiatives such as EPMM (Ending Preventable Maternal Mortality); ENAP (Every Newborn Action Plan); FP2020 (Family Planning 2020); RBM (Roll Back Malaria); the ICCM (Integrated Community Case Management) Task Force; APR (A Promise Renewed).

2.1 Below are a number of statements regarding the MCSP’s global leadership in promoting evidence-based, high-quality RMNCH programs, priorities and policies. Please indicate with an “X” the extent to which you agree or disagree with each statement:

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The MCSP is a global leader in supporting evidence-based assistance to</td>
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<td>the promotion of RMNCH programs, priorities and policies.</td>
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<td>b. The MCSP has been effective in linking country-level learning to inform</td>
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<td>global-level engagement.</td>
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</table>
2.2 For those statements above (2.1) with which you agreed, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

c. The MCSP has been effective in linking global-level learning with country-level engagement.

2.3 For those statements above (2.1) with which you did not agree, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

2.4 What are the greatest strengths of MCSP’s global leadership in RMNCH?

2.5 What are the greatest challenges associated with MCSP’s global leadership in RMNCH?

2.6 How is MCSP responding to these challenges?

2.7 What are the missed opportunities or gaps associated with MCSP’s global leadership?
2.8 Additional comments on MCSP’s Global Leadership:

3. **Integration and cross-cutting areas:** As USAID/ GH’s flagship RMNCH project, the MCSP has significant potential to maximize opportunities for comprehensive RMNCH platforms at the country and global levels.

3.1 Below are a number of statements regarding the MCSP’s promotion of integration and its focus on cross-cutting areas. Please indicate with an “X” the extent to which you agree or disagree with each statement. Please mark not applicable only if the MCSP activities with which you are familiar do not work at a level for which the cross-cutting issue could be reasonably incorporated into the approach.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The MCSP has demonstrated leadership in contributing to integrated RMNCH services at country level.</td>
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<td>b. The MCSP has incorporated principles of gender equality and empowerment in the design and implementation of activities.</td>
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<td>c. The MCSP has advanced community and civil society engagement towards improved RMNCH outcomes at global level.</td>
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<td>d. The MCSP has advanced community and civil society engagement towards improved RMNCH outcomes at country level.</td>
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<td>Statements</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<td>e. The MCSP has been effective in promoting strategic learning in RMNCH.</td>
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<td>f. The MCSP has advanced health systems strengthening towards improved RMNCH outcomes at country level.</td>
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<td>g. The MCSP has advanced quality of care towards improved RMNCH outcomes at country level.</td>
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<td>h. The MCSP has advanced RMNCH equity towards improved outcomes at country level.</td>
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<tr>
<td>i. The MCSP has advanced RMNCH innovation towards improved outcomes at country level.</td>
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3.2 For those statements above (3.1) with which you agreed, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

3.3 For those statements above (3.1) with which you did not agree, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.
3.4 What are the greatest strengths associated with MCSP’s integration of RMNCH platforms?

3.5 What are the greatest challenges associated with MCSP’s integration of RMNCH platforms?

3.6 How is MCSP responding to these challenges?

3.7 What are the missed opportunities or gaps associated with MCSP’s integration of RMNCH platforms?

3.8 Additional comments on integration and crosscutting areas:

4. **Future Mechanisms**: As USAID/GH’s flagship RMNCH project, the MCSP is expected to complete its activities in March 2019. Given the importance that it has assigned to raising global awareness and engagement in addressing RMNCH issues, USAID is considering the possibility of designing a follow-on project. Accordingly, the evaluation team would appreciate your response on the following issues.
4.1 Below are a number of statements regarding the potential focus of an MCSP follow-on program. Please indicate with an “X” the extent to which you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. USAID/GH’s approach to management of the global project is effective.</td>
<td>☐</td>
<td>☐</td>
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<td>b. The MCSP’s current design for enhancing synergy and coordination between core and field investments is effective.</td>
<td>☐</td>
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<tr>
<td>c. The MCSP’s current design for enhancing synergy and coordination between MCSP and other projects is effective.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>d. There is a role for increased private sector engagement in a follow-on project.</td>
<td>☐</td>
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</table>

4.2 For those statements above (4.1) with which you agreed, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

4.3 For those statements above (4.1) with which you did not agree, the evaluation team would appreciate any comments or observations that will assist us in understanding the basis for your selection.

4.4 Based on your response to the above statements (4.1) , please respond to the following requests for information that could be used in the design of a follow-on project:

4.4.1 Please recommend and prioritize ways in which USAID/GH’s management approach for the follow-on project could be enhanced.

4.4.2 Please recommend and prioritize ways in which a future project could enhance synergies and coordination between core and field investments.

4.4.3 Please recommend and prioritize ways in which a future project could enhance synergies and coordination with other projects (including other USAID-funded projects).
4.4.4 Please indicate, with an X in the applicable boxes, which of the MCSP's current components should be included in the future project's technical focus.

- Maternal Health
- Newborn Health
- Child health
- Immunizations
- Family planning
- Nutrition
- Malaria
- HIV/AIDS
- Water and Sanitation
- HSS
- Community Health and Civil Society Engagement
- Other technical components (Please specify):

4.5 Additional comments on future mechanisms:

5. Additional comments:

Thank you for your response to the above e-survey. We would value additional comments on the MCSP as well as on the strengths and challenges associated with completing this survey.

6. Future Contact

The evaluation team would welcome the opportunity to contact you by email or telephone to clarify or expand upon your responses to this survey.

6.1 Would you be willing to have us contact you during the month of May 2017? ☐ Yes ☐ No

6.2 If yes, please indicate how best to contact you:

   a. Email: _______________________
   b. Telephone: ____________________
   c. Skype: _________________________

Many thanks,

Bill Emmet
William Emmet, MPH, Dr.P.H. Team Lead
MCSP Midterm Evaluation
Email: ghpro341@gmail.com
Telephone: 1-207-529-5779
Mobile: 1-207-592-2251
Skype: william.le.roy.emmet
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**Project Work Plans - PMPs**

| **MCSP 18-month Work plan** | August 7, 2014 |
| **MCSP PY 2 Implementation Plan** | October 7, 2015 |
| **MCSP PY 3 Work Plan** | August 31, 2016 |
| **MCSP Global PMP** | February 2017 |
| **MCSP Ghana PMP** | February 2017 |
| **MCSP Madagascar PMP** | February 2017 |
| **MCSP Nigeria MNH PMP** | January 2017 |
| **MCSP Rwanda PMP** | February 2017 |
| **MCSP Ghana Five Year Strategic Plan and PY 1 Implementation Plan** | January 21, 2015 |
| **MCSP Ghana PY 2 Implementation Plan** | October 30, 2015 |
| **MCSP Ghana PY 3 Implementation Plan** | October 20, 2016 |
| **MCSP Madagascar PY 1&2 Work Plan** | June 12, 2015 |
| **MCSP Madagascar PY 3 Work Plan** | December 22, 2016 |
| **MCSP Rwanda PY 1 Work Plan** | September 14, 2015 |
| **MCSP Rwanda PY 3 Work Plan** | November 16, 2016 |

**Annual and Quarterly Reports**

<p>| <strong>MCSP Start Up Period Report</strong> | February 2015 |
| <strong>MCSP PY 1 Annual Report</strong> | February 2016 |
| <strong>MCSP PY2 Annual Report</strong> | February 2017 |
| <strong>Ghana MCSP Y1 Annual Report</strong> | January 2015 |
| <strong>Ghana MCSP Y2 Annual Report</strong> | November 7, 2016 |
| <strong>Ghana MCSP Y3 Q1 Report</strong> | March 2017 |
| <strong>MCSP Madagascar Baseline Report</strong> | No date |
| <strong>MCSP Madagascar Annual Report Y2</strong> | November 2016 |
| <strong>MCSP Rwanda Baseline Report</strong> | No date |
| <strong>MCSP Rwanda Annual Report Y2</strong> | 2017 |
| <strong>MCSP Rwanda Quarterly Report Oct-Dec 2016</strong> | 2017 |</p>
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<td>MCSP Rwanda PY 3 Summary Budget</td>
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<td>MCSP Internal Review Findings for USAID</td>
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<td><strong>USAID Global Initiatives and Strategies</strong></td>
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<td>The Global Strategy for Women's Children's and Adolescents' Health (2106-2030)</td>
<td>2015</td>
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<td>Every Newborn: An Action Plan to End Preventable Deaths</td>
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<td>Strategies toward ending preventable maternal mortality</td>
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<td>Global Call to Action: To Increase National Coverage of Intermittent Preventive</td>
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<td>Treatment of Malaria in Pregnancy for Immediate Impact</td>
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<td>FP2020: Momentum at the Midpoint</td>
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<td>Preliminary Results of an Analysis of the maternal and Newborn Content of Routine</td>
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<td>Policy Change to Advance Scale Up of High-Impact Reproductive, Maternal, Newborn, and</td>
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<td>MCSP Madagascar Clinical Governance/Quality Improvement: A strategy for managing and</td>
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<td>MCSP Madagascar Technical Brief: Maternal and Newborn Health</td>
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<td>MCSP Madagascar Digital Health Brief: Utilizing mHealth and mMentoring to build capacity and improve quality of care</td>
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<td>Impact Madagascar: A national family planning conference mobilizes stakeholders to increase their commitment to universal access</td>
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<td>Impact Madagascar: How providers' behaviors impact beneficiaries and their utilization of PPFP services</td>
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<td>Formative research on the individual, family, and community factors and of services influencing the utilization of reproductive health services by young parents in two regions of Madagascar: Menabe and Vakinankaratra</td>
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<td>Recommendations for Augmentation of Labour: Highlights and Key Messages from WHO’s 2014 Recommendations</td>
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<td>Postnatal Care for Mothers and Newborns: Highlights from the WHO 2013 Guidelines</td>
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<td>WHO Recommendations on Interventions to Improve Pre-Term Birth Outcomes: Highlights and Key Messages from the WHO’s 2015 Recommendations</td>
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<td>MCSP Madagascar First Time Parents Study: Findings from Formative Research</td>
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<td>MCSP: Child Health</td>
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<td>MCSP Nutrition Brief: Junk Food Consumption is a Nutrition Problem Among Infants and Young Children: Evidence and Program Considerations for Low and Middle Income Countries</td>
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<td>Legacy Brief: Quality: Improving Quality of RMCNH Services for Better Health Outcomes</td>
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<td>Legacy Brief: Equity: A Core Commitment for MCSP</td>
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<td>MCSP Ethiopia Baseline Report</td>
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**Presentations**

- MCSP Maternal Health Summary of Mid-Term Evaluation Brief Presentation               | March 22, 2017 |
- MCSP Madagascar: MCAP Mid-Term Evaluation                                            | April 2017     |
- Country Briefings: Overview Ghana, Rwanda, Madagascar                                | March 22, 2017 |
- MCSP Newborn Health                                                                  | March 22, 2017 |
- Technical Team Session: Child Health, Immunization, Malaria (iCCM), and Nutrition (CH) | March 22, 2017 |
- Analysis of Equity of RMNCH Indicators in MCSP-Supported Countries                  | No date        |
- The Maternal and Child Survival Program                                              | March 22, 2017 |
- MCSP Rwanda: MCAP Mid-Term Evaluation                                                | March 2017     |
- MCSP Ghana: MCAP Mid-Term Evaluation                                                 | April 2017     |
Annex IX. Biographical Sketches of Evaluation Team

Allyson Bear is a maternal and child health subject matter expert with 18 years of experience designing, managing, and evaluating public health programs, including 11 years living and working in Africa and Asia. Ms. Bear joined USAID in 2009, serving in Mali (2010 – 2012) as a nutrition and WASH advisor and Bangladesh (2012-2015) as the deputy director of the Office of Population, Health, Nutrition, and Education. In 2016, she assumed her current position as a maternal and child health advisor in the USAID Global Health Bureau. Before joining USAID, Ms. Bear held a faculty appointment in the Department of International Health at Johns Hopkins School of Public Health. Prior to that, she managed diverse development portfolios for international nonprofit organizations in the areas of maternal and child health, nutrition, reproductive health, economic growth, agriculture, and food security. Ms. Bear is currently a doctoral candidate at the Johns Hopkins School of Public Health, where she earned a master’s of public health. She also holds a bachelor of science in social policy from Northwestern University, and speaks French in addition to her native English.

William Emmet, team lead, is an international public health program management specialist with 47 years of experience in communicable diseases, maternal health, child survival, diarrheal diseases, immunizations, HIV/AIDS, reproductive health, family planning, and public health policy. Dr. Emmet has served as a resident chief of party for six international public health projects and as a US-based senior program operations, management, governance, and evaluation adviser for projects and programs in Africa, the Middle East, Asia, and Eastern Europe. As an independent consultant since 2007, he has led evaluation teams in assessing 12 health care projects and programs in Washington and Asia, and in African Francophone and Anglophone countries. Dr. Emmet has a doctorate in public health from the University of Texas Health Science Center School of Public Health – Houston, a master’s of public health from the University of California Los Angeles School of Public Health, and a bachelor of arts in political science from the University of Pennsylvania.

Elizabeth Noonan is an immunization advisor in USAID’s Office of Maternal and Child Health and Nutrition. In this role, she supports the management and oversight of the US Government’s investment in Gavi, the Vaccine Alliance, with a focus on strengthening country-level coordination to ensure global and bilateral resources are strategically aligned and complementary. Prior to joining USAID, Ms. Noonan worked for Jhpiego supporting the closeout of USAID’s flagship Maternal and Child Health Integrated Program and in Bangladesh as a visiting research student with the International Center for Diarrheal Disease Control. She was a Peace Corps Volunteer in Armenia and holds a master’s of public health from George Washington University and a bachelor of science from the University of San Francisco.

Pamela Putney is a maternal newborn and child health specialist with almost 35 years of domestic and international experience in 37 countries in the design, implementation, management, and evaluation of programs focusing on maternal, neonatal, child and reproductive health, gender issues, health policy, sustainable health systems, human resource development, training, strategic planning, organizational development, quality of care, HIV/AIDS, behavior change/communication, proposal and grant writing, fundraising, and leadership development. She has a master’s of science and certification in nurse-midwifery from Columbia University, and has served as a team member on eight global project evaluations.
ANNEX X. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

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

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

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

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient’s “need to know” or “need to access” Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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<th>Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.</th>
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<td>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.</td>
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**ACCEPTANCE**
The undersigned accepts the terms and conditions of this Agreement.

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<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>William Le Roy Emmet, II</td>
<td>02/01/2017</td>
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<td>William Le Roy Emmet, II</td>
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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.

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<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Pamela J. Putney</td>
<td>12/24/2016</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
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