PERFORMANCE (ENLINE) EVALUATION OF THE ADVANCING PARTNERS AND COMMUNITIES PROJECT

October 2018

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The evaluation team is grateful to the staff of the Advancing Partners & Communities (APC) Project at John Snow, Inc. Research & Training Institute and FHI 360 in the United States, Benin, and Uganda who, despite many other pressing commitments, were responsive to our repeated requests. APC staff was supportive throughout the evaluation, providing resources and documents and arranging our program. We would also like to acknowledge the support of the USAID agreement officer’s representative, Dr. Melissa Freeman and her colleagues at USAID, and the participation of APC implementing partners in the United States and Africa. We thank respondents from international organizations, cooperative agencies, and research institutions who gave their time to respond to our interviews, including Mission staff and grantees who responded to online surveys. The authors also acknowledge the support of staff members at the Beninese and Ugandan ministries of health and related institutions, USAID/Benin and USAID/Uganda, and the collaborating agencies, development partner agencies, and a wide range of nongovernmental organizations in Benin and Uganda. We also appreciate the cheerful and extensive support and participation of GH Pro staff, who set up and attended conference calls, provided comments on draft documents, and showed tremendous patience and flexibility in setting up our final schedule. The evaluation team hopes this evaluation and the recommendations presented in this report will contribute to future USAID-supported programs to promote family planning, especially in the area of community-based family planning and related program innovations, to improve access to reproductive health services for women, men, and couples in underserved areas around the world.
ABSTRACT

The Advancing Partners & Communities (APC) Project is a five-year USAID cooperative agreement with the John Snow, Inc. Research & Training Institute, in collaboration with FHI 360, funded from October 2012, with a two-year extension until September 2019. This evaluation assessed the extent to which APC has achieved its objectives and identified community-based family planning (CBFP) activities that might warrant future investment. The evaluation questions examined APC’s global leadership and advocacy for CBFP, its sub-grant program, and its efforts to strengthen the capacity of private voluntary organizations/nongovernmental organizations to implement effective programs. USAID will use the evaluation to inform future programming.

The evaluation team visited APC projects in Benin and Uganda, conducting 114 key informant interviews, online surveys of Missions and grantees, and group discussions with health workers and clients. Key APC achievements included global- and country-level support for family planning (FP) and CBFP in 16 FP projects and implementation of HIV/AIDS, post-Ebola, and other health initiatives in 38 countries. CBFP advocacy focused on the global and country levels, where it promoted innovative CBFP programs, networking with local partners to advocate for changing policy/regulations in several African countries to allow community health workers to inject depot medroxyprogesterone acetate (DMPA), to improve drug shops’ provision of injectable contraceptives, and ensure links to FP within broader community health policy agendas.

Testing the efficacy of self-injection of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) was a major achievement; however, global advocacy for CBFP was not as focused. Key recommendations include improving monitoring and evaluation of sub-grants and related activities and continuing to collaborate with USAID and global partners to ensure wide and effective CBFP advocacy.
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ACRONYMS

ABMS/PSI  Association Béninoise pour la Mobilisation Sociale (Benin Association for Social Mobilization)/Population Services International
ADRA  Adventist Development and Relief Agency
AOR  Agreement officer’s representative
APC  Advancing Partners & Communities
CBA2I  Community-based access to injectables
CBD  Community-based distributor
CBFP  Community-based family planning
CCIH  Christian Connections for International Health
CDC  Centers for Disease Control and Prevention
CHS  Community Health Systems
CHW  Community health workers
CORP  Community-owned resource person
CPA  Concerned Parents Association
DFID  UK Department for International Development
DMPA  Depot medroxyprogesterone acetate
DMPA-IM  Intramuscular depot medroxyprogesterone acetate
DMPA-SC  Subcutaneous depot medroxyprogesterone acetate
DSME  Direction de la Santé de la Mère et de l’Enfant (Ministry of Health’s Directorate for Maternal and Child Health, Benin)
ECP  Emergency contraceptive pill
FBO  Faith-based organization
FP  Family planning
FP2020  Family Planning 2020
FY  Fiscal Year
GEM  Gender equitable men
GH  Bureau for Global Health
GSM  Grants, Solicitation, and Management Project
HTSP  Healthy timing and spacing of pregnancies
JSI  John Snow, Inc.
K4Health  Knowledge for Health
KII  Key informant interview
LARC  Long-acting and reversible contraceptive
M&E  Monitoring and evaluation
m4RH  Mobile for Reproductive Health
MCH  Maternal and child health
MNCH  Maternal, newborn, and child health
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>NDA</td>
<td>National Drug Authority</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>PHE</td>
<td>Population, health, and environment</td>
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<tr>
<td>PIHI</td>
<td><em>Paquet d’Intervention à Haut Impact</em> (Package of High-Impact Interventions)</td>
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<td>PRH</td>
<td>Office of Population and Reproductive Health (USAID)</td>
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<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>PVO</td>
<td>Private voluntary organization</td>
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<td>QA</td>
<td>Quality assurance</td>
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<td>RH</td>
<td>Reproductive health</td>
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<td>SBC</td>
<td>Social and behavior change</td>
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<td>SDI</td>
<td>Service Delivery Improvement (USAID)</td>
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<td>SGJ</td>
<td>Sonke Gender Justice</td>
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<td>SOW</td>
<td>Scope of work</td>
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<tr>
<td>TA</td>
<td>Technical assistance</td>
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<td>TICA</td>
<td>Technical Integration for Coverage and Access</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UPMB</td>
<td>Uganda Protestant Medical Bureau</td>
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<tr>
<td>VHT</td>
<td>Village health team</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>YFHS</td>
<td>Youth friendly health services</td>
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EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The primary purpose of this endline evaluation was to assess the extent to which the Advancing Partners & Communities (APC) Project has achieved its objectives. A secondary purpose was to identify community-based family planning (CBFP) activities that might warrant future investment and to better understand the roles of the partners. Its two other objectives were to improve program planning in APC’s final years and inform programming beyond the life of the project.

The four main evaluation questions are presented in the table below. The first three questions address APC’s three primary results, while the fourth refers to the overall extent that APC has achieved its objectives.

<table>
<thead>
<tr>
<th>Result</th>
<th>Evaluation Question</th>
<th>Purpose of Additional Questions</th>
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<tr>
<td>1. Strengthened global leadership and advocacy for community-based programming and effective program approaches and tools, primarily for family planning (FP) [Advocacy and Technical Assistance (TA) at all levels]</td>
<td>1. Has APC provided global leadership and advocacy for CBFP? If yes, how? If no, why not?</td>
<td>Identify successes, missed opportunities, and lessons learned.</td>
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<tr>
<td>2. Innovative private voluntary organization (PVO)/nongovernmental organization (NGO) community programs expanded and strengthened (Grants Management)</td>
<td>2. Has APC’s sub-grant program expanded and strengthened innovative PVO/NGO community programs? Yes or no? If so, how? If no, why not?</td>
<td>Identify innovative approaches implemented through the APC sub-grant program, the outcomes of the program, and contributions it made to USAID’s Office of Population and Reproductive Health (PRH) priorities, especially Method Choice, FP Workforce, Social and Behavior Change, Youth, and Gender.</td>
</tr>
<tr>
<td>3. PVOs/NGOs prepared to receive USAID funds and implement effective community-based programs, especially FP (Capacity Building)</td>
<td>3. Has APC strengthened PVOs/NGOs to implement effective programs? 4. To what extent did APC achieve its objective?</td>
<td>Identify approaches utilized by APC to strengthen the technical and organizational capacity of sub-grantees; approaches used to provide technical support to PVOs/NGOs to advance effective programming and the extent to which these approaches were successful; and technical support activities that could have been eliminated or reduced while achieving the same level of project success.</td>
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TARGET AUDIENCE AND ANTICIPATED USE OF THE RESULTS

USAID’s Service Delivery Improvement (SDI) Division and PRH will use the evaluation to inform future CBFP programming, and APC can use the results to prioritize and inform activities in its final year.

PROJECT BACKGROUND

APC is the Bureau for Global Health’s (GH) mechanism for global leadership in CBFP. It provides global leadership for community- and facility-based health programming, manages a large sub-award program, and builds the technical and organizational capacity of NGOs to implement effective programs that
comply with USAID rules and requirements and achieve health-related impact in family planning (FP),
maternal and child health (MCH), HIV/AIDS, and infectious diseases.

In October 2012, GH/PRH/SDI awarded APC, a five-year cooperative agreement, to John Snow, Inc.'s
(JSI) Research & Training Institute as the implementing partner, with FHI 360 as a collaborative partner.
The project has a current ceiling of $251 million, which includes a two-year, $41 million extension that
was approved in March 2017, resulting in a new project end date of September 30, 2019.

In 2007, PRH identified CBFP as a global Technical Priority to help improve access to FP in rural and
underserved areas. APC is a continuation of a series of USAID GH investments in CBFP, building on
lessons learned under previous projects, including the Grants, Solicitation, and Management Project

PRH initiates, funds, and manages the project with a focus on CBFP and increasing access, choice, and
quality of FP. However, because of increasing buy-in from local Missions and their emphasis on other
health areas (e.g., HIV/AIDS, Ebola, tuberculosis, malaria, and nutrition) funding for FP accounted for less
than 25 percent of the total funding. Since 2012, 38 countries have received support from APC through
core investments or field support buy-in. Funding received (but not limited to) includes FP; Ebola,
HIV/AIDS; Bureau for Democracy, Conflict, and Humanitarian Assistance; tuberculosis; malaria; and
nutrition.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

Overall approach
The evaluation used a mixed-methods methodology consisting of quantitative and qualitative approaches.
An interdisciplinary team with diverse expertise and extensive experience conducted the evaluation,
which combined a desk review of pertinent project documents (e.g., annual management reviews, special
reports commissioned by APC, and statistics on different aspects of the project available at APC) and
application of qualitative techniques through key informant interviews (KIIs) with 57 men and 57 women
(for a total of 114). Field visits to Benin and Uganda (seven and six days, respectively) were included due
to these countries’ importance in APC’s FP activities. The team visited locations where APC was in
progress or activities had been completed. In addition to the KIIs, they conducted four group
discussions with community health workers (CHWs), one with midwives, and two with predominantly
male Emanzi groups, which encourage constructive roles for men in sexual reproductive health, to get
their perspectives.

The evaluation team developed two web-based instruments, one for USAID’s local Missions and one for
grantees. Invitations to participate in the web-based surveys were sent to 28 USAID staff and seven
Centers for Disease Control and Prevention staff (35 total) in 20 countries where APC has worked or
is currently working and 84 grantees (who carried out a total of 104 APC grants). After sending two
reminders, the team received 13 responses from the Missions and 22 from grantees; the data collected
has been analyzed and used in the evaluation to give quantitative support to the KII analysis.

Data analysis methods
Well-established frameworks pertinent to FP were adapted for the data collection, analysis, and
evaluation writing (Bruce 1990; Rivero-Fuentes, Estela, et al. 2008; Pelto et al. 2014). Each data
collection method was carried out in its entirety and analyzed separately over the same period. The
analysis considers how APC has contributed to increasing access to FP, contraceptive choice, and quality
of services using CBFP, as well as how the sub-grant scheme and TA has helped to build NGOs’
capabilities and other questions related to Evaluation Questions 2 and 3. Because this is a mixed-
methods evaluation, quantitative and qualitative data have been integrated to get precise answers to the
evaluation questions.
Limitations of evaluation methods
The evaluation team acknowledges limitations to the evaluation design. First, most informants/participants for KII and informal group discussions were selected purposively. However, a conscious attempt was made to include all types/groups of informants to capture variations in perceptions and responses. This was maintained in selecting informants in the United States, Benin, and Uganda. Second, the team visited only two of the 38 countries APC covers, as identified in the scope of work.

FINDINGS AND CONCLUSIONS1

Result 1
The challenges to demonstrate leadership at the global level for strengthening and advocating for CBFP can be quite different when working at the country level, often constrained by local context. Therefore, the evaluation team looked at APC achievements in global leadership and advocacy for CBFP separately from the country-level initiatives to strengthen and expand CBFP services.

Key findings for global leadership and advocacy for CBFP
APC carried out many activities to demonstrate global leadership in strengthening and advocating for CBFP. For example, it participated in and took the lead in 11 global and regional meetings to provide leadership to popularize CBFP and share its innovative work. Perhaps its most important global contribution was demonstrating that CHWs could efficiently deliver and inject injectable contraceptives at home and at the community level. Though this has been demonstrated elsewhere (e.g., Bangladesh), it was the first time it had been successfully demonstrated in many African countries, where the environment is much more challenging. Efforts in Benin and Uganda provided examples of the possibility of community-based access to injectables (CBA2I) using CHWs, which is now gaining momentum in other countries.

Benin and Uganda illustrate one of APC’s most important contributions: that lower-level cadres of health workers (i.e., CHWs) can safely and successfully administer injectables at the community level. Under APC in Malawi, FHI 360 conducted a randomized control trial to compare continuation rates between women who self-injected subcutaneous depot medroxyprogesterone acetate (DMPA-SC) compared to women who received DMPA-SC from a provider, including CHWs. The results showed self-administration led to a more than 50 percent increase in continuous DMPA-SC pregnancy protection through 12 months than provider-administered injections. The study also demonstrated that CHWs can safely train women to self-inject. This is a groundbreaking study, and APC has shared its findings at national and international forums, including publication in *The Lancet Global Health*. Furthermore, the World Health Organization is considering using the results to inform its guidelines for home and self-injection of DMPA-SC. In Malawi, even though the government has yet to change its policy, the Ministry of Health (MOH) is planning to scale it up. In Benin, the MOH has allowed the introduction of DMPA-SC and its provision through CHWs.

APC reports it has produced or modified existing publications/tools and published at least 116 materials related to CBFP. Some of these materials are useful and could be used for CBFP sensitization and advocacy. For example, the Community Health Systems (CHS) Catalog provides detailed information on community health and FP policies across 25 priority countries in a single volume; it could be used as a CBFP resource book, and would be useful for researchers, policymakers, and program managers.

The evaluation showed that APC has implemented several important initiatives for strengthening global leadership and advocacy for community-based programming. However, it is not clear to what extent this

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1 The USAID AOR and APC Project, after completing a careful review of this evaluation report, did not agree with several of the findings and conclusions of the report. A Statement of Differences can be found in Annex V of this report.
has made a difference. One reason could be that APC did not have a clear strategy or pathway on how to provide the required global leadership and what activities it should systematically support to give momentum to the CBFP initiative. During in-depth interviews, most APC informants could not answer if they had visualized a clear pathway that could lead to global acceptance of CBFP as an effective way to deliver contraceptive services at the community level. APC activities and initiatives were often ad hoc; more often, they were not pursued far enough to yield the required results.

**Key findings for country-level initiatives to strengthen and expand CBFP services**

In contrast, APC played a more aggressive role in working with MOHs for task-shifting and changing policy/regulations to empower CHWs to deliver contraceptives, including intramuscular depot medroxyprogesterone acetate (DMPA-IM), DMPA-SC, and emergency contraceptive pills. APC representatives at the country level have kept close links with the government and provide TA in policy formulation, coordinating task forces/working committees for the MOH and the National Drug Authority (in Uganda, for drug shops). APC has advocated for task-shifting with the MOH for changing policy to allow CHWs to provide CBA2I. Advocacy publications such as *Community Health Worker Provision of Injectable Contraceptives: An Effective CBA2I Strategy* and companion materials in support of drug shops’ provision of injectables, were shared with governments of various countries, including Benin, Burkina Faso, Guinea, Madagascar, Pakistan, Uganda, and Zambia. These efforts have helped in many countries to change the policy or, in the case of Benin, Uganda, and Zambia, provided permission to test the feasibility, effectiveness, and quality of providing DMPA-SC and DMPA services delivered by CHWs.

But many countries have yet to change their policy or are in the process of discussing changes. APC has successfully advocated to shift policy in Benin, Uganda, and Zambia. In Benin, it advocated to the government to introduce CBA2I, supported a pilot in 2015 to provide CBA2I outreach services through CHWs, and is supporting the government-led introduction of DMPA-SC in three health zones that will be rolled out in seven more health zones. In Uganda, the MOH and the National Drug Authority have approved provision of DMPA-SC and DMPA-IM by drug shops in 20 districts as part of a phased nationwide scale-up plan. APC is networking with other local partners and representatives of other international agencies in country [e.g., the United Nations Population Fund, the International Planned Parenthood Federation, Save the Children, and University Research Corporation] to strengthen advocacy for CBFP. TA to the MOH and close networking with local and international partners has been a successful strategy of APC to achieve its objectives.

Additionally, TA to district health authorities to establish the Centre for Excellence in the District Uganda Busia, where APC, with USAID Mission funds, developed and tested a model for ensuring quality assurance of FP services provided by community health volunteers, is an excellent initiative and has huge potential for expansion. Similarly, visits to other sub-grantees such as the Salvation Army, WellShare, and the Uganda Protestant Medical Bureau revealed that all these small grants are important, and their impact and lessons learned should have been evaluated and documented to share the findings with wider audiences. However, the evaluation team felt that APC in general has neglected this and considers it a major missed opportunity. One possible reason is that core funding from USAID was very limited. Therefore, evaluation of the impact of all projects may not be feasible; however, taken together, a systematic process documentation and data review could have significantly reduced this limitation.

The evaluation team feels that, despite these constraints, APC has tried hard to provide global and country leadership to increase CBFP. However, its performance at the country level was more focused and strategically planned, particularly in working with the MOH and networking with local partners to influence policy change. This raises a question: Should both of these roles (i.e., provision of leadership for strengthening CBFP globally and country-level initiative) be kept with one agency or shared between two agencies?
Result 1 Conclusions

The evaluation shows that APC worked hard to provide global and country leadership to increase CBFP. Performance at country level was much more focused and strategically planned, particularly in working with MOHs and networking with local partners to influence policy change to support CBFP locally rather than through global leadership. In part, this may be because the countries visited have buy-in funds from the local Missions that augmented the core-funded work. The small FP grants awarded to NGOs and institutions at the country level were important; however, monitoring and evaluation (M&E) was either not done or used only service statistics to assess the results of the interventions (e.g., the core-funded projects), but did not include further information, such as documentation on processes, challenges, lessons learned, or chances for replicability. Throughout the evaluation, the team felt that APC had generally neglected M&E and considered this a major missed opportunity. To what extent project publications have contributed to advocacy, sensitization, or popularizing CBFP is not clear. The CHS Catalog is an important contribution and has been downloaded in many countries. A concerted effort to increase utilization of APC’s advocacy materials for CBFP was not apparent.

Result 2

This question, related to how the APC sub-grant program expanded and strengthened innovative PVO/NGO community programs, was addressed using results from the surveys of Missions and APC grantees and responses during KIIs. The quantitative data from the online surveys show that the Missions ranked APC above average in achieving in-country health goals and rated project performance above average with respect to understanding the country’s health needs. A majority of Missions rated APC’s capacity-building efforts above average in providing better-quality services. Similarly, the survey of grantees revealed that they appreciated APC because they viewed it as an excellent resource for TA support, believed the TA providers from the United States were knowledgeable, and the project has both technical and financial strengths. A majority felt that the TA they received improved implementation of their project and/or that outcomes had improved and reported improvement in staff skills in overseeing grant management. When grantees were asked to suggest alternative ways of providing APC technical support for ensuring sustainability of outcomes, responses included helping NGOs to create better profiles to be independent to sell services, greater exchange with other grantees, documenting lessons from other grantees and sharing them with the group, and providing more direct one-to-one TA to their partners.

The grantees were also asked to explain what they considered the single greatest shortcoming/weakness in APC’s/implementing agencies’ TA. Responses were diverse, and a single greatest shortcoming was not apparent. Weaknesses cited included that high reporting demands took time away from project implementation and expectations of field staff were considered unrealistic/irrelevant, such as compliance with USAID policies for in-country staff to learn the names of U.S. FP/reproductive health laws — a USAID requirement for all donor recipients. KII respondents’ opinions about the sub-grant program varied. Several grant recipients were able to receive follow-up funds from USAID or grants from other donors. Based on reporting from a senior USAID staff member with good knowledge of APC, some former grant recipients did report achieving additional funds.

The JSI finance team was responsible for APC’s sub-award component; it handled the program with relatively low overhead costs, generally less than 8 percent, and has been proactive in preparing grantees for financial transactions. About half of the 84 grantees have required intensive assistance with their grants.

Result 2 Conclusions

Mission and grantee surveys and personal discussions with NGOs during field visits showed that the grant process was effective in developing key USAID skills and acquiring follow-up funding. This conclusion should be taken with caution, however, because of the small number of responses and self-selection bias. Respondents felt that grantees could be trained with low overhead costs and that there
was effectiveness in getting follow-up funding. Grant management was cost-efficient. There is a need for M&E from the beginning of each grant, and more comprehensive monitoring data with someone to examine them closely. This should be part of the design level at the beginning of each program.

**Result 3**

For Years 4 and 5, a series of standard indicators (indicators 3.1 through 3.5) showed consistent progress in strengthening PVO/NGO technical and organizational capacity. There were compelling examples of efforts to strengthen implementation of effective programs, such as the Package of High-Impact Interventions (PIHI) Program in Benin. Three NGOs — BUPDOS, Dedras, and Sian’son — have implemented this program, and received 68 APC training courses on nine topic areas, including on key requirements to receive USAID funding as well as training to implement their focus activities, which include high-impact interventions related to MCH and FP. Based on interviews and a review of project documents, these trainings were effective not only for PIHI activities, but also in relation to adherence to requirements for implementation of CBFP, CBA2I, and DMPA-SC.

In Uganda, WellShare received two sub-grants. One focused on FP/HIV integration in Arua district of the West Nile region (2014–2015) and another focused on CBA2I and CHW provision of emergency contraceptive pills in two districts in the East and East–Central regions (2014–present). The project in Arua demonstrated progress by reaching 3,522 clients (724 males and 2,798 females) with CBFP services through project-trained community-resource persons and community health volunteers. It also reached 19,016 people (6,686 males and 12,330 females) with FP messages during group discussions and home visits. Groups such as WellShare in Uganda or ChildFund in Benin and Zambia have relatively strong capacity, providing APC with a strong country platform in which to scale up CBFP efforts. This is an important consideration for the level of TA capacity that may be needed for a particular grantee.

Training was the primary approach APC used to provide technical support for PVOs/NGOs to advance effective programming. The FP-related programs APC supported emphasized training as a basis for advancing effective PVO/NGO programming.

**Result 3 Conclusions**

APC succeeded in supporting effective FP projects in Benin, Uganda, and other countries. Training has been the primary intervention for improving FP services, but improving administrative and management performance was also important. The project has demonstrated success in increasing grant recipients’ organizational capacity, but their technical skills for FP service delivery were somewhat more limited, especially for M&E.

**RECOMMENDATIONS**

**Result 1**

- APC management and grantees need to improve M&E of sub-grants and related activities. The evaluation team did not see any systematic measures that could help in accreditation of NGOs as “graduated” to implement a high-quality program independently.

- When possible, project management should make global advocacy, especially for CBFP, a focused activity with a clear pathway. A well-thought-out strategy and a sustained effort are required to achieve this goal.

- APC should continue to work with USAID agreement officer’s representatives (AORs) and global partners to ensure that CBFP advocacy is both wide and effective.

- APC should continue CBFP activities using sub-grants to engage new local partners and build capacity for country self-reliance.
Result 2

- APC and USAID should continue the sub-grant process for FP programs, with an emphasis on developing compatibility with USAID grant requirements while maintaining low overhead rates.

- APC and USAID should ensure M&E for the duration of projects and use data to inform, adapt, and strengthen activities.

- Abruptly discontinuing a project activity reduces its chances of scaling up. While many of the core FP sub-grants were continued year to year, they often changed program focus, discontinuing promising efforts. For successful project-supported activities, if possible, APC or USAID should consider a small follow-up grant to create conditions for scaling up and sustainability, and/or for Missions to build on or incorporate these successes into existing or future projects.

Result 3

- APC or USAID should continue current sub-grants for FP projects to develop and improve program performance.

- USAID should continue APC’s capacity-building approaches to strengthen sub-grantees’ technical and organizational capacity.

- M&E skills should be an integral component in APC-supported training of grantees and should be imparted to make grantees capable of working independently. Performance monitoring is as important as financial management and could be measured by introducing a process of APC- or USAID-supported accreditation of PVOs/NGOs for enhanced capability.
1. INTRODUCTION

ANALYTIC PURPOSE AND EVALUATION QUESTIONS

The purpose of the evaluation was to:

- Assess the extent to which the Advancing Partners & Communities (APC) Project has achieved its objectives
- Identify community-based family planning (CBFP) activities that may warrant future investment
- Improve program planning in the final years of the project
- Inform programming beyond the life of the project

The evaluation questions, grouped by result, are presented below.

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<th>Result</th>
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<tbody>
<tr>
<td>1. Strengthened global leadership and advocacy for community-based programming and effective program approaches and tools, primarily for family planning (FP) [Advocacy and Technical Assistance (TA) at All Levels]</td>
<td>1. Has APC provided global leadership and advocacy for CBFP? If yes, how? If no, why not?</td>
</tr>
<tr>
<td>2. Innovative private voluntary organization (PVO)/nongovernmental organization (NGO) community programs expanded and strengthened (Grants Management)</td>
<td>2. Has APC’s sub-grant program expanded and strengthened innovative PVO/NGO community programs? Yes or no? If so, how? If no, why not?</td>
</tr>
<tr>
<td>3. PVO/NGOs prepared to receive USAID funds and implement effective community-based programs, especially FP (Capacity-Building)</td>
<td>3. Has APC strengthened PVOs/NGOs to implement effective programs?</td>
</tr>
<tr>
<td></td>
<td>4. To what extent did APC achieve its objectives?</td>
</tr>
</tbody>
</table>

TARGET AUDIENCE AND ANTICIPATED USE OF THE RESULTS

USAID’s Service Delivery Improvement (SDI) Division and Office of Population and Reproductive Health (PRH) will use the evaluation to inform management decisions for the final year of implementation and for future programming for CBFP. APC can use the results to prioritize and inform activities in its final year.
2. PROJECT BACKGROUND

APC is the Bureau for Global Health’s (GH) mechanism for global leadership in community-based programming. In October 2012, GH/PRH/SDI awarded APC, a five-year cooperative agreement for $210 million, to John Snow, Inc’s. (JSI) Research & Training Institute as the prime implementing partner, in collaboration with FHI 360. A two-year extension was approved in March 2017, increasing the project ceiling to $251 million, with a new end date of September 30, 2019. The project focuses on community-based health programming. It provides global leadership for community- and facility-based health programming, manages a large sub-award program, and builds the technical and organizational capacity of NGOs to implement effective programs that comply with USAID rules and requirements, achieve health-related impact in FP and maternal and child health (MCH), and to combat HIV/AIDS and infectious diseases.

In 2007, PRH identified CBFP as a global Technical Priority to help improve access to FP in rural and underserved areas. APC is a continuation of a series of USAID GH investments in CBFP, building on lessons learned under previous projects, including the Grants, Solicitation, and Management (GSM) Project (2004–2012) and the Flexible Fund grant program (2002–2012).

PRH initiates, funds, and manages the project with a focus on CBFP and increasing access, choice, and quality of FP. However, because of increasing buy-in from local Missions and their emphasis on other health areas (e.g., HIV/AIDS, Ebola, tuberculosis, malaria, and nutrition) funding for FP accounted for less than 25 percent of the total funding. Since 2012, 38 countries have received support from APC through core investments or field support buy-in (see Figure 1). Funding received includes FP; Ebola; HIV/AIDS; Bureau for Democracy, Conflict, and Humanitarian Assistance; tuberculosis; malaria; and nutrition.

Figure 1. Locations of APC Project Activities

Advancing Partners & Communities (APC) provides technical support, capacity strengthening, and administrative oversight to community health programs worldwide. APC is currently working in 38 countries with four APC country offices in Benin, the Dominican Republic, Guyana and Sierra Leone.

The full list of countries APC is working in includes: Bangladesh, Benin, Burundi, Buru, Cambodia, Cameroon, Colombia, the Dominican Republic, the Democratic Republic of the Congo (DRC), El Salvador, Ethiopia, Ghana, Guinea, Guyana, Haiti, India, Kenya, Laos, Liberia, Madagascar, Malawi, Moldova, Nepal, Nicaragua, Papua New Guinea, the Philippines, Romania, Senegal, Sierra Leone, South Africa, Suriname, Tanzania, Thailand, Trinidad & Tobago, Uganda, Vietnam, Zambia and Zimbabwe.
APC works toward its goal of advancing and supporting community programs that seek to improve the overall health of communities, especially in relation to FP, by implementing five overarching strategies:

1. Global advocacy for effective, evidence-based, and innovative CBFP programming
2. Rapid, efficient, and transparent grant management
3. Mutual collaboration and respect for PVOs/NGOs
4. Sustainability and ownership through integrated, sustainable capacity-building
5. Contribute to strengthening USAID’s position as a global leader in CBFP

These strategies are used across APC’s three main results, which are the key organizing structures for project activities:

**Result 1:** Strengthened global leadership and advocacy for community-based programming and effective program approaches and tools, primarily for FP (Advocacy and TA at All Levels)

**Result 2:** Innovative PVO/NGO community programs expanded and strengthened (Grants Management)

**Result 3:** PVO/NGOs prepared to receive USAID funds and implement effective community-based programs, especially FP (Capacity-Building)

To strengthen the focus on the results, the evaluation team developed a revised logic model (Figure 2) that summarizes its understanding of the pathways by which APC affects change. It shows the results and their associated activities, and illustrates indicators at the output, outcome, and impact levels, yielding a clearer mapping of how results lead to outputs, outcomes, and impact.

**Figure 2. Revised APC Project Logic Model**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Results/Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• JSI &amp; FHI 360 staff expertise, skills, and experience&lt;br&gt;• Sub-awardee and partners (PVOs/NGOs, MOH, other CAs, etc.) expertise, skills, and experience&lt;br&gt;• Existing community-based health best practices, tools, &amp; materials&lt;br&gt;• Existing capacity building best practices, tools, &amp; materials&lt;br&gt;• International and regional partners&lt;br&gt;• Financial resources</td>
<td><strong>Result 1</strong>&lt;br&gt;• GTL, advocacy, technical assistance, collaboration, and support for CBFP, including the design and documentation of country-level CBFP programs</td>
<td><strong>Sub-awards issued and successfully managed</strong>&lt;br&gt;<strong>Technical assistance provided to countries, partners, or programs on CBFP, CBA2I, CHS and other innovations</strong>&lt;br&gt;<strong>Materials and/or resources developed to strengthen and support CBFP</strong>&lt;br&gt;<strong>Innovative CBFP approaches assessed, documented, and shared</strong>&lt;br&gt;<strong>CBFP &amp; related innovations introduced, advanced, and scaled up.</strong>&lt;br&gt;<strong>PVOs/NGOs utilize, adapt resources and tools to plan, implement and monitor CBFP.</strong>&lt;br&gt;<strong>Increased support for and commitment to CBFP in priority countries</strong></td>
<td><strong>Sub-awards lead to improved measures of performance in community-based health programs †</strong></td>
<td><strong>Contribute to increased quality of, access to, and demand for family planning services within communities where the project operates</strong>&lt;br&gt;<strong>Contribute to expanded contraceptive method mix in project communities</strong></td>
</tr>
<tr>
<td><strong>Result 2</strong>&lt;br&gt;• Solicitation, management, and monitoring of sub-awards for innovative PVO/NGO community-based health programs</td>
<td><strong>Output 1</strong>&lt;br&gt;<strong>Technical assistance provided to countries, partners, or programs on CBFP, CBA2I, CHS and other innovations</strong>&lt;br&gt;<strong>Materials and/or resources developed to strengthen and support CBFP</strong>&lt;br&gt;<strong>Innovative CBFP approaches assessed, documented, and shared</strong>&lt;br&gt;<strong>CBFP &amp; related innovations introduced, advanced, and scaled up.</strong>&lt;br&gt;<strong>PVOs/NGOs utilize, adapt resources and tools to plan, implement and monitor CBFP.</strong>&lt;br&gt;<strong>Increased support for and commitment to CBFP in priority countries</strong></td>
<td><strong>Impact</strong>&lt;br&gt;<strong>Contribute to increased quality of, access to, and demand for family planning services within communities where the project operates</strong>&lt;br&gt;<strong>Contribute to expanded contraceptive method mix in project communities</strong></td>
<td><strong>Contribute to increased quality of, access to, and demand for family planning services within communities where the project operates</strong>&lt;br&gt;<strong>Contribute to expanded contraceptive method mix in project communities</strong></td>
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</tr>
</tbody>
</table>

† Referenced measures will depend on the sub-award design and objectives as agreed upon by APC and USAID
3. EVALUATION METHODS AND LIMITATIONS

OVERALL APPROACH

The evaluation methodology used a mixed-methods approach consisting of quantitative and qualitative methods. An interdisciplinary team with diverse expertise and experience conducting similar evaluations carried out the study. Annex VII contains summary biographical background information of the team members.

The mixed-methods approach included a desk review of pertinent project documents (e.g., annual management reviews, special reports commissioned by APC, and statistics on different project aspects available at APC). Key informant interviews (KII) were used to collect pertinent data. The 114 key informants who were interviewed included USAID staff, JSI and FHI 360 project staff, Ministry of Health (MOH) officials in Benin and Uganda, implementing partners, donor agencies, and other stakeholders. Benin and Uganda were included as part of the evaluation due to their importance in APC’s FP activities. Although the visits to Benin (seven working days) and Uganda (six working days) were brief, the evaluation team visited locations where the project or its activities were being carried out. Additionally, the evaluation team developed two web-based instruments, one for USAID’s local Missions and one for grantees. Invitations to participate in the surveys were sent to 28 USAID Mission staff and seven Centers for Disease Control and Prevention (CDC) staff in 20 countries where APC has worked or is currently working and to 84 grantees that had implemented 104 grants, including some that had received multiple grants. During the field visits, the evaluation team conducted seven group discussions: four with community health workers (CHWs) and village health team (VHT) workers, one with midwives, and two with male Emanzi groups, which encourage constructive roles for men in sexual reproductive health.

This mixed-methods approach to data collection helped the team to understand APC from the perspectives of donors, government officials, health care providers, CHWs, and VHTs. There was limited opportunity to capture the community perspective; this was partially addressed through provider and CHW/VHT interviews and their perceptions of how the project had met the community needs.

Before the start of the evaluation, APC’s USAID agreement officer’s representative (AOR) discussed and approved the methodology and suggested final tools for data collection.

SELECTION OF LOCATION OF HEALTH FACILITIES

In Benin and Uganda, the evaluation team and the local APC representative jointly decided on the locations for site visits based on the desire to capture a wide spectrum of project activities related to CBFP. Some locations were quite remote, far from the major cities of Cotonou in Benin and Kampala in Uganda, requiring six to eight hours of driving. Table 1 shows the sites and the types of activities.

Table 1. Name of the Site Visits and APC Activities Observed in Benin and Uganda

<table>
<thead>
<tr>
<th>Country</th>
<th>Name of the Site</th>
<th>Project Activities Observed / Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Calavi</td>
<td>• USAID/Benin, APC team, and senior MOH officials: the general secretary of the Direction de la Santé de la Mère et de l’Enfant [the MOH’s Directorate for Maternal and Child Health (DSME)] with the deputy of FP/DSME, the division chief of Paquet</td>
</tr>
<tr>
<td></td>
<td>Abomey Calavi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tchaourou health zone</td>
<td></td>
</tr>
</tbody>
</table>

2 Only three team members participated in the Benin site visit, as Linda Sussman was committed to another activity.

3 Community health volunteers are referred to as CHWs in Benin and VHTs in Uganda.
### Performance Evaluation of the APC Project

<table>
<thead>
<tr>
<th>Country</th>
<th>Name of the Site</th>
<th>Project Activities Observed / Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>d’Intervention à Haut Impact [Package of High-Impact Interventions (PIHI)], and the DSME office</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BUPDOS, an NGO for PIHI-Com Project Management Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health zone under USAID sub-grants: PIHI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sian’son NGO PIHI-Com Project (Parakou)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tchaourou health zone management team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health center and relais communautaires (the lowest cadre of CHWs) in Tchaourou</td>
<td></td>
</tr>
<tr>
<td>Calavi:</td>
<td><strong>Health Center</strong></td>
<td>CHWs who work with subcutaneous depot medroxyprogesterone acetate (DMPA-SC)</td>
</tr>
<tr>
<td></td>
<td>Calavi: relais communautaires</td>
<td>Meeting with Association Béninoise pour la Mobilisation Sociale (Benin Association for Social Mobilization)/Population Services International (ABMS/PSI) department head of FP/HIV and ABMS’s department head of mass media communications</td>
</tr>
<tr>
<td></td>
<td><strong>Kampala</strong></td>
<td>USAID Mission; APC staff; member task force for drug shops; MOH FP focal person; Salvation Army [emergency contraceptive pill (ECP)]; PATH for DMPA-SC effectiveness study; WellShare; Uganda Protestant Medical Bureau (UPMB) for faith-based activity; WellShare; Concerned Parents Association (CPA); and Straight Talk</td>
</tr>
<tr>
<td></td>
<td><strong>Western Uganda:</strong> Mwenge in Kyenjojo district — PFP</td>
<td>FP/HIV integration sites</td>
</tr>
<tr>
<td></td>
<td>Kahungye — I</td>
<td>Emanzi group</td>
</tr>
<tr>
<td></td>
<td>Kasese</td>
<td>St. Paula, UPMB facility</td>
</tr>
<tr>
<td></td>
<td>Maliba</td>
<td>Emanzi group</td>
</tr>
<tr>
<td></td>
<td><strong>Central Uganda</strong></td>
<td>Decentralized supervision role of district health teams for gaps in CBFP system; district officials and rural health center; the implementers of the Gender Roles, Equality, and Transformation Project (CPA and Straight Talk)</td>
</tr>
<tr>
<td></td>
<td>Busia district</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Central Uganda</strong></td>
<td>Decentralized supervision role District Health Team for gaps in CBFP systems</td>
</tr>
<tr>
<td></td>
<td>Second Health Center</td>
<td></td>
</tr>
</tbody>
</table>

### Key Data Sources

#### Document and Data Review

Prior to arriving in Benin and Uganda and conducting KIIs in Washington, D.C., and Chapel Hill, North Carolina, the evaluation team conducted a detailed desk review of project documents, such as annual and quarterly reports, monitoring/service statistics of selected projects provided by APC, lists of sub-grantees, specific financial data, and research reports. They also reviewed information on project Web sites. A list of the documents reviewed can be found in Annex IV.

#### In-Depth Interviews with Key Informants

Semi-structured interviews with a wide range of stakeholders were conducted at all levels. At the initial stage, the first 29 KIIs were conducted (31 respondents; 7 men and 24 women) with APC staff at JSI, FHI 360 staff in North Carolina and Washington, D.C., and USAID staff, researchers, and development partners. The list of the informants was shared with and approved by the project AOR. Interviews were also conducted during site visits in Benin and Uganda, where 145 people were contacted and interviewed: KIIs were conducted with 83 informants (50 male, 33 female) and informal group discussions were held with 62 informants (39 male, 23 female).

Informants were selected purposively, and care was taken to ensure all relevant departments at JSI and FHI 360 (i.e., those involved in APC) were covered. In addition to the director, this included other...
senior APC functionaries, such as the grant and operation manager, finance and operations, and departments/individuals representing different broad aspects of APC research activities, including program officers related to CBFP, monitoring and evaluation (M&E), knowledge management and utilization of research, youth and gender, and those in charge of the post-Ebola program.

During site visits, selection of informants in key departments and institutions was largely based on the informant’s position, with a preference for top officials. Within each country, APC’s local representatives were consulted before finalizing the institutions/NGOs and departments to be covered. For CHWs/VHTs, most information was collected during informal group discussions.

The KII instrument was designed to cover the four evaluation questions, as well as issues that USAID was interested in examining for the remaining implementation period. (See Annex II for a copy of the KII instrument.) The interviews provided insights into the effectiveness of APC, the activities it implemented to build the capacity of the providers, and promotion of CBFP. Annex III contains a list of people the evaluation team contacted, including all key informants.

**Web-based survey of USAID Missions and grantees**

Because the evaluation team visited only two of the 38 countries covered under APC, it was decided to conduct two web-based surveys (using SurveyMonkey) to collect quantitative and qualitative data from the USAID Missions and grantees on project performance and support. The survey to the Missions covered their opinions on APC performance in terms of assistance they received for requests; providing TA support to their grantees; understanding of the country’s health priorities and needs; quality of TA and support provided to the MOHs; and leadership demonstrated in the implementation and expansion of CBFP. Answers to most questions were recorded on a five-point scale. Similarly, the instrument for the grantees focused on management of sub-grants and TA they received from APC staff. Questions also addressed the guidance grantees received in financial management, project implementation, preparing progress reports, and M&E skills. Twenty-eight USAID staff and seven CDC staff (35 total) from 20 countries where APC has worked or is currently working were invited to participate in the survey. After two reminders, 13 responses from the Missions and 22 responses from grantees were received. The data collected was analyzed and used in the report to give support to the KII analysis. The two questionnaires can be found in Annex II.

**Secondary data analysis**

The objective of the secondary data analysis was primarily confined to financial and project management information. Data on any pre- or post-evaluation of interventions was not available, except for 11 core-funded projects, which provided some information on the uptake of contraceptives over time. Results of some of the operations research studies undertaken on DMPA-SC were analyzed, so additional analysis was not necessary. Some of APC’s financial data were analyzed to assess the allocation of funds, particularly for the FP programs.

**Group discussions with community health volunteers**

The team conducted seven group discussions: four with CHW/VHTs, one with midwives, and two with Emanzi groups involved in increasing male participation in sexual reproductive health. All the discussion groups were mixed, with men and women participants, except one of the Emanzi groups, which was all men. Many of the CHWs and VHTs had been working well before APC began and were able to provide some observations on positive changes that the project had brought. The discussion with VHTs in Central Uganda, where APC has helped establish a Centre of Excellence in a quality improvement program, was very rewarding. The evaluation team could feel the excitement and motivation of the VHTs, who were proud of what they were doing and confident about the continuation and expansion of their work into other areas. Group discussions were conducted with volunteers in Kahungye and Maliba in Western Uganda who were implementing the Emanzi program.
Group discussions with CHWs and VHTs focused primarily on general issues, such as reasons for deciding to become health volunteers; the perceived benefits of being a health volunteer; views on support and training from APC; how they function in the community and provide information on primary health care and contraceptive services; what is being done to ensure good quality services; and interest in continuing as health volunteers, particularly if APC discontinues support for their activities. In the case of the Emanzi men’s groups, the evaluation team probed on issues such as impressions of the program’s curriculum, what was learned, topics discussed, and wives’ reactions. A brief guideline was developed to use in such informal interviews (see Annex II). However, the team added or omitted questions depending on the location and in light of any special activities being carried out with APC support. A total of 62 people (39 men, 23 women) participated in the group discussions; of these, 32 (16 men, 16 women) were CHW/VHTs, 4 were female midwives, and 26 (23 men, 3 women) were from the Emanzi groups.

**Data collection tools and instruments**

As indicated earlier, the team developed a number of data collection tools and instruments for all data sources, including the semi-structured KII instrument, surveys for USAID Missions and grantees, and informal group discussion guidelines for CHWs/VHTs. All data collection tools focused on key evaluation questions and were pre-tested and revised prior to data collection. See Annex II for the data collection tools.

**Data analysis methods**

Well-established frameworks pertinent to FP were adapted for the data collection, analysis, and report writing (Bruce 1990; Rivero-Fuentes, Estela, et al. 2008; Pelto et al. 2014). Each data collection method was carried out in its entirety and analyzed separately over the same period. The analysis considered how APC had contributed to increasing access, contraceptive choice, and quality of services using CBFP; how the sub-grant scheme and TA had helped to build NGO capabilities; and other questions related to Evaluation Questions 2 and 3. Because this is a mixed-methods evaluation, both quantitative and qualitative data were integrated to address the evaluation questions.

**Limitations of evaluation methods**

The evaluation team acknowledges limitations to the evaluation design. First, most of the informants and participants for the KIIs and informal group discussions were selected purposively, although, as discussed earlier, a conscious attempt was made to include all types/groups of informants to capture variations in perception and response. This consideration was maintained in selecting informants in Benin, Uganda, and the United States. Second, the evaluation team was able to visit only two of the 38 countries covered by APC. In these countries, which USAID selected for the evaluation, work on CBFP and DMPA-SC had been carried out, and the visits provided an opportunity to understand the process and effort invested in scaling up or replicating activities.

The locations for site visits were selected in consultation with the local APC staff based on the different ongoing initiatives and interventions. For informal group discussions with CHWs/VHTs, all volunteers attached to a health center were invited; attendance varied, with six to nine participants included in each discussion. For the online survey, the invitation was sent to all Missions where APC had worked or is currently working. Only 13 responded. Similarly, only 22 of 84 grantees contacted responded. The low response rate to the two online surveys, coupled with the chances of self-selectivity, means there may be potential biases in the results, which must be analyzed with caution. Therefore, the evaluation cannot generate findings that statistically represent the larger population from which they were drawn. Yet, the KIIs and informal discussions assessing the perception and experiences of participants yielded useful insights on ways APC had functioned and efforts USAID and other donors must make for future programming. The learning from this evaluation could also suggest some actions that could be taken during APC’s remaining extension period, with the aim of trying to create conditions for scaling up.
**Gender considerations**

Although APC does not have a mandate to focus on gender, it has implemented some gender activities. Because males in the concerned African countries play a significant role in family decision-making, particularly related to fertility and contraceptive use, specific attention was given to gender considerations while collecting and analyzing data. The evaluation team sought to ensure that gender was incorporated in evaluation design (i.e., both women and men were interviewed and participated in KII and group discussions) and during site visits/interviews where gender issues had been raised. For example, the team visited two sites in Uganda where Emanzi groups were being implemented, and staff working on gender issues at USAID/Washington, D.C. (senior gender advisors in health at the Gender Office) were also contacted and interviewed. Gender issues were also addressed during the discussion with CHWs/VHTs. These observations and comments have been included wherever possible.

**Ethical considerations and confidentiality**

The team obtained verbal consent from all KII and group discussion participants according to USAID Evaluation Policy guidelines. Interviewees were given the option to opt out of specific questions or the entire interview and were assured of personal confidentiality for the information provided. Informed consent was incorporated into the KII tool. The web-based surveys also included an informed consent statement prior to respondents answering any questions.
4. FINDINGS

EVALUATION QUESTION 1

Has APC provided global leadership and advocacy for CBFP? If yes, how? If no, why not?

APC has a wide mandate, working at the global and country levels, and covers a large area (38 countries). In its first five years (2012–2017), APC covered many other important topics in addition to FP, such as HIV/AIDS, post-Ebola, and water and sanitation, supported by Mission buy-ins. About 25 percent of total project funding has been spent on FP or strengthening CBFP, which is the focus of this evaluation. The discussion below primarily considers the initiatives that APC has taken to strengthen and advocate for CBFP activities. Because the challenges to demonstrate leadership at the global level for strengthening and advocating CBFP can be quite different from those at the country level, the evaluation team looked at APC achievements in global leadership and advocacy for CBFP separately from its country-level initiatives.

Global leadership and advocacy

The assessment of APC performance in demonstrating global leadership in strengthening and advocating for CBFP was examined and measured against certain activities that the evaluation team considered to be important components of global leadership. This included creating a supportive global environment by working with global partners, such as USAID and its collaborators [e.g., the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the International Development Research Center, the Bill & Melinda Gates Foundation, and the UK Department for International Development (DFID)], to popularize the concept of CBFP and its components. This entails working closely with global advocates and providing hard data with scientific rigor to support global advocacy [e.g., CHWs injecting DMPA-SC and intramuscular depot medroxyprogesterone acetate (DMPA-IM) and self-injecting DMPA-SC] and seeking the endorsement of organizations such as the WHO, which has worldwide credibility. This requires taking the lead in task forces, presenting well-documented quantitative findings at international conferences, and publishing synthesis papers based on multiple countries where similar interventions have been carried out, and disseminating the results aggressively via different forums. As the principles of science underline, particularly in the case of expanding and rolling out an innovation, a clear work plan and a focused strategy could help — and accelerate — the process of wider CBFP dissemination.

APC initiative for global leadership

Advocacy and dissemination of information on CBFP in national and international forums

With the above parameters for global leadership and advocacy as reference points, the evaluation team found that APC tried many of these activities and took the lead to demonstrate global leadership in strengthening and advocating for CBFP. For example, it participated in and took the lead in 11 global and regional meetings to provide leadership to popularize CBFP and share its innovative work. APC staff or project partners and grantees presented papers related to CBFP at the International Conference on Family Planning, centering on using CHWs to distribute the ECP. The project also participated in a panel on ECP at the EC Jamboree, UNFPA-USAID Total Market Approach Working Group Meeting, a pre-workshop meeting on FP at the annual conference of Christian Connections for International Health (CCIH), taking a leading role in the Technical Working Group to find ways and means to promote task-sharing across multiple cadres and the Family Planning 2020 (FP2020) Midpoint. Furthermore, APC has presented papers and distributed materials and tools on different aspects of CBFP at regional- and country-level meetings to popularize and stress the importance of CBFP.

APC is proud of its work to popularize Community Health Systems (CHS), its human-centered design, and its linkage with CBFP. The project believes this has been one of its major contributions. The
evaluation team strongly agrees, and also feels that APC’s CBFP approach has been strengthened by use of the human-centered design approach and activities. This approach is inclusive of all stakeholders, including community members, health workers/providers, local leaders, and government officials. At the country level, decentralized planning is gaining popularity thanks to many donors and UN organizations (e.g., UNICEF and WHO). APC has used the CHS approach effectively to strengthen health systems, particularly working in buy-in projects.

APC is also actively involved at the global and country levels in advocating change in countries’ regulations that could allow drug shops to stock and provide some contraceptive services, including injecting DMPA-IM and DMPA-SC. In 2015, APC collaborated with USAID and other global partners to help the Bill & Melinda Gates Foundation organize a consultation on the significant role that drug shops could play in increasing accessibility to contraceptive services and provision of injectable contraceptives. As a part of providing supportive document/technical briefs for advocating for drug shops’ provision of community-based access to injectables (CBA2I), APC analyzed Demographic and Health Survey data to assess the current FP market for drug shops in selected sub-Saharan African countries. The technical brief also provided a profile of people who use drug shops to get their contraceptive supplies; the volume of the market for drug shops if they are able to store and provide some FP contraceptive services; and guidance on how best to target FP products, information, and services.

**Advocacy and popularization of best practices initiatives in FP**
APC staff work with USAID, WHO, PATH, and the Implementing Best Practices Initiative to coordinate a meeting of MOH “gatekeepers” from Ghana, Liberia, Nigeria, Tanzania, and Uganda to highlight best practices, share successes, and advocate for liberalized policies in the region that could allow task-shifting. The meeting is expected to take place in early 2019. Other country-level initiatives on drug shops have occurred in many countries, including Uganda. The APC publication, “Provision of Injectable Contraceptives within Drug Shops: A Promising Approach for Increasing Access and Method Choice,” is a useful informative advocacy tool, as is Drug Shops & Pharmacies: A First Stop for Family Planning and Health Services, but what do we know about the clients they serve?

**Collaborating with faith-based organizations (FBOs)**
Another important APC initiative for strengthening CBFP efforts at the global level is the effort to involve FBOs to sensitize religious leaders on contraception and increase FP uptake through their influence on communities. To achieve this, the project collaborated with the CCIH, an international partner headquartered in Washington, D.C. CCIH worked with more than 100 agencies to organize an annual pre-conference on Youth and FP and publish a special FP issue of the Christian Journal for Global Health, a journal that focuses on provision of global health care by FBOs. CCIH also has strong links in East Africa with the UPMB, which retains significant influence on Christian FBOs in and around the region. With a sub-grant to CCIH, APC has used these forums to organize activities to improve the capacity of FBO partners to integrate FP into existing programs by developing communications resources and providing training and technical support. For example, in 2015 and 2016, CCIH organized one-day, pre-conference meetings on FP topics prior to its annual conference of members. It published an FP supplement for its Christian Journal for Global Health, as well as a special issue (vol 4, no.2, 2017), The Global Church and Family Planning: Creative Collaboration, which focused on operational and ethical approaches to healthy timing and spacing of pregnancy, along with several other articles on faith-based partnerships and training community-based religious leaders to advise and advocate for FP.

In addition to these global efforts to involve FBOs in family health, APC, along with CCIH, has worked with FBOs at the country level, primarily in Uganda. According to the interview with the director of CCIH, under the APC sub-grant, CCIH is developing a low-literacy booklet on FP that community-based

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4 Available at: [https://www.advancingpartners.org/sites/default/files/technical-briefs/apc_tech_brief-drug_shops_pharmacies.pdf](https://www.advancingpartners.org/sites/default/files/technical-briefs/apc_tech_brief-drug_shops_pharmacies.pdf)
FBOs and CHWs can use in behavior change communication/counseling to sensitize community members about FP. To complement this effort, CCIH recently developed a six-page pamphlet entitled, *Faith Matters: A Christian Approach to Engaging Youth in Family Planning*.

APC should make further efforts to develop new resource materials, such as training manuals for religious leaders, counseling tools that could be used by faith-based community workers, and leaflets highlighting acceptance of FP within the frameworks of Christianity and Islam, and widely disseminate them using electronic and other media. Developing such materials and making them widely available through the network of FBOs globally would be useful in sensitizing religious leaders far beyond the project area. This idea, however, has not received much attention. According to a senior USAID official who helped manage APC, project officials were involved in multiple activities and could not focus on this activity. One CCIH official noted, however, that USAID staff were somewhat critical, and that getting them to approve a proposal was difficult. For example, the official said that CCIH wanted to start a project with UPMB in Uganda, but it took a long time to be approved.

**Advocating for task-shifting**

Perhaps APC’s most important global contribution in CBFP has been to demonstrate that CHWs could efficiently deliver injectable contraceptives in homes and at the community level. This is not the first time that the effectiveness of home-based provision of DMPA by community-level workers has been demonstrated. In the Bangladesh Matlab Extension project more than 25 years ago, the Population Council demonstrated the feasibility of using community-based workers to provide DMPA at home, the quality of these services, and the effectiveness of DMPA in increasing the contraceptive prevalence rate. This practice has been part of Bangladesh’s national program for years. However, APC has demonstrated the feasibility of introducing DMPA in more than one African country where the local context is much different and more challenging. Small grants in Benin and Uganda have provided examples of the possibility of CBA2I using CHWs. This work could have a positive effect in countries where the law does not permit CHWs to provide injectables. (This is discussed in greater detail below under country-level initiatives.) APC’s *Community Health Worker Provision of Injectable Contraceptives: An Effective CBA2I Strategy* has been well-received and is an important resource for advocacy. By drawing global attention to the feasibility of such task-shifting across different cadres of providers, APC is taking a lead role on the Technical Working Group on task-shifting.

Another important project initiative is testing and documenting self-injection of DMPA-SC by women in Malawi. Under APC, FHI 360 conducted a randomized control trial to compare continuation rates of women who self-inject DMPA-SC and women who receive the contraceptive from a provider, including CHWs. The results showed self-administration led to a more than 50 percent increase in continuous DMPA-SC pregnancy protection through 12 months. The study recruited more than 700 women who sought FP services at six MOH clinics or from CHWs. The women were either trained to self-inject and then sent home with three units or given DMPA-SC from a provider or a CHW and asked to return for subsequent injections. No difference was observed in the frequency of unintended pregnancy, nature of complications, or overall side effects between the two groups.

The study also demonstrated that women could efficiently self-inject DMPA-SC and that CHWs were effective in training women to self-inject. The findings have been shared at national and international forums, including a presentation to USAID at the partner’s meeting of PRH’s SDI Division and WHO, which is considering using the findings to inform its guidelines for home and self-injection of DMPA-SC. The findings were also published in *The Lancet Global Health*, 5 which led UNFPA to include DMPA-SC in its reproductive health (RH) kits for humanitarian crises. Another paper about self-injection is about to

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be published in a special supplement about DMPA-SC in the journal *Contraception*, which is also reviewing another article about the contraceptive.

The Malawi MOH’s FP Technical Working Group accepted the results of the self-injection study, has set up a task force to plan scale-up, and is exploring the possibility of a policy change to allow self-injection of DMPA-SC. APC is also in conversations with the MOH in Zambia to pilot self-injection in the private sector and is working in Uganda to pilot DMPA-SC in the public sector. Similarly, APC worked with the MOH in Benin to establish a working group, for which it acted as secretariat, to explore allowing CHWs to provide DMPA-SC. The working group included many national and international partners, such as the local PSI and International Planned Parenthood Federation (IPPF) affiliates. Advocacy to the Benin MOH to introduce CBA2I (Noristerat) began in 2012, and advocacy to introduce DMPA-SC began in 2015. Using a phased approach, the MOH has allowed the introduction of DMPA-SC using CHWs in 10 or more health zones. Training of CHWs in three health zones has been completed and CHWs have started providing DMPA-SC; in the coming months, it will be rolled out to more health zones.

**Scientific rigor matters**

APC’s evidence-based advocacy is a key factor driving MOHs in Benin, Malawi, and other countries to include international organizations supporting the introduction of CBA2I and the potential expansion of DMPA-SC. The Malawi APC study of self-injecting DMPA-SC is a good example of scientific rigor (random control trials), and the quality of data collected demonstrates the intervention’s impact. M&E has relied primarily on available service statistics (e.g., the 11 core-funded FP projects), achievements against yearly targets provided by funding agencies, or methods that cannot demonstrate outcomes or impact. Given available funding and scope (most core-funded grants ranged from $100,000 to $200,000), it was not feasible to conduct rigorous studies, such as the study for the home and self-injecting DMPA-SC done in Malawi. However, greater M&E data and process documentation are required and would have been useful. Stronger M&E systems, particularly related to the small grants, could have provided further evidence for advocacy and instilled confidence in the donors/users that these grantee activities could be replicated or rolled out. M&E has been limited in scope (see section on country-level activities) and needs attention in future programming.

**Publications and advocacy materials**

APC has printed and disseminated as many as 116 publications that could be used for sensitization and advocacy of CBFP. These are either new publications or have been reproduced after modifying existing tools and publications. KIIIs revealed that although some of the tools/publications were known and had been used by a larger audience globally (e.g., the CHS Catalog), knowledge of others was mostly confined to the country where they were developed and used. Most of these publications are available on the APC website or USAID’s Knowledge for Health (K4Health) Project Web site, but efforts do not appear to have been made to popularize these publications and/or increase their utilization.

The CHS Catalog is a useful publication that consolidates detailed information on community health and FP policies across 25 priority countries. It could be used as a resource on CBFP, and is useful for researchers, policymakers, and program managers. APC Web site data shows that targeted audiences have frequently used this resource. According to project statistics, viewers from 120 countries have visited 15,500 pages of the catalog over the last four years (see Figure 3); however, most page visits were very brief, from one to three minutes. The short duration could be because viewers visited the home page only to identify their country of interest and then went directly to the relevant page or, instead of reading online, they downloaded the relevant page(s). If the latter is true, then some insight could be gained by looking at the number of people who downloaded a document; indeed, an analysis shows that 779 users from 25 countries had downloaded some pages of the catalog, most of which concerned countries where APC has conducted activities.
 According to a recent briefing from APC, it disseminated the CHS Catalog through its e-newsletter and other listservs; blogs; infographics; brownbag presentations; a social media campaign; a toolkit with pictograms; and partner project channels such as the Maternal and Child Survival Program and the Strengthening Partnerships, Results, and Innovations in Nutrition Globally Project. It also updated promotional materials for disseminating the catalog at conferences and meetings, including the 2016 Health Systems Research Conference in Vancouver, Canada, and the 2017 First International Symposium on CHWs in Kampala, Uganda. Because the catalog is an important contribution that is being used for research and policy advocacy in multiple countries, APC should continue to update it and use every opportunity to further enhance its utilization globally.

Below is an illustrative list of significant publications that should be disseminated globally. A more detailed list can be found in Annex IV.

- The CHS Catalog
- *Provision of Injectable Contraceptives within Drug Shops: A Promising Approach for Increasing Access and Method Choice*
- *Drug Shops & Pharmacies: A First Stop for Family Planning and Health Services, but What Do We Know about the Clients They Serve?*\(^6\)
- *Community Health Policy Matters: The Case for Family Planning* (Video available at: https://vimeo.com/211377068)
- *Community Health Worker Provision of Injectable Contraceptives: An Effective CBA2I Strategy*, July 2014
- Brief on *Self-Injection of DMPA-SC Leads to Improved Continuation Rates*. The findings of the study have been published in The Lancet Global Health and a follow-up paper has been accepted in Contraception.
- *In support of community-based emergency contraception*, 2016 paper in Contraception
- *Nepal’s Community-based Health System Model: Structure, Strategies, and Learning*, February 2017\(^7\)
- *The Added Value of Integrating Family Planning into Community-based Services: Learning from Implementation*, March 2017
- *Faith Matters: A Christian Approach to Engaging Youth in Family Planning*

Though we know that these documents have been visited or downloaded, the extent to which they have contributed to advocacy, sensitization, or popularizing the concept of CBFP is not clear. As noted in most KIs, few informants were aware of the publications and their utilization. Most APC staff only

\(^6\) Available at: https://www.advancingpartners.org/sites/default/files/technical-briefs/apc_tech_brief-drug_shops_pharmacies.pdf.

\(^7\) There is a similar brief on Malawi available at: https://www.advancingpartners.org/resources/technical-briefs/malawi-community-based-health-system-model.
referred us to the project Web site or the K4Health Web site. One explanation could be that many publications were country-specific, so not everyone may have had the chance to see them. The summary and briefs are important publications about diverse topics to which APC has contributed.

APC has taken several important initiatives for strengthening global leadership and advocacy for community-based programming. However, to what extent these initiatives have made a difference is again not clear. One reason could be that APC did not have a clear strategy or pathway on how to provide the required global leadership and what activities it should systematically support to give momentum to the CBFP initiative. During in-depth interviews, most APC key informants could not say if they had visualized a clear pathway that could lead to global acceptance of CBFP for increased access and choice of contraceptives and services at the community level. Project activities and initiatives were important for CBFP, but they were often implemented on an ad hoc basis or were not pursued long enough to yield required results. For example, with task-shifting, the key point was how much time APC spent at the global level; it was not enough to make a measurable difference. This could be due to changing donor priorities, limited core funding, or opportunities created by other partners/donors — or a combination of all of these. As APC indicated, some of its efforts have been influenced by shifting priorities at USAID during Years 1–5. In contrast, the project played a much more aggressive role in working with MOHs for task-shifting and changing policy/regulations to empower CHWs to deliver contraceptives in their communities, including CBA2I and DMPA-SC. APC's active efforts to collaborate with local partners and other international NGOs to advocate for CBFP and task-shifting were effective and yielded positive results.

APC leadership and advocacy to strengthen CBFP at the country level

APC has worked in countries in Africa, Asia, and Latin America; managing such a large portfolio is challenging. Project leadership and advocacy for promoting CBFP at the country level is reflected in implementing activities that create a supportive environment for CBFP, working closely with governments to change the policy allowing provision of CBA2I and DMPA-SC through CHWs, and advocating with the MOHs’, national pharmacy councils and drug authorities to allow drug shops to provide injectable contraceptives and build the capacity of providers. Conceptually, many of these activities are global in scale, but at the country level, APC has demonstrated strategies to achieve these objectives.

Below, we discuss some APC activities and comment on their strengths and weaknesses. APC representatives at the country level have kept close links with the governments by assisting in providing TA in policy formulation, coordinating task forces/working groups for the MOH (in Uganda, for drug shops), and networking with other local partners. APC has collaborated with representatives of other international agencies to strengthen advocacy for CBFP (e.g., UNFPA, IPPF, PATH, Save the Children, and the University Research Company).

APC is directly involved in efforts to shift policy to allow CHWs to provide CBA2I in Benin, Uganda, and Zambia. In Benin, it advocated to the government to introduce CBA2I and supported a pilot in 2015 to provide CBA2I services through CHWs, and it currently supports government-led introduction of DMPA-SC in three health zones that will be rolled out in seven additional health zones. Policy change for this high-impact practice is imminent. During the site visit to Benin and in meetings with the MOH, ministry officials said they wanted to scale up DMPA-SC to the entire country but needed donor support and expressed desire for continued technical support from APC. Benin stands out as an example of where USAID Missions have provided substantial field support to ensure progress. In Zambia, advocacy efforts through sub-grantee ChildFund led to authorization to allow CBA2I scale-up in 2016. In Fiscal Year (FY) 2018, with TA from APC, ChildFund will train community-based distributors (CBDs) to provide DMPA-SC in two districts in Zambia. In Uganda, APC's advocacy efforts, leveraging the FHI 360 bilateral project, led to the authorization to stock injectable contraceptives in private drug...
shops in 20 selected districts in 2017. The Uganda MOH has asked to test the feasibility, usefulness, and quality of providing DMPA-SC and DMPA services at drug shops.

As a global leader, APC advocates in other countries for task-shifting to allow CHWs to provide CBA2I by disseminating its publications, such as *Community Health Worker Provision of Injectable Contraceptives: An Effective CBA2I Strategy*, the CBA2I Map, and materials in support of drug shops. The project annual report shows that APC shared these publications with governments, including Benin, Burkina Faso, Guinea, Madagascar, Pakistan, Uganda, and Zambia. Some of these countries, however, have yet to consider or allow provision of CBA2I.

**Working with drug shops to expand accessibility and services of CBA2I and DMPA-SC**

In Uganda, APC’s advocacy efforts, leveraging the FHI 360 bilateral project, organized a national task force and acted as the secretariat of the group to conduct a stakeholder mapping exercise, develop an advocacy strategy, and hold meetings with health training institutions, civil society organizations, and decision-makers in the MOH and National Drug Authority (NDA). These efforts led to NDA authorization to stock injectable contraceptives in private drug shops in 20 selected districts for one year. The expansion of service provision will be conducted in 2018. It is anticipated that APC will evaluate and document the results of this initiative with scientific rigor; if the results are positive, it could help the MOH and NDA to expand the service provision through drug shops nationwide in all 121 districts in Uganda. The results could also be used for global advocacy. In the absence of convincing hard data, it is difficult to use the findings for effective advocacy. If one government does not support drug shops to legally provide injectable contraception, it will be difficult to effectively advocate for expansion to other countries. In summary, CBFP initiatives by APC and its grantees have contributed to increased accessibility to contraceptives and, according to service statistics and KIIs, contraceptive uptake has increased.

**Tracking of countries on policy changes related to CBA2I**

In addition to advocating for CBFP in its focus countries, APC has been tracking and documenting advocacy efforts and supportive policy changes in sub-Saharan countries and disseminating findings through the CBA2I Map. (APC has developed a map which shows where different countries have adopted CBA2I.) According to APC, between 2005 and March 2017, Ethiopia, Guinea, Kenya, Madagascar, Mali, Mozambique, Nigeria, Senegal, and Uganda, have adopted supportive CBA2I policies.

**Sub-grants and TA to MOH**

APC has also supported sub-grants to promote CBFP. During its visit to Uganda, the evaluation team held discussions with many sub-grantees who were funded by APC to carry out innovative CBFP projects. In particular, the 11 core-funded APC FP projects have enhanced CBFP in different countries (see Table 2). Activities and sub-grantees the team visited included the Centre for Excellence, a CBFP learning site in the Busia District of Uganda, where APC developed and tested a model for ensuring quality assurance (QA) of FP services provided by VHTs at the community level. Through APC Mission buy-in, FHI 360 Uganda also developed and tested a model for ensuring QA of FP services provided by VHTs at the community level. Although this activity was funded with Mission funds, FHI 360 applied the CBFP Learning Site tools that were developed with core funds to conduct the baseline assessment. For this purpose, APC and national trainers from the MOH-trained, district-level officials in QA; with technical support from APC using a cascade approach, these officials trained staff down to the midwife level at health centers. Midwives, with some support from district officials and technical support from APC, trained VHTs.
Table 2. Overview of the 11 Core-funded Projects and Their Contributions to CBFP/FP

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<thead>
<tr>
<th>Country &amp; Project Title</th>
<th>Implementing Agency</th>
<th>Project Duration</th>
<th>Total Budget</th>
<th>Approach Used</th>
<th>Key Observations on Thrust Areas</th>
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<tbody>
<tr>
<td>1. ETHIOPIA Integrating FP with health hygiene and water sanitation</td>
<td>Global Team for Local Initiatives, United States APC-GM-0043</td>
<td>March 1, 2014, to December 31, 2016</td>
<td>$422,726</td>
<td>Integration with population, health, and environment (PHE) activities</td>
<td>Linkages between maternal health and having healthy child. Healthy timing and spacing of pregnancies (HTSP) were promoted. Demand for FP service increased. Community participation in PHE increased.</td>
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<tr>
<td>2. GUINEA Scaling up of CBA2I and setting up learning site for CBA2I</td>
<td>Save the Children APC-GM-0039</td>
<td>January 1, 2015, to February 29, 2016</td>
<td>$300,000</td>
<td>CBFP and enhancing MCH services</td>
<td>Scaling up of CBA2I in areas with a population of 8.45 million. Setting up a site for learning CBA2I. MOH approved the effort and the project provided partners to set up CBA2I. Curtailed in Year 2 due to Ebola epidemic.</td>
</tr>
<tr>
<td>3. KENYA Integrating FP with maternal and neonatal health + project</td>
<td>Health Right International APC-GM-0044</td>
<td>February 1, 2014, to March 30, 2016</td>
<td>$249,947</td>
<td>Integration of FP with maternal and neonatal health services</td>
<td>The project aimed to enhance demand of FP services at community and facility levels by training 500 in CBFP and 14 quality supervisors (CHWs). Integrating with maternal, newborn, and child health (MNCH) helped improve quality and services.</td>
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<td>4. KENYA Garba Tulla HTSP FP Integration Project</td>
<td>World Vision, Inc. APC-GM-0048</td>
<td>March 1, 2014, to September 30, 2018</td>
<td>$574,178</td>
<td>Integration of HTSP/FP in MCH project; engaging male and religious leaders in HTSP</td>
<td>Improved capacity of CHWs helped inform community members about HTSP/FP. Trained 30 providers to provide high-quality LARCs or permanent methods of contraception services. Educated religious leaders on HTSP to help their followers and congregations make informed choices related to health and well-being. Knowledge of HTSP and practice increased among men, women, and adolescents.</td>
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<tr>
<td>5. NEPAL Development of local economy to eradicate poverty: Technical integration for coverage and access of FP</td>
<td>Adventist Development and Relief Agency International APC-GM-0042</td>
<td>February 1, 2014, to January 31, 2016</td>
<td>$249,999</td>
<td>Integration of FP with a non-health development sector. Community-based providers were trained in FP messaging</td>
<td>Community members reached with FP messages. Number of youth attending RH classes increased. Number of youth trained as adolescents and youth volunteers increased. All helped in improved access of FP.</td>
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<td>6. TANZANIA Tuungane II Project</td>
<td>Pathfinder International APC-GM-0045</td>
<td>February 1, 2014, to January 31, 2016</td>
<td>$249,786</td>
<td>Integrating FP in PHE activity through CHWs, PHE champions, and</td>
<td>Integrated FP/RH in programming to leverage conservation to increase access to FP services to 120,000 women of reproductive age and to raise awareness of links between HTSP and</td>
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<td>Country &amp; Project Title</td>
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<td>7. UGANDA Salvation Army-integrated FP project</td>
<td>Salvation Army Uganda APC-GM-0046</td>
<td>May 2014 to May 2016</td>
<td>$494,686 ($250,000 from APC; $244,686 from Salvation Army &amp; other donors)</td>
<td>Integrated effort of Project SCORE. CBFP using VHTs and community mobilization for HTSP</td>
<td>Covered 24 sub-counties from seven districts. Collaboration with district health authorities using VHTs. Built capacity of 240 VHTs in FP and for injection, mobilized 378 youth peer educators, and promoted HTSP. Provided FP messages to 30,849 and counseled 7,937 on FP and HTSP.</td>
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<td>8. UGANDA Scaling up CBA2I</td>
<td>WellShare International APC-GM-0041</td>
<td>January 1, 2014, to June 30, 2018</td>
<td>$921,267 CBFP with CBA2I, collaboration with MOH and district authorities, building capacity of health centers and VHTs in DMPA-SC</td>
<td>Scaling up of CBA2I in 10 of 24 counties in two districts. Used cascade training approach to build capacity of district health authorities to health center providers to VHTs in CBA2I. 161 VHTs trained in CBA2I, 77 in DMPA-SC, and 59 VHTs achieved competency in DMPA-SC. Teen pregnancies declined and CBFP service/DMPA-SC increased. Introduced CHW provision of emergency contraception and produced training, job-aids, and CHW fact sheets that have been endorsed by the MOH and distributed to CBFP implementing partners.</td>
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<td>9. UGANDA Integrating FP in HIV/AIDS preventive services project</td>
<td>WellShare International APC-GM-0047</td>
<td>February 1, 2014, to October 31, 2015</td>
<td>$249,330 FP integrated in an existing HIV/AIDS preventive project. CBFP approach and FP/HIV/AIDS outreach clinic was organized. Partnership with district health authorities covering 10 counties of Aura district</td>
<td>Youth (15-24) and discordant couples with HIV/AIDS were key targets. Total target population was 13,802. Built capacity of 50 CHWs for CBFP and CBA2I and 17 health providers for supervision. Evaluation shows significant increase in youth friendly clinic score; 2,734 target group reached with FP messages; FP acceptance and continuation increased.</td>
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<td>10. ZAMBIA Scaling up of CBFP/CBA2I in two districts.</td>
<td>ChildFund International APC-GM-0038</td>
<td>January 1, 2014, to September 30, 2018</td>
<td>$676,257 A CBFP/CHA2I approach scaled up in two districts; strengthened</td>
<td>The population in the two new districts was 300,794. Project trained 36 new CHW teams, reached 31,863 with FP messages, and motivated 4,713 new acceptors for modern</td>
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<td>Country &amp; Project Title</td>
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<td>linkages of CBA2I with community and district medical officer in two pilot districts</td>
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<td><strong>11. USA</strong> Faith-based activities in support of FP</td>
<td>Christian Connection for International Health APC-GM-0065 Uganda</td>
<td>January 1, 2014, to November 30, 2018.</td>
<td>$350,000</td>
<td>Provided global leadership, expanded the evidence base, and created an enabling environment for faith-based partners to extend FP services and programming</td>
<td>FP methods. Total CHWs involved in CBFP reached 163 and 9,442 couple-years of protection was achieved. A learning site for CBA2I was established. CCIH worked with UPMB and other Ugandan stakeholders to improve the capacity of faith partners (regional/district and sub-district) to integrate FP into existing programs. Developed a faith-friendly, youth-targeted FP issue brief, <em>Youth Matters: A Christian Approach to Engaging Youth in FP</em>, and an action document on faith and FP, <em>Faith Matters — International Family Planning from a Faith Perspective</em>. Coordinated and convened a two-day technical consultation of faith and FP in Washington, D.C., attended by 30 FBOs. Disseminated findings and products to global faith and FP communities and at global conferences and meetings. Facilitated an FP focus for an entire 2017 issue of the <em>Christian Journal for Global Health</em> (vol. 4, no 2, 2017), <em>The Global Church and Family Planning: Creative Collaboration</em>.</td>
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QA training focused on good counseling and male involvement. Six indicators were used to monitor VHTs after training: FP clients receive adequate counseling from VHTs on side effects, including long-acting and reversible contraceptives (LARCs); more men should receive FP information, counseling, referral, or methods from VHTs if they are to effectively support their wives; couples counseling should be encouraged if women are to get support from their husband/partner for contraceptive use; more VHTs should be supported on side effect counseling by the midwife/health worker; ensure more female clients are retained on FP (percentage of female clients returning to VHT for resupply); and increase the number of clients referred for LARCs or permanent methods. To encourage VHTs, the monitoring should be participatory, with the intent of using indicators as a tool for improving the program. As part of this, VHTs were asked to plot the performance on graphs so they could see the trend of their performance against each of the six indicators (see Figure 4).

Figure 4. Example of a VHT Monitoring Graph

These graphs have become a source of motivation for the VHTs, who have started to self-monitor their work and try to find reasons to explain any weak outcomes. Staff/VHTs of other locations have visited this Centre of Excellence and have started learning from each other. VHTs and midwives from the Centre have visited other health centers to share their experience where this program is being rolled out. With help from APC, the Centre is being scaled up in four more locations in other districts. This is a good model for improving the quality of services VHTs/CHWs provide at the community level. However, this monitoring process needs good documentation and dissemination, but no such effort was observed. Given that APC will soon withdraw from this area, there is no certainty that the scale-up will continue — it will depend on the local Mission’s priorities and the agency to which it has provided the grant. The evaluation team hopes these observations will help the local Mission and USAID/Washington, D.C. continue and expand this program.

The evaluation team visited other sub-grantees, including the Salvation Army, whose work during 2014–2016 in eastern Uganda incorporated FP information and services, including CBA2I, into household visits; community action teams; and village savings and loan associations. The NGO WellShare is introducing CBFP services, including DMPA-SC and ECPs in Kumi and Iganga districts, East and East Central (2014–2018). A UPMB project to systematically integrate FP and HIV services in seven Protestant health clinics concluded in April 2017; this was identified as a missed opportunity to support community-level religious leaders as agents of change. The CPA and Straight Talk Foundation completed a project for which they were given limited financial and technical support to sensitize youth in FP and RH. They trained around 1,000 adolescents and youths, but the outcomes have not been assessed and the evaluation team is not aware of a report detailing the project’s process or achievements.

UPMB and the Salvation Army carried out APC efforts to involve FBOs in Uganda. For example, in May 2015, UPMB and CCIH convened more than 40 Salvation Army religious leaders, FBO representatives,
and government officials in Kampala for a two-day meeting on the role of faith leaders in promoting healthy families and FP. Earlier in 2018, APC gave a one-year grant to UPMB to support a pilot cascade training in three dioceses of the Anglican Church of Uganda, which includes four churches that own and operate four health facilities. FHI 360 will monitor and document the experience.

All these small grants are important, and their effect and lessons learned should have been measured, evaluated, and documented to share the findings with a wider audience. However, throughout the evaluation, the team felt that APC and USAID had missed an opportunity to develop sound evidence through more rigorous M&E and/or documentation of these small grants. The team also learned that the project’s M&E person had never visited any of the field areas and, in the case of core-funded FP projects, only gave advice virtually. One possible reason could be that the core funds were limited (approximately $3 million annually), so M&E of CBFP could not be prioritized. For future programming, USAID should pay more attention to M&E. The key aspects of such small grants are that the intervention improves the prevalence of contraceptives, improves method mix, and increases reach of the contraceptive choice to the most disadvantaged populations. Although rigorous M&E may not be required every time and for all projects, process documentation and performance reviews could be done systematically. Service statistics, which most small grants have access to, along with information from process documentation, documentation of challenges in implementation, chances of replicability and scaling up in the given context, or the type of modifications required in the intervention or implementation could provide good insights and reliable data about the effects of the initiatives. In addition, this information could be useful for providing feedback on the progress of the program and an opportunity for midpoint correction. Use of data for iterative learning and improvement is also exemplified in the quality improvement activities mentioned above.

Many projects had a good chance of sustainability, particularly those that involved CHWs and VHTs, and should have had a second small grant to provide TA to the government structure/staff to assume responsibility from APC, or USAID Mission funding for follow-on activities. Abruptly ending these projects without proper evaluation, documentation, or sharing of findings and results is significant lost opportunity, including loss of experience and knowledge gained. Not integrating ECPs with CBFP is yet another missed opportunity. The formative study on ECPs was encouraging. KIs indicated that it might be possible to introduce ECPs in other countries such as Kenya, but APC, considering challenges implementing existing programs (e.g., strikes), felt it was unwise to attempt to carry out new activities. However, others felt that this was a missed opportunity. WellShare introduced ECPs in two districts (Kumi and Iganga), but no data were available at the time of this evaluation to assess the feasibility of including ECP at the community level.

The team concluded that, despite a variety of constraints, APC has tried hard to use its available resources to provide global- and country-level leadership to increase CBFP. Project performance at the country level was more focused and strategically planned, particularly in working with the MOHs and networking with local partners to influence policy change supportive for CBFP locally. By comparison, APC leadership at the global level was often ad hoc and unfocused. This raises a question that senior USAID leadership should discuss: Should both roles — global and local leadership for strengthening CBFP — be kept with the same agency or shared between two different agencies? There are advantages and disadvantages to both options.

APC rightly believes that using the same organization will be better as it enables a bottom-up approach, where insights gained in the field can be synthesized and used globally for advocacy. Indeed, APC’s excellent work at the country level demonstrates project insights in the local context that could lead to success in many countries. The problem is that the pressure of doing so much work at the country level and carrying out a large number of non-FP/CBFP buy-in projects from Missions might mean APC could not provide focused, strategically planned, and consistent global leadership to enhance utilization and expansion of lessons learned in different countries, which would demand greater time and resources for
global advocacy and using global forums to change policy. It is important to appreciate that this analysis does not point to weakness or lack of capabilities on the part of APC partners; instead, it points to the pressures of work, particularly from buy-in projects, and the need to balance these two vital components of the project. The best option would be for the same organization/project to dedicate adequate human resources and finances to both components. But if it is not possible, having two independent teams with dedicated objectives and measurable parameters to assess the impact will be safer. Ultimately, it falls to USAID to determine which path to choose and how to ensure a close link between the two components while still doing the work as planned.

**EVALUATION QUESTION 2**

*Has APC’s sub-grant program expanded and strengthened innovative PVO/NGO community programs? if so, how? If no, why not?*

This question was answered in two parts:

- **2A:** Has APC’s sub-grant program expanded and strengthened innovative PVO/NGO community programs? If so, how? If no, why not?
- **2B:** Three key aspects of the APC sub-grant program: innovative approaches implemented through the APC sub-grant program; outcomes of the sub-grant program; and contributions of sub-grant programs to PRH priorities, especially method choice, FP workforce, social and behavior change (SBC), youth, and gender

**Evaluation Question 2A. Has APC’s sub-grant program expanded and strengthened innovative PVO/NGO community programs? If so, how?**

This primary question about the sub-grant program is addressed below using results from the data collected through the survey of Missions, the survey of APC grantees, and the responses to KII.

**Survey of Missions: Views on APC sub-grants**

For the most part, Missions were positive about APC’s performance through the sub-grant program. Of 28 Missions contacted, 13 replied. For these Missions, the activities where APC helped through buy-in support included seven for HIV/AIDS, two for FP and RH, two for TA for NGO/private sector, one for TA to the public sector, and one “other.” Interpreting these results requires caution due to the small number of responses and potential for selectivity biases (see Table 3).

**Table 3. Opinion of 13 Missions Responding to the Online Survey on APC Performance**

<table>
<thead>
<tr>
<th>Q14: How would you grade the APC project’s contribution to achieving your Mission’s in-country health goals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Excellent</td>
</tr>
<tr>
<td>30.77% (4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q16: Based on your experience with APC technical support since October 2012, how would you grade APC performance in your country with respect to the understanding of your country’s health needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Excellent</td>
</tr>
<tr>
<td>38.46% (5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q19: Based on your experience with APC technical support since October 2012, how would you grade APC performance in your country with respect to providing leadership to MOHs/NGOs/other partners for developing CBFP projects?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Good</td>
</tr>
<tr>
<td>30.77% (4)</td>
</tr>
</tbody>
</table>
Q20: Based on your experience with APC technical support since October 2012, how would you grade APC performance in your country with respect to helping NGOs develop and implement CBFP?

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>15.38% (2)</td>
</tr>
<tr>
<td>Good</td>
<td>46.15% (6)</td>
</tr>
<tr>
<td>Average</td>
<td>7.69% (1)</td>
</tr>
<tr>
<td>Don't Know</td>
<td>30.77% (4)</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

Q21: Based on your experience with APC technical support since October 2012, how would you grade APC performance in your country with respect to building capacity of the local NGO and partners to provide improved quality of services?

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>23.08% (3)</td>
</tr>
<tr>
<td>Good</td>
<td>46.15% (6)</td>
</tr>
<tr>
<td>Average</td>
<td>15.38% (2)</td>
</tr>
<tr>
<td>Don't Know</td>
<td>15.38% (2)</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

Q24: Apart from deliverables and immediate outputs achieved by the end of the APC assignment(s) in your country, did APC’s or its implementing partners’ (JSI/FHI360) provision of technical assistance achieve any longer-term outcomes such as capacity-building of NGOs in project management and improved grant implementation and performance?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely yes</td>
<td>25% (3)</td>
</tr>
<tr>
<td>Yes</td>
<td>50% (6)</td>
</tr>
<tr>
<td>Not sure/depends</td>
<td>16.67% (2)</td>
</tr>
<tr>
<td>Please explain/skiped</td>
<td>8.33% (2)</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

Q27: How likely would you be to recommend the APC Project to another office within your Mission or to another Mission colleague?

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely yes</td>
<td>46.15% (6)</td>
</tr>
<tr>
<td>Yes</td>
<td>15.38% (2)</td>
</tr>
<tr>
<td>Not sure/depends:</td>
<td>30.77% (4)</td>
</tr>
<tr>
<td>Please explain</td>
<td>7.69% (1)</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

As shown in Table 3, the Missions ranked APC above average (11/13) in achieving their in-country health goals (Q14). They also felt that APC performance was above average (12/13) with respect to understanding their country’s health needs (Q16). Nine of the 13 Missions responded regarding CBFP activities, while only two responded that they had funded FP programs (Q19). This was surprising, but understandable, given that some of the projects included CBFP activities beyond the central scope of the grants. Eight of the nine Missions where support was provided to NGOs for implementing CBFP ranked APC performance as “good” or “excellent” (Q20). A majority of the Missions rated APC’s capacity-building efforts above average (9/13) in providing better-quality services (Q21). Nine of the Missions felt that APC support had achieved some longer-term outcomes, such as capacity-building of NGOs in improved project management, improved grant implementation, and performance (Q24). A majority (8/13) expressed no hesitation in recommending APC to other staff at their Mission (Q27).

Survey of APC grantees: Views on APC sub-grants

Only 22 of 84 grantees responded to the survey, but all had favorable views of the sub-grant program. Eight of the respondents were primarily focused on HIV/AIDS, seven on FP/RH, one post-Ebola, and six “other.” Of all 84 grantees, 25 percent had FP-related funding (12 core FP, four FP/other, four gender, and one PHE). As with the Mission surveys, interpreting these results requires caution due to the small number of responses and potential for selectivity biases.

Grantees were asked to suggest alternative ways of providing APC technical support for ensuring sustainability of outcomes. Responses included helping NGOs to create better profiles to be independent to sell services in the future; increasing exchanges between other grantees, with lessons from other grantees documented and shared with the group; and providing more direct one-to-one technical support to their partners. The grantees also discussed what they considered the single greatest shortcoming/weakness in APC’s/implementing agencies’ technical support. Problems included that frequent reporting demands took time away from implementation and that field staff had unrealistic/irrelevant expectations. For example, the reporting forms were too large for low-resource Internet access, and it was unnecessary for in-country staff to learn the names of U.S. FP/RH laws — a
USAID requirement for all donor recipients. Another problem cited concerned advance planning of TA provided (i.e., that site visits were often announced at the last minute).

Asked what they liked about APC, grantees stated that it was an excellent and helpful TA provider, the U.S. consultants were knowledgeable, and APC/JSI has both technical and financial strengths. Eighteen of the 22 believed that TA improved their project implementation and/or outcome, and 19 reported improvement in overseeing staff's grant management skills. Eighteen also said they would recommend APC for TA, and more than half (12) believed their improved capability has helped in getting new project funding. Of the 11 respondents who said they received new funding, seven reported receiving just one grant, one reported seven grants (all from USAID), two reported three grants, and one reported two grants. Twenty-one grantees believed that project TA had helped increase their knowledge of USAID policy, procedures, and processes, and 19 believed that APC resource persons were competent to provide TA. Financial management and branding planning was the most commonly cited training topic (12 of 22 respondents), followed by FP compliance monitoring (10), and Dashboard and FP compliance follow-up reporting (8).8

Responses to KIs
Opinions on the sub-grant program varied. A senior USAID official closely affiliated with APC felt that Result 2 of the sub-grant program was the most important of the three results and was exceptional for cost-effectiveness and efficient management. JSI designed the program to be as efficient as possible. The JSI finance team led the program and handled it with low overhead costs (less than 8 percent). The team has been proactive about preparing grantees for financial transactions. Discussions with the team revealed that about half of the 84 grantees required intensive assistance with their grants. Many of the NGOs overseas were selected with the understanding that they were receiving U.S. government funds for the first time and that their accounting systems were not geared to meet USAID standards. The JSI team worked with them closely, as most had never encountered grant-related management issues. While grantees may have possessed excellent technical skills, all received an in-depth, pre-award survey to help JSI determine their financial management weaknesses, which were then built into their grants with mitigation measures. Of the 104 grants to date, only a few instances of fraud have been found; of these, only one required the grant to be ended (JSI finance team and FHI 360 finance person).

Several grant recipients received follow-up funds from USAID or grants from other donors. Based on reporting from a USAID staff member with good knowledge of APC, there were numerous instances where former grant recipients reported receiving additional funds. A total of 46 of 84 NGOs under the sub-award program have graduated capacity-building activities and started to obtain additional funding from USAID or other sources independently after the completion of their initial APC grant (APC data).

If APC’s sub-grant program has not expanded and strengthened innovative PVO/NGO community programs, why not?
There was a variety of challenges to achieving project objectives through the sub-grant process.

FP challenges
NGO staff turnover at the national level was a problem in some countries, resulting in a need to rebuild relations with the MOHs. There were also sensitive issues related to FP, such as working with religious leaders to address ways to discuss FP. There were problems with financing and the amount of time needed to move initiatives forward at the national level, which requires persistence. For example, an NGO country director supported by APC found that it may take as many as four meetings with national leadership to make progress.

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8 It should be noted that eight received FP compliance follow-up reporting, although seven respondents were FP/RH. This is to be expected, as all grantees for USAID funding are required to follow FP compliance regulations.
**Post-Ebola efforts to provide FP**

In Sierra Leone, APC developed effective training programs for CHWs in five districts and worked hard to encourage the MOH to take on FP for health posts. The project did make progress but was not very successful with the CBFP because the MOH had a very conservative view about the role of health workers in FP. APC improved outreach at different levels with the training of 2,000 staff from health posts and facility management committees. Community health and FP was a key service component of the APC cooperative agreement. The post-Ebola program made headway getting CHWs to be more active — beyond distributing pills and condoms — but did not succeed in expanding their roles. More recently, as of 2017, there has been expression of interest in piloting DMPA-SC in one district, which could open up new opportunities for FP (Update provided by APC staff, January 2018).

**Travel for APC staff**

A discussion with APC staff revealed that a higher allocation of travel funds, especially for finance and M&E staff, is critical as new APC grantees need assistance. Annual travel is necessary so staff is not limited to Skype and phone calls to address finance and M&E issues. One informant mentioned that they were unable to visit the field even once, and that Skype alone was used to provide all TA. APC management (and USAID) must consider this while reviewing the projected budget for the next year. As one informant said, “We would like to visit at least once a year in the field to provide required TA, but this is not feasible. It would help if you are sitting right next to the person. Even for those that do not have problems, it would help to have site visits. It could improve the communication.”

**Improved M&E**

Performance monitoring plans should be available at the beginning of each grant, and there should be more comprehensive monitoring data with dedicated staff to analyze them to inform management. This should be part of the design stage at the beginning of each grant activity. A representative from the Bureau for Democracy, Conflict, and Humanitarian Assistance mentioned that after a certain number of grants had been implemented, “We found we need better data from the beginning, more comprehensive monitoring data.”

**Evaluation Question 2B. Three key aspects of the APC sub-grant program**

**Innovative approaches implemented through the APC sub-grant program**

The following are examples of innovative approaches from APC pilot projects. They are relatively small and would need to be scaled up to assess their effectiveness.

The Global Team for Local Initiatives implemented a project with innovative efforts to reach pastoralists in Ethiopia, including a PHE initiative that increased community participation rates, strengthened women’s participation, and increased the number of acceptors of modern contraceptives. Participation in a functional vocational literacy program appeared to increase the number of women who chose FP. Although the initiative was modest in scope, it had significant results for pastoralists: 380 female adults requested FP referrals and 162 females became new acceptors of modern contraceptives.

The Adventist Development and Relief Agency (ADRA) implemented another innovative approach in Nepal. The Technical Integration for Coverage and Access (TICA) project encouraged expansion of FP messages outside of traditional FP service delivery sites, with a provision for improvement of FP services at 10 locations. TICA integrated needed FP services into ADRA’s Develop Local Economy to Eradicate

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9 See the final report covering March 1, 2014, through December 31, 2016.
Poverty Project, leveraging activities, community access points, and resources to address FP needs and challenges in the targeted areas.11

Pathfinder International’s Tuungane II Project developed an innovative project in Western Tanzania’s Greater Mahale Ecosystem, in an area bordering the shores of Lake Tanganyika.12 The goal was to reduce threats to biodiversity conservation and natural resources (terrestrial and freshwater) degradation while improving the health and well-being of local communities by creating sustainable livelihoods and access to FP/RH services. The project strengthened the systems for delivery of contraceptives and PHE messages in the community and in health facilities. From 2014 to 2015, the use of LARCs and permanent methods increased 567 percent, from 362 in 2014 to 2,421 in 2015, thanks to the introduction of LARC services in health facilities and quarterly outreach clinics in all villages.

In addition, APC has supported efforts to promote the expansion of CHWs’ provision of injectable contraception, such as Depo-Provera. A good example was a ChildFund effort in Zambia that included CBA2I and was implemented in one additional project district. APC continues to fund ChildFund and is working with them on expanding access to DMPA-SC in Zambia, including a pilot for offering self-injection in the private sector. The grant in Zambia is using the APC learning site tools to help ensure high-quality CBFP services are implemented and scaled up.

**Outcomes of the APC sub-grant program**

There are many examples of clear progress toward successful outcomes, including the Benin program (CBA2I and DMPA-SC), many of the activities in Uganda (CBA2I, CBFP, DMPA-SC, and drug shops), and the sub-grant in one district in Zambia (CBA2I). Despite progress on CBFP in Uganda, there is some concern over a possible lack of follow-through. Regarding the larger picture, beyond FP, a key finding was an increase in the number of grantees that have acquired the basic expertise required to qualify for additional grants from USAID and other sources. Many grantees have qualified for grants elsewhere as a result of APC support.

**Method choice.** Several sub-grantees have expanded options for method choice to include injectables, DMPA-SC, and/or ECP, including Benin (where APC does not fund sub-grantees, but implements training) and Uganda, as well as in multiple sub-grants in Ethiopia, Kenya, Tanzania, and Zambia.

**FP workforce.** APC made clear progress in training the FP workforce in Benin and Uganda, as well as in multiple sub-grants in Ethiopia, Kenya, Nepal, Tanzania, and Zambia.

**SBC.** There was limited evidence of an active APC role in expanding access to SBC activities at the field level. One example is the Mobile for Reproductive Health (m4RH) service, an automated, interactive, on-demand short message service (i.e., text message) system that provides simple, accurate, and globally relevant information on RH via cell phones. FHI 360 has adapted m4RH for 10–24-year-olds in Northern Uganda and added additional content on puberty, sex, pregnancy, health choices, gender-based violence, and dual protection.13

**Youth.** There was evidence of success with youth, though it was limited. In addition to m4RH, ADRA’s TICA project in Nepal worked to reach youth outside of clinic locations, and Salvation Army/Uganda worked to integrate boys into its activities, especially for peer education. A respondent from WellShare

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International said efforts for youth-friendly services for adolescents had occurred at health centers, but more needed to be done, especially relating to FP2020 goals.

**Gender.** The *Emanzi* program, described in detail below, showed indications of success with male involvement in APC. However, apart from a recent assessment of their *Emanzi* work, much of APC’s other gender work lacked data to substantiate progress. The evaluation team found strong support for the activities and a willingness to expand the program to other areas during visits to two sites in Western Uganda.

*The Emanzi program*

FHI 360 first assessed *Emanzi* in 2013. APC Uganda adapted it as a buy-in based on evaluation results, which noted areas for improvement that could make it more effective, and with scale-up in mind.

The program consists of a sequence of nine 60-minute sessions, implemented over two to three months. The sessions included Understanding Gender Roles and Stereotypes; Men, Gender, and Health; Healthy Relationships; Pleasure in Relationships; Understanding Violence against Women; Importance of Healthy Timing and Spacing of Pregnancy; Communication about FP; Condoms; and Closing Reflections: Men and Change. The sessions were facilitated by pairs of VHTs who were trained to be *Emanzi* group leaders; 112 were trained in three districts (22 in Kanungu, 36 in Kamwenge, 54 in Kasese). Every pair facilitated four groups, each with 10 to 12 participants. Supportive supervision and QA was conducted by the district and sub-county supervisors. From 2015 to 2017, more than 3,000 men aged 18 to 45 completed all nine sessions and graduated in the three districts.

The evaluation team’s discussions with two groups of *Emanzi* participants revealed strong support for the program, with a clear endorsement for expansion to include other men in the communities. Findings from the first group included testimony from men who said they were happy to be working together as a family — that they could now sit down together and discuss issues as a family. “We used to beat our wives, but not beating them is actually stronger,” one respondent said. "The men used to take a lot of alcohol and go back home very late and we no longer do that. We used to force women to have sex, but now we talk about it. So, when [a] wife is having the periods it can be understood, we don’t force them to have sex.” Another commented, “For me personally, I help now in cooking when [my] wife is not around, getting firewood and even bathing the children.”

In the second group, which included women, participants said men realized their shared responsibilities, such as looking after children and preparing food. One respondent said that after participating in the sessions, he realized women needed to participate in discussions at home and husbands did not have to dictate to their wives because women’s opinions also matter. Another respondent said the session about condoms was important because it clarified misconceptions and helped him change his attitude. Many men in the group agreed with this change in attitude about condoms. Even after the sessions had concluded, the men continued to meet to work on self-help activities. For example, one group mentioned they had a savings system in which they had saved funds with the right to make low-interest loans to *Emanzi* participants.

In 2017, FHI 360 conducted a quantitative evaluation of the program in seven communities in Kasese district. Approximately 250 men and their partners were followed over a period of nine months in 2016–2017. Using the gender equitable men (GEM) scale to measure gender norms, men were asked a series of questions related to gender norms, gender-based violence, sexuality, masculinity, and RH. The GEM scale measured items on a three-point Likert scale (agree, partially agree, disagree); a greater score meant more support for gender-equitable beliefs. Three key findings were:

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The mean predicted value of the GEM score was 2.23 at baseline and increased an average of 0.41 points between baseline and three months (interim). The scores continued to increase between interim and endline (six months) by an average 0.08. This statistically significant finding demonstrates that men retained information from *Emanzi*, and that the program had lasting improvements on gender-equitable attitudes.

The shared decision-making score captured the extent to which a person made decisions with their partner. *Emanzi* participants and their partner’s attitudes toward shared household decision-making increased significantly at interim, and men’s scores continued to increase slightly at endline.

*Emanzi* participants’ and their partners’ use of FP increased from baseline to interim. The increase was statistically significant among men, suggesting that participating in *Emanzi* improved FP use.

FHI 360 also conducted a qualitative assessment in Kanungu district two years after the first group of *Emanzi* participants graduated. It included participants, their partners/wives, and implementers. The aim was to understand the factors that led to the continuation of *Emanzi* activities and income-generating activities that participants started organically after they completed the curriculum. Participants reported improved communication and cooperation after completing *Emanzi*. Some men reported increased communication with their wives about finances, joint budgeting and savings, and paying for school fees. Almost all participants said men engaged in discussions with their partners about FP. Some groups wanted to continue to meet and discuss gender topics and start income-generating activities, such as rearing chickens, pigs, and rabbits and/or pooling funds for household goods and school fees. Forty *Emanzi* groups continued meeting post-intervention.

There was some evidence that South African-based Sonke Gender Justice (SGJ) did successful gender work for the Ethiopia Mission, although the Mission’s demand for and SGJ interest in doing further work was limited. SGJ did, however, implement some other positive gender activities. For example, it trained Salvation Army/Uganda staff on integrating and engaging men and boys into their activities and did a successful presentation on men and gender at a conference in Washington, D.C. Furthermore, World Vision’s Garba Tulla HTSP Integration Project in Northern Kenya worked with men, imams, and sheiks as part of its integration of FP into MCH services.15

**EVALUATION QUESTION 3**

*Has APC strengthened PVOs/NGOs to implement effective programs? If yes, how? If no, why?*

**Overview of efforts to strengthen PVOs/NGOs to implement effective programs**

As outlined in the APC performance monitoring documents for Years 4 and 5, Result 3 is intended to strengthen NGO technical and organizational capacity.16 Under Result 3, “APC provides technical and organizational capacity building to grantee organizations to enable them to implement successful programs, comply with reporting requirements and prepare them to receive USAID funds.” As shown in Table 4, indicators 3.1 through 3.5 show consistent progress under Result 3.

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15 For more information about these SGJ and World Vision projects, see, respectively, the APC, Draft Performance Monitoring Report, Year 4, Version 1, December 1, 2016; and Garba Tulla, Year 3, Healthy Timing and Spacing of Pregnancy/Family Planning Project, Quarter 2 April–June 2016 Report.

Table 4. Result 3 Indicators from Performance Monitoring Reports, Years 4 and 5

<table>
<thead>
<tr>
<th>No.</th>
<th>Result 3: Strengthen PVO/NGO technical and organizational capacity</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Target</td>
<td>Result</td>
</tr>
<tr>
<td>3.1</td>
<td>No. of sub-grantees who completed their environmental, FP, and gender compliance documents</td>
<td>47</td>
<td>54</td>
</tr>
<tr>
<td>3.2</td>
<td>No. of sub-awardees who have submitted required FP plans</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>3.3</td>
<td>No. of grantees monitored through the Grants Management database to ensure timely tracking and reporting of expenses</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>3.4</td>
<td>No. of organizations to which APC has provided capacity-building and/or TA on financial management &amp; USAID compliance</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>3.5</td>
<td>Number of organizations to which APC has provided capacity-building and/or TA</td>
<td>43</td>
<td>45</td>
</tr>
</tbody>
</table>


Examples of efforts to strengthen implementation of effective programs
Many of the countries receiving TA from APC fall into the category of “last mile” communities, fragile areas that have yet to benefit from overall health systems improvements (e.g., PHE programs in eco-fragile areas). This is an important aspect of APC’s work and one of the most important roles for CBFP and community-based programs as a bridge to large-scale national programs. It should be acknowledged that working in these communities is more costly and difficult than working in other areas.

**Benin**
Funding for APC in Benin was provided primarily by the Mission, not APC headquarters. Project activities have been effective in strengthening organizations involved in the PIHI Program, implemented by BUPDOS, Dedras, and Sian’son. APC delivered 68 training courses on nine topic areas to these NGOs, such as requirements to receive USAID funding and implementing their focus activities, which include high-impact interventions related to MCH and FP (basic training in FP and training for CBA2I, CBFP, and DMPA-SC). Training included supervision of CHWs for data collection of the PIHI Program; assistance with work plans, M&E plans, and performance management plans USAID funding requirements (e.g., branding and co-branding, filling in USAID templates, FP compliance); and training M&E staff on use of collected data to develop PIHI performance indicators. Based on interviews and review of project documents, these training courses have been effective for both PIHI activities and adherence to requirements for implementation of CBA2I, CBFP, and DMPA-SC.

**Uganda**
APC activities in Uganda have strengthened PVOs/NGOs to implement effective programs. For example, WellShare has long-term experience in Uganda and has focused on intensive projects in a limited number of districts, enabling it to maintain its overall capacity to provide assistance and withstand changes. WellShare has close ties with APC core funding through FHI 360, which has helped it maintain

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17 There was also $425,000 of core funding for APC Benin: $125,000 for the CBA2I pilot project, and $300,000 for DMPA-SC introduction.
18 See APC, Benin Quarterly Progress Report, April–June 2017, Benin’s Community-Based Access to Injectable Contraceptives Pilot Project, and Health Trainings with Local NGOs in Benin, APC Trainings Table in Benin April 12, 2017. As shown in the summary table of health trainings for local NGOs in Benin, APC supported the completion of 68 trainings on nine topic areas for the three NGOs in 10 health zones. On average, each local NGO within a given health zone received 6.8 trainings. These trainings took an estimated 198 days to complete. This does not include three trainings for NGO management on leadership and USAID funding.
its funding over time. WellShare’s Arua District Partnership for HIV/AIDS and Family Planning Integration Project was awarded an APC sub-grant in February 2014 (Award No. APC-GM-0047) to integrate FP into an existing HIV/AIDS program.\textsuperscript{19} The project engaged community-owned resource persons (CORPs) to scale up access to, and information on, FP methods among key populations in the Arua district in Western Uganda through home visits and group discussions. The CORPs integrated FP into HIV counseling and testing outreaches and community dialogues (using the Stepping Stone Model of Population). WellShare trained 50 CORPs in CBFP service delivery, including CBA2I, and community-level FP/HIV integration targeting out-of-school youth and people living with HIV/AIDS. Thirty-eight of the CORPs were youths (28 male, 10 female) and 12 were people living with HIV/AIDS (five male, seven female). In addition, WellShare selected one health worker from 17 health facilities and trained them in supportive supervision of CORPs and provision of Youth Friendly Health Services (YFHS). The project demonstrated significant progress by reaching 3,522 clients (724 males and 2,798 females) with CBFP services through project-trained CORPs/VHTs and 19,016 people (6,686 males and 12,330 females) were reached with FP messages during group discussions and home visits. Of the health facilities assessed for YFHS, all but one had improved its YFHS scores.

**Other issues to be addressed. Please identify.**

**APC approaches to strengthen the technical and organizational capacity of sub-grantees**

**Technical capacity.** As shown in Table 5, APC's approach to strengthen the technical and organizational capacity of sub-grantees was training-intensive and supported by a variety of TA and site visits. Although APC provided non-training TA in many areas, the evaluation team feels that training was the most important area of support for strengthening technical and organizational capacity. Based on summary data provided by APC for 10 FP grantees, a total of 6,555 people were trained (3,420 men, 3,135 women), the majority of which were CHWs (5,098), followed by people working in health facilities (1,270) and Administrative/Management (187). On a per grant basis, this is an average of 127 people trained for FP facility (49 men, 78 women) and 510 CHWs trained per grant (280 men, 230 women).

**Table 5. Summary of Training Provided to 10 APC FP Grantees by Type and Gender**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Trained</th>
<th>Men Trained</th>
<th>Women Trained</th>
<th>Average Trained per Grantee</th>
<th>Average Men per Grantee</th>
<th>Average Women per Grantee</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP counseling/services for providers working in health facilities</td>
<td>1,270</td>
<td>492</td>
<td>778</td>
<td>127</td>
<td>49</td>
<td>78</td>
</tr>
<tr>
<td>FP counseling/services for CHWs</td>
<td>5,098</td>
<td>2,803</td>
<td>2,295</td>
<td>510</td>
<td>280</td>
<td>230</td>
</tr>
<tr>
<td>Administrative/Mgt.</td>
<td>187</td>
<td>125</td>
<td>62</td>
<td>19</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,555</strong></td>
<td><strong>3,420</strong></td>
<td><strong>3,135</strong></td>
<td><strong>656</strong></td>
<td><strong>342</strong></td>
<td><strong>314</strong></td>
</tr>
</tbody>
</table>

Note: APC has given 16 FP-related grants but has maintained data for only these core 10 FP grantees. These trainings are an undercount of all trainings APC supported: They are for the 10 core grantees monitored by APC and do not include data for faith-based FP trainings for UPMB in Uganda supported by CCIH.

Source: APC, Core Grantee Data 01-11-17 Excel spreadsheet.

**Organizational capacity.** APC has strengthened the organizational capacity of sub-grantees through a consistent set of training in management, finances, and USAID regulatory adherence for grantees in all program areas (e.g., FP, HIV/AIDS, post-Ebola). As shown in Table 5, for the 10 core FP grantees, 187

people were trained in administrative and management issues (125 male and 62 female). This is an average of 19 people trained on management issues per grant (13 men, six women).

**APC approaches to provide technical support to PVOs/NGOs to advance effective programming and the extent to which these approaches were successful**

APC’s primary approach to provide technical support for PVOs/NGOs to advance effective programming is through training, supported by a variety of TA and site visits. All FP-related programs supported by APC emphasize training as a key basis for advancing effective PVO/NGO programming. To date, the training provided for Benin’s three NGOs (BUPDOS, Dedras, and Sian’son) has focused on essential requirements for eligibility for USAID/Benin funding, including leadership, Excel, FP compliance, quarterly and annual report training, and training on managing USAID funding. This required 114 of the 198 total days of training. (In contrast, training on DMPA-SC took only 10 days.) This shows that it takes time to achieve readiness to receive USAID funding and that there is a need to focus on key inputs that will benefit program outcomes. The training on technical support for FP, whether DMPA-SC or other FP service delivery skills, is essential to achieve project goals.

**Technical support activities that could have been eliminated or reduced while achieving the same level of program success**

Based on a review of the FP grants supported by APC, none of the technical support activities appeared to be irrelevant or inappropriate. However, it is difficult to determine if technical support activities were ineffective. Some respondents did feel that core training for grant recipients in management and financial expertise was not essential and could be eliminated. The trend of grant recipients not receiving capacity-building or TA on financial management and USAID compliance suggests that the number of grantees that require this type of training has diminished.

**EVALUATION QUESTION 4**

*To what extent did APC achieve its objectives?*

APC demonstrated leadership and advocacy for CBFP in many countries (e.g., Benin, Malawi, and Uganda) by being instrumental in changing policy in favor of CBFP and CHWs’ delivery of CBA2I and DMPA-SC. Country-level leadership was more prominent then global effects.

Based on the evaluation team’s observations in Benin and Uganda and the responses to the online surveys, APC’s sub-grant program and processes of implementation were effective in building NGOs’ financial capabilities, compliance with USAID rules, and preparing progress reports. However, the general impression is that M&E and interpreting data for improving the program could have been better.

All this indicated that NGOs’ technical skills, particularly in M&E and assessment to improve implementation, need further support. This is true for NGOs in Benin and Uganda, where UPMB, WellShare, and other institutions implementing FP or RH education for youth received little or no TA in monitoring or measuring their program results.

The overall TA provided by APC for building the capability of national health and FP programs in government and other research/training appears to range between good and average. Lack of skills development in M&E was the main limitation that cut across many countries. The evaluation team could not determine if the capability of NGOs was adequate to work independently once APC is over and other TA is not available. The team did not see any systematic measures that could help in accreditation of NGOs as “graduated” to implement a high-quality program independently.

The quality of TA to the MOHs in Benin and Uganda on policy and technical aspects was strong and highly appreciated by all. TA to district-level authorities, particularly for QA of services provided at the community level, and training of CHWs in Benin or VHTs in Uganda was a bold and strong initiative.
5. CONCLUSIONS

RESULT 1

Despite constraints, such as limitation of core funds, and the pressure to establish buy-ins to meet the Missions’ requirements where very few supported CBFP, the evaluation showed that APC worked hard to provide global and country leadership to increase CBFP. Performance at the country level was much more focused and strategically planned than at the global level, particularly in working with MOHs and local partners to influence policy change supportive of CBFP. The findings, such as self-injecting DMPA-SC, task-shifting, and providing CBA2I to CHWs in Benin, Malawi, and Uganda are important contributions and need to be promoted globally.

The FP grants awarded to NGOs and institutions made useful contributions in the field, but performance monitoring was either not done or relied on only facility-level service statistics to assess the results of the interventions. Even when impact evaluation was not built into the project, process documentation should have been done systematically. Good process documentation — especially for challenges in implementation, the chances of replicability and scaling up in a given context, the type of modifications required in the intervention or implementation process, and program monitoring — provide good insight on the impact of the program. Dissemination of findings to wider audiences was also limited, and outcomes and lessons learned should have been more consistently documented to share the findings. Throughout the evaluation, the team felt that APC in general had not adequately pursued M&E or process documentation. We consider this a major missed opportunity.

It is not clear to what extent APC’s 116 publications have contributed to advocacy, sensitization, or popularizing CBFP. The CHS Catalog is an important contribution and has been downloaded in many countries for research purposes and for advocating policy change. All publications do not demand the same treatment, but thematic publications (e.g., those focused on increasing CBFP, task-shifting, and organizing FBOs for supporting contraceptive use) need a systematic and sustained effort to enhance their utilization.

RESULT 2

Mission and grantee surveys (using SurveyMonkey) and personal discussions with NGOs during field visits made a clear case that the grant process was effective in developing key management skills and acquiring follow-up funding. This conclusion should be taken with caution, however, because of the small number of responses and self-selection bias.

Respondents concluded that grantees could be trained at low overhead costs and that getting follow-up funding had been effective. Grant management was cost-efficient, generally at less than 8 percent overhead.

There is a need for performance monitoring and/or process documentation from the beginning of each grant, and more comprehensive monitoring data that is closely reviewed regularly at each level, including the AOR team, to assess overall performance and documentation. This should be part of the design process at the beginning of each program.

RESULT 3

APC has succeeded in supporting effective FP projects in Benin, Uganda, and other countries.

Training has been the primary intervention for improving FP services, as well as improving administrative and management performance of APC-supported grant recipient agencies.
APC has demonstrated success in increasing grant recipients’ organizational capacity, mostly related to financial record-keeping and reporting and adhering to USAID rules and regulations, thus building essential capacity for continued funding. Improvement in technical skills for FP service delivery was more limited for grant recipients, especially for M&E of services. At the MOH, district, and health center levels, assistance has helped improve technical ability, monitoring, and FP service delivery skills.
6. RECOMMENDATIONS

RESULT 1

- APC management and grantees need to improve M&E of sub-grants and related activities. The evaluation team did not see any systematic measures that could help in accreditation of NGOs as “graduated” to implement a high-quality program independently.
- When possible, project management should make global advocacy, especially for CBFP, a focused activity with a clear pathway. A well-thought-out strategy and a sustained effort is required to achieve this goal.
- APC should continue to work with USAID AORs and global partners to ensure that CBFP advocacy is wide and effective.
- APC should continue CBFP activities using sub-grants to engage new local partners and build capacity for country self-reliance.

RESULT 2

- APC and USAID should continue the sub-grant process for FP programs, with an emphasis on developing compatibility with USAID grant requirements while maintaining low overhead rates.
- APC and USAID should ensure M&E for the duration of projects and use data to inform, adapt, and strengthen activities.
- Abruptly discontinuing a project activity reduces its chances of scaling up. While many of the core FP sub-grants were continued year to year, they often changed program focus, discontinuing promising efforts. For successful project-supported activities, if possible, APC or USAID should consider a small follow-up grant to create conditions for scale-up and sustainability. If not feasible, then these successes should be highlighted so that Missions can build on them, scale them up, and/or incorporate these successes into existing or future projects.

RESULT 3

- APC or USAID should continue current sub-grants for FP projects to develop and improve program performance.
- USAID should continue APC’s capacity-building approaches to strengthen sub-grantees’ technical and organizational capacity.
- M&E skills should be an integral component in APC-supported training of grantees and should be imparted to make grantees capable of working independently. Performance monitoring is as important as financial management and could be measured by introducing a process of APC- or USAID-supported accreditation of PVOs/NGOs for enhanced capability.
ANNEX I. SCOPE OF WORK

Assignment #: 445 [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: 08-04-17
Last update: 9-14-17

I. TITLE: PERFORMANCE (ENDLINE) EVALUATION OF THE ADVANCING PARTNERS AND COMMUNITIES PROJECT

II. REQUESTER / CLIENT
☑ USAID/Washington
Office/Division: GH / PRH / SDI

III. FUNDING ACCOUNT SOURCE(S): (CLICK ON BOX(ES) TO INDICATE SOURCE OF PAYMENT FOR THIS ASSIGNMENT)
☐ 3.1.1 HIV ☐ 3.1.4 PIOET ☐ 3.1.7 FP/RH
☐ 3.1.2 TB ☐ 3.1.5 Other public health threats ☐ 3.1.8 WSSH
☐ 3.1.3 Malaria ☐ 3.1.6 MCH ☐ 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): September 20, 2017
Anticipated End Date (on or about): March 31, 2018

VI. LOCATION(S) OF ASSIGNMENT: (INDICATE WHERE WORK WILL BE PERFORMED)
The Advancing Partners and Communities (APC) Project has two implementing partners — JSI is located in Arlington, Virginia and FHI360 is located in Durham, North Carolina. In addition to visiting partners in these two locations, it is expected that the evaluators will visit one or two countries in Africa: Benin and Uganda. Uganda was selected because APC is supporting the implementation of a sub-award implemented by WellShare and the implementation of an innovative approach working with faith-based organizations, and APC is receiving field support to implement activities. Benin was selected because APC has an office in Benin and has been working with the government to introduce CHW provision of injectables and Sayana Press into public sector programs, both of which are PRH priorities.

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.

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

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

☐ 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 Evaluation 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

Project being evaluated:

<table>
<thead>
<tr>
<th>Project/Activity Title:</th>
<th>Advancing Partners and Communities (APC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award/Contract Number:</td>
<td>AID-OAA-A-12-00047</td>
</tr>
<tr>
<td>Award/Contract Dates:</td>
<td>10/1/2012-9/30/2019</td>
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<tr>
<td>Project/Activity Funding:</td>
<td>$251,000,000 ceiling</td>
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<tr>
<td>Implementing Organization(s):</td>
<td>JSI Research &amp; Training Institute, Inc.</td>
</tr>
<tr>
<td>Project AOR:</td>
<td>Victoria Graham</td>
</tr>
</tbody>
</table>
Background of project/program/intervention

Program Overview
Advancing Partners and Communities Project
The APC Project is a central mechanism managed by Office of Population and Reproductive Health (PRH) and provides global leadership and technical support in community-based family planning programming and manages a large sub-award program. In October 2012, GH/PRH/SDI (Bureau for Global Health/Office of Population and Reproductive Health/Service Delivery Improvement) awarded the APC project, a 5-year $210 million Cooperative Agreement to John Snow Inc. (JSI) as the prime implementing organization with FHI 360 as their partner. A two-year, $41 million extension was executed March of 2017, resulting in a new project end date of September 30, 2019, and a revised ceiling of $251 million.

In addition to providing global leadership and technical assistance for community health programming, APC manages a large sub-award program and builds the technical and organizational capacity of non-governmental organizations (NGOs) to implement effective programs that comply with USAID rules and requirements. APC works to achieve health-related impact in family planning, maternal/child health, HIV/AIDS and infectious disease.

The APC project is a continuation of a series of USAID Global Health investments in community-based family planning and builds on lessons learned under previous activities, including the Grants, Solicitation, and Management Project (GSM) (2004 to 2012) and the Flexible Fund grant program (2002 to 2012). The Flexible Fund (2002–2005) was established as a PRH budget earmark to support NGO/PVO FP programming. Solicitations were conducted, and competitively selected awardees were funded through many USAID mechanisms from across Bureaus. When it was decided that the difficulty of identifying eligible mechanisms and monitoring awardees spending and progress was difficult and technical support for programs was needed, the Grants Solicitation and Management Project (2005–2013) was procured to solicit, execute, and manage sub-awards. The GSM Project received funds from HIDN, DCHA, and missions from around the world. Technical support for FP sub-awardees supported by the GSM project was procured separately and initially in collaboration with the Child Survival and Health Grants Program (CSHGP). With the impending end of the successful GSM Project, design efforts began for a follow-on project that combined technical assistance for community-based family planning with a sub-award program, primarily for family planning, capable of receiving all types of funding in support of a range of activities. In part, this program was designed to advance the Agency’s new USAID Forward agenda that called for capacity building of local NGOs. As Agencies’ priorities shifted and new leadership emerged, the support for this aspect of the program waned. APC is a flexible cost-effective mechanism designed to be a high volume, low cost grant making mechanism for both Washington and the field.

There has been great demand for APC in USAID/Washington and in Missions. In fact, more than 20 missions and over 38 countries have received support from APC through either core investments or field support buy-ins. The types of funding received by APC include, Family Planning (FP), Ebola, MCH (Maternal Child Health) HIV/AIDS, DCHA (Bureau for Democracy, Conflict, and Humanitarian Assistance), TB (Tuberculosis), Malaria, and Nutrition. The project is housed and managed in the Service Delivery Improvement Division of the Office of Population and Reproductive Health, the management team includes the Agreement Officer Representative, AOR (Victoria Graham) Technical Advisor (Amy Uccello), and Program Analyst (Alanna White).

Strategic or Results Framework for the project/program/intervention

Results Framework, key activities, and geographic scope:
The overarching goal of the APC Project is to advance and support community programs that seek to
improve the overall health of communities, especially in relation to family planning. Three complementary project results are shown below:

**Result 1:** Strengthened global leadership and advocacy for community-based programming and effective program approaches and tools, primarily for FP. Activities implemented under this result will provide relevant information to the global community on CBFP; expand community-based programs through the establishment of new CBFP programs, introduction of new methods at the community-level, and supportive of policy change; and provide technical support to national family planning efforts. These activities are primarily supported with modest funding from PRH.

**Result 2:** Innovative PVO/NGO (Private and Voluntary Organizations/Non-Governmental Organizations) community programs expanded and strengthened. Activities implemented under this result include the establishment and management of a large and cost-effective sub-award program capable of issuing small- to medium-sized awards supported by a variety of funding from all health categories; support to pilot programs that address key PRH and other USAID priorities; and a granting mechanism that supports Mission programming. These activities are primarily funded by field support from Missions, and other USAID offices and bureaus.

**Result 3:** PVO/NGOs prepared to receive USAID funds and implement effective community-based programs, especially family planning (Capacity building). Activities implemented under this result will strengthen the capacity of grantees and enable them to implement a USAID funded award, including compliance to all USAID regulations and requirements. As the Agencies priorities have shifted and new leadership emerged, the demand for activities under this project result have waned. When capacity building activities have been conducted, they have been specifically requested and budgets agreed upon before beginning program implementation.

APC has issued over 100 small grants since its inception. Sub grants range in size from under $100,000 to several million. All grants funded by GH funds aim to improve health outcomes and strengthen capacity of local organizations.

APC provides a wide range of technical services to Missions, some of which include:

- Introduce and promote innovative and high-impact strategies, provide virtual or on-the-ground technical assistance to bilateral programs in the design of demonstration projects and national scale-up efforts of private and public-sector community family planning programs and other health areas.
- Provide grant-making services: Conduct fully open and targeted competitive solicitations; determine eligibility of awardees; prepare cooperative agreement documents for execution by USAID; execute actionable Sub-awards; and execute sub-awards competed by an APS.
- Provide Missions a wide range of grant management and oversight services for awards to local organizations; monitoring of progress and expenditures of programs, ensuring financial accountability of grantees, supporting program monitoring and evaluation, ensuring compliance with all USAID requirements, including branding and family planning requirements.
- Provide technical and organizational capacity building services for local NGOs that will prepare them to implement and monitor effective programs and receive funding directly from USAID.

The APC Project has developed a logic model that demonstrates the link between the project activities to the project goal, outputs, outcomes, and ultimately impact. The logic model is found in Annex A.
APC is a global project that provides technical support, capacity strengthening, and administrative oversight to community health programs worldwide. APC is currently working in 38 countries with four APC country offices in Benin, the Dominican Republic, Guyana and Sierra Leone. The full list of countries APC is working in includes: Bangladesh, Benin, Burundi, Burma, Cambodia, Cameroon, Colombia, the Dominican Republic, the Democratic Republic of the Congo (DRC), El Salvador, Ethiopia, Ghana, Guinea, Guyana, Haiti, India, Kenya, Laos, Liberia, Madagascar, Malawi, Moldova, Nepal, Nicaragua, Papua New Guinea, the Philippines, Romania, Senegal, Sierra Leone, South Africa, Suriname, Tanzania, Thailand, Trinidad & Tobago, Uganda, Vietnam, Zambia and Zimbabwe. These country activities can be characterized by the following categories: Community Health & Service Delivery; Policy, Advocacy, Information and Tools; Research, Surveys, Evaluation and Data as shown in Annex B.

Definitions:
Community-based family planning (CBFP) — CBFP brings family planning information and methods to women and men where they live rather than requiring them to visit health facilities. Though CBFP programs work through a variety of channels, including community health workers, community depots, drug shops, mobile services, and the private sector.

**IX. PURPOSE, AUDIENCE & APPLICATION**

**A. Purpose:**
The purpose of this endline evaluation is to assess the extent to which APC has achieved its objectives. A secondary purpose of this evaluation is to identify community-based family planning activities that may warrant future investment and to better understand the roles of the partners.

**B. Audience:**
The evaluation results will be used by the Service Delivery Improvement (SDI) Division and PRH leadership to inform future procurements for community-based family planning. It will also be used by the project to prioritize and inform program activities in the final years of the project.

**C. Applications and use:**
This evaluation is timely as USAID is in the process of realigning foreign assistance and seeking opportunities for improving efficiencies and program results. The evaluation results will inform important future program decisions related to community-based family planning. And, since there are still two years remaining in the life of the project the results will inform future activities.
### X. EVALUATION/ANALYTIC QUESTIONS & MATRIX:

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Suggested Methods for Answering this Question</th>
<th>Sampling Frame</th>
</tr>
</thead>
</table>
| **Result 1: Strengthened global leadership and advocacy for community-based programming and effective program approaches and tools, primarily for family planning** | **Main data sources:** See Annex C  
**Data collection and analysis methods:** document review, KIIs, FGDs, Field visits | **To be determined by the evaluation team based on availability, relevance, and coverage of information.** |
| **1. What are the achievements of providing global leadership and advocacy for CBFP?**  
*Please identify:*  
- successes and missed opportunities  
- lessons learned | **Main data sources:** See Annex C  
**Data collection and analysis methods:** document review, KIIs, FGDs, Field visits | **To be determined by the evaluation team based on availability, relevance, and coverage of information.** |
| **Result 2: Innovative PVO/NGO community programs expanded and strengthened** | **Main data sources:** See Annex C  
**Data collection and analysis methods:** KIIs, FGDs, Field visits | **To be determined by the evaluation team based on availability, appropriateness, and coverage of information.** |
| **2. How has APC expanded and strengthened community programs?**  
*Please identify:*  
- innovative approaches implemented  
- outcomes of this program  
- contribution of these programs’ implementation to PRH priorities, especially Method Choice, FP Workforce, SBC, Youth and Gender | **Main data sources:** See Annex C  
**Data collection and analysis methods:** KIIs, FGDs, Field visits | **To be determined by the evaluation team based on availability, appropriateness, and coverage of information.** |
| **Result 3: PVO/NGOs prepared to receive USAID funds and implement effective community-based programs, especially family planning** | **Main data sources:** See Annex C  
**Data collection and analysis methods:** document review, KIIs, FGDs, Field visits | **To be determined by the evaluation team based on availability, appropriateness, and coverage of information.** |
| **3. How has APC strengthened PVOs/NGOs to implement effective programs?**  
*Please identify:*  
- approaches utilized by APC to strengthen the technical and organizational capacity of sub-grantees  
- approaches used by APC to provide technical support to PVOs/NGOs to advance effective programming and the extent to which these approaches were successful  
- technical support activities that could have been eliminated or reduced, while achieving the same level of program success | **Main data sources:** See Annex C  
**Data collection and analysis methods:** document review, KIIs, FGDs, Field visits | **To be determined by the evaluation team based on availability, appropriateness, and coverage of information.** |
Assessment of Partnership - Please submit this as a separate internal memo to APC’s AOR.

4. What has been the role of the prime and the partner in advancing the implementation of this project? Please identify:
   a. collaboration, particularly to ensure the production of quality deliverables

   Key informant reviews with Project Director and project staff from the prime and implementing organizations and the USAID APC management team

   To be determined by the evaluation team based on availability, appropriateness, and coverage of information.

Recommendations for Future Programming - Please submit this as a separate internal memo to APC’s AOR.

5. What do you recommend be considered for future programming? Please identify:
   a. emerging themes and opportunities in community-based family planning
   b. benefits of the sub-award program implemented by APC to USAID/Washington and Missions
   c. aspects of the sub-award that should be maintained, changed, or eliminated
   d. the extent to which the cross-sectoral nature of funding facilitated results that benefit various health elements

   Main Data sources:
   See Annex C

   To be determined by the evaluation team based on availability, appropriateness, and coverage of information.

XI. METHODS:

General Comments related to Methods:
The evaluation will use pre- and post-comparisons of available institutional data to make comparisons before and after the intervention. As a performance evaluation, no counterfactuals have been established and therefore, the results will not address a cause and effect relationship through rigorous methods. However, the APC Project has tracked progress throughout various interventions. As much as possible, the influence of APC over these changes will be explored in the context of other factors which may have contributed to such changes.

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

Field Visits: The evaluation team is expected to travel together to two countries, selected based on the large scale and variety within their CBFP programming and for representation of field programs: Benin and Uganda. The full team will determine how best to cover visits to these two countries. It is expected that USAID staff will accompany the team on the field visits, so that a minimum of two
People will visit each country. The evaluation team is expected to interview project staff, USAID Mission Health Office staff, other implementing organizations and donors, and partners (including local NGOs, churches, public sector representatives, etc.) and beneficiaries in these two countries, and review a sample of service delivery records in health facilities and at selected service delivery points. Points of contact for each country will be identified by USAID and APC staff. The APC AOR will take responsibility for notifying the Missions of the evaluation team visits.

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

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this endline evaluation. Documents and data to be reviewed include:

APC project documents, including but not limited to:
- Request for Application (RFA)
- Cooperative Agreement
- Annual work plans
- PMP and indicator data
- Financial reports
- Annual management review reports/annual progress reports
- Annual results review reports
- SOWs for field funded activities, as applicable
- Mission-assessment question responses
- Resource materials and technical documents developed under APC
- Past internal and external evaluation reports related to APC (Flex Fund/GSM Project), as applicable

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

The team is also expected to review APC’s website, which includes a database of community health systems, publications and activities (see [https://www.advancingpartners.org/](https://www.advancingpartners.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 (a preliminary list of stakeholders and partners is attached in Annex C, but the evaluation team should add to this list as necessary). Whenever possible, the evaluation team should conduct face-to-face interviews with informants. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. APC and USAID staff will give advance notice to several key informants, and then the evaluation team will follow-up to schedule the interviews in coordination with APC and USAID staff.

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

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

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

The APC management team designed and implemented a web-based survey (i.e., Survey Monkey) of USAID regional and country Missions that have partnered with APC regarding their level of satisfaction and experiences with the project. Survey Access to be distributed to the Evaluation Team Separately.
The evaluation team should take into account this previously conducted Mission survey in making a determination whether or not another survey should be designed for Mission input.

The evaluation team should design and implement a web-based self-assessment survey to poll outside organizations that have partnered with APC to obtain data about APC on their effective approaches, lessons learned, best practices, etc. A list of those organizations can be provided by the project. Both survey questionnaires, if another Mission survey is created, will be reviewed and approved by PRH/SDI before the surveys are implemented.

The Evaluation team will draft a self-assessment questionnaire for APC project staff to reflect on the grants project.

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

Field Visits: During country visits to Benin and Uganda, where APC has worked with MoH offices and the local staff, the Evaluation Team may decide to visit villages and community clinics to conduct semi-structured observations.

Work during these site visits will include key informant and group interviews. While interviewing grantees, Mission staff and stakeholders in the field about the APC project, it is essential that the evaluation team determine the extent to which the project achieved their targets to enhance policy change, test new methods, leverage integration opportunities, and/or innovative approaches to achieve CBFP results.

### XII. HUMAN SUBJECT PROTECTION

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

During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)
XIII. ANALYTIC PLAN
Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

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

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

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

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

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 evaluation. These include Advancing Partners and Community Based Family Planning proposal, annual work plans, M&E plans, quarterly 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 four-day team planning meeting (TPM) will be held at the initiation of this assignment and before data collection begins. The TPM will:
- Review and clarify any questions on the evaluation SOW
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID’s approval
- Develop a preliminary draft outline of the team’s report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation, the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include all Evaluation Team experts, but will be determined in consultation with the Mission. 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 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 project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief USAID and GH Pro 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 into the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

- **IP and 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 Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

**Fieldwork, Site Visits and Data Collection** — The evaluation team will conduct site visits for data collection. It is expected that the evaluators will visit two countries in Africa during the period of the evaluation, Benin and Uganda. Benin was selected because APC has an office in Benin and has been working with the government to introduce CHW provision of injectables and Sayana press into public sector programs, both of which are PRH priorities. Uganda was selected because APC has an ongoing sub-award program, a new program targeting faith-based organizations, and a family planning program supported by field support. Secondary country options include Malawi and Senegal if the first options are not possible. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

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

1. Team Lead will submit **draft evaluation** report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the **final Evaluation/Analytic Report**, as needed, and submit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.
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 the 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

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (Estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Launch briefing</td>
<td>September 25, 2017</td>
</tr>
<tr>
<td>☑ In-brief with USAID</td>
<td>October 10, 2017</td>
</tr>
<tr>
<td>☑ Work plan and methodology review briefing</td>
<td>October 19, 2017</td>
</tr>
<tr>
<td>☑ Work plan with timeline submitted to USAID</td>
<td>October 16, 2017</td>
</tr>
<tr>
<td>☑ Analytic protocol with data collection tools (included with Workplan)</td>
<td>October 16, 2017</td>
</tr>
<tr>
<td>☑ In-brief with APC</td>
<td>October 12, 2017</td>
</tr>
<tr>
<td>☑ Routine briefings</td>
<td>weekly as mentioned above; each Friday during field work</td>
</tr>
<tr>
<td>☑ Out-brief with USAID with PowerPoint presentation</td>
<td>December 12, 2017</td>
</tr>
<tr>
<td>☑ Findings review workshop with IP and stakeholders with PowerPoint presentation</td>
<td>December 7, 2017</td>
</tr>
<tr>
<td>☑ Draft report</td>
<td><em>Submit to GH Pro: December 22, 2017 GH Pro submits to USAID: January 2, 2018</em></td>
</tr>
<tr>
<td>☑ Final report</td>
<td><em>Submit to GH Pro: January 26, 2018 GH Pro submits to USAID: January 29, 2018</em></td>
</tr>
<tr>
<td>☑ Raw data (cleaned datasets in CSV or XML with data dictionary)</td>
<td>January 26, 2018</td>
</tr>
<tr>
<td>☑ Report Posted to the DEC</td>
<td>March 31, 2018</td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review the Report? 10 Business days

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

Team Qualifications: Please list technical areas of expertise required for this activity

The evaluation team will be a mixed team consisting of evaluators external to USAID and a team member internal to USAID. The evaluation team should have three members that have collective knowledge, experience, and context in evaluation methods, human resources for health (HRH), health system strengthening, and local context.

Team Lead: This person will be the external evaluation expert, 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 lead 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 health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analyses, 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 Benin and Uganda is desirable
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1
Title: Evaluation Expert

Roles & Responsibilities: Serve as the external evaluator and team lead for the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, evaluation protocols, data management and data analysis. S/He will oversee the training of all persons engaged in data collection, ensuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:
- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years M&E and or managing evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English
- Good writing skills, including extensive report writing experience
• Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
• Familiarity with USAID and PEPFAR M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

**Key Staff 2**

**Title:** FP/RH Specialist

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

**Qualifications:**

- At least 10 years’ experience with FP/RH projects; USAID project implementation experience preferred
- Expertise in supply and demand for FP services at the community and clinical level
- Experience working in FH/RH at the national and local level
- Experience working on FH/RH at the global level is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Ability to work in French is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

**Key Staff 2**

**Title:** Senior Technical and Research Specialist/Advisor (USAID)

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing technical expertise on family planning, research and quality assurance of the data collection procedures, analysis and reporting. The Sr. Technical Research Specialist will offer guidance on evaluation issues, including methods, assist in the development of data collection instruments, evaluation protocols, data management and data analysis. S/He will serve as the key technical advisor to the team lead that is responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are performed to meet the needs of this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing offering guidance and sections of the report.

**Qualifications:**

- Expertise working with family planning research, training and utilization in developing countries, with a firm understanding of evaluations and the goals of PRH.
- Experience in individual and organizational capacity development related to family planning and/or research
- Experience in stakeholder engagement
- Experience in conducting USAID evaluations of health programs/activities
- An advanced degree in public health, or related field
- At least 10 years’ experience in USAID health program management, oversight, planning and/or implementation (family planning and HIV projects is desirable)
- At least 5 years of experience in USAID M&E procedures and implementation
- Able to work well on a team
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report writing experience
- Proficient in written and spoken English; additionally, French is desirable
Key Staff 3 Title: Program Analyst (USAID)
Roles and Responsibilities: Serve as a member of the Evaluation Team, participating in data collection, analysis and reporting and will support the Team with all logistics and administration to allow them to carry out this evaluation. To support the Team, s/he will need to efficiently liaise with in-country APC staff to finalize arrangements and help conduct KII’s. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes move forward smoothly. S/he may also be asked to assist with note taking at interviews and meetings, as well as with translation of data collection tools and transcripts. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing offering guidance and sections of the report.

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

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

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

Will USAID participate as an active team member or designate other key stakeholders to act as an active team member? This will require full time commitment during the evaluation or analytic activity.
☑ Full member of the Evaluation Team (including planning, data collection, analysis and report development) — If yes, specify who: It is anticipated that Linda Sussman and Alanna White will work as full members of this Evaluation Team
☐ Some Involvement anticipated — If yes, specify who:
☐ No
### Staffing Level of Effort (LOE) Matrix:

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

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Team Lead / FP Specialist</th>
<th>Evaluation Specialist</th>
<th>Sr Tech Adv</th>
<th>Prog Analyst</th>
<th>Logistics/Prog Assist/ Translator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons →</td>
<td>1</td>
<td>1</td>
<td>1 USAID</td>
<td>1 USAID</td>
<td>3 (1 PA BEN and UGA; 1 Translator)</td>
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<tr>
<td>1 Launch Briefing</td>
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<tr>
<td>2 HTSOS Training</td>
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<tr>
<td>3 Desk review</td>
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<tr>
<td>4 Travel to/from DC</td>
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<td>2</td>
<td>2</td>
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<td>5 In-brief with USAID/GH/PRH/SDI</td>
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<td>0.5</td>
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<td>7 Workplan and methodology briefing with USAID</td>
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<td>9 In-brief with project</td>
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<td>10 Data Collection DQA Workshop (protocol orientation/training for all data collectors)</td>
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<td>13 Travel — International and Domestic</td>
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<tr>
<td>14 In- &amp; Out-Brief with Benin &amp; Uganda Missions</td>
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<td>2</td>
<td>2</td>
<td>1</td>
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<tr>
<td>15 Data collection / Site Visits (including travel to sites)</td>
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<td>18 IP &amp; Stakeholder debrief workshop with prep</td>
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<tr>
<td>20 GH Pro Report QC Review &amp; Formatting</td>
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<td>21 Submission of draft report(s) to Mission</td>
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<td>22 USAID Report Review</td>
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<tr>
<td>23 USAID manages Stakeholder review (e.g., IP(s), government partners, etc.) and submits any Statement of Difference to GH Pro.</td>
<td></td>
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<tr>
<td>24 Revise report(s) per USAID comments</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>25 Finalize and submit report to USAID</td>
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<tr>
<td>26 USAID approves report</td>
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<tr>
<td>27 Final copy editing and formatting</td>
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<td>28 508 Compliance editing</td>
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<td>29 Eval Report(s) to the DEC</td>
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<tr>
<td><strong>Total LOE per person</strong></td>
<td>55</td>
<td>54</td>
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<td>43</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total LOE</strong></td>
<td>55</td>
<td>54</td>
<td>43</td>
<td>43</td>
<td>24</td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted  ☐ Yes  ☑ No
**Travel anticipated**: List international and local travel anticipated by what team members.

- **US**: Washington, DC area for Arlington meetings & data collection; Durham, NC for data collection
- **Overseas**: Travel to Benin and Uganda as preferred locations of travel as per the reasoning stated above. Second option countries for travel include Malawi and Senegal.

### XVII. LOGISTICS

#### Visa Requirements

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

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

#### Clearances & Other Requirements

**Note**: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it.

GH Pro does **not** provide Security Clearances, but can request **Facility Access**. Please note that Facility Access (FA) requests processed by USAID/GH (Washington, DC) can take 4-6 months to be granted. If you are in a Mission and the RSO can grant a temporary FA, this can expedite the process. If FA is granted through Washington, DC, the consultant must pick up his/her FA badge in person in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required, 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 must 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 (must register approximately 3-4 months in advance). Additionally, there will be the cost for one week’s lodging and M&E 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): Once countries for site visits are finalized, the need for ECC will be verified.
- ☐ High Threat Security Overseas Seminar (HTSOS) (required in most countries with ECC)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working in-country more than 45 consecutive days)
☐ GH Pro workspace
Specify who will require workspace at GH Pro: As needed, GH Pro can provide work and meeting space in DC
☐ Travel -other than posting (specify): GH Pro will arrange travel for GH Pro consultants (non-USAID staff)
☐ Other (specify): 

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
● Meeting Arrangements. Assist the team with the logistics of arranging and coordinating meetings with stakeholders, including transportation to said meetings
● Provide methods of in-country travel (i.e., car rental companies and other means of transportation)
● 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.

**USAID Roles and Responsibilities**

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

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

a. The report must not exceed **30 pages** (excluding executive summary, table of contents, acronym list and annexes).

b. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).

c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.

d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

**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:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- Project Background: describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
  1. Annex I: Evaluation/Analytic Statement of Work
  2. Annex II: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
  3. Annex III: Data Collection Instruments
  4. Annex IV: Sources of Information
     - List of Persons Interviews
     - Bibliography of Documents Reviewed
     - Databases
     - [etc.]
  5. Annex V: Statement of Differences (if applicable)
  6. Annex VI: Disclosure of Any Conflicts of Interest
  7. 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>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Melissa Freeman</td>
<td>Alanna White</td>
</tr>
<tr>
<td>Title: Reproductive Health Advisor (AOR for APC)</td>
<td>APC Management Team (Program Analyst)</td>
</tr>
<tr>
<td>USAID Office: Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI)</td>
<td>Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI)</td>
</tr>
<tr>
<td>Email: <a href="mailto:mefreeman@usaid.gov">mefreeman@usaid.gov</a></td>
<td><a href="mailto:awhite@usaid.gov">awhite@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone: 571-551-7009</td>
<td>571-551-7068</td>
</tr>
<tr>
<td>Cell Phone: 571-214-3952</td>
<td></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 Program management team staff)

<table>
<thead>
<tr>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
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</thead>
<tbody>
<tr>
<td>Name: Amani Selim</td>
<td></td>
</tr>
<tr>
<td>Title: Evaluation Technical Advisor</td>
<td></td>
</tr>
<tr>
<td>USAID Office: Office of Population &amp; Reproductive Health</td>
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</tr>
<tr>
<td>Email: <a href="mailto:aselim@usaid.gov">aselim@usaid.gov</a></td>
<td></td>
</tr>
<tr>
<td>Telephone: 571-551-7528</td>
<td></td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
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</table>

XXII. OTHER REFERENCE MATERIALS

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

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Details</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award and Project Management Documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperative Agreement</td>
<td>1. Cooperative Agreement 2. CA signature page 3. CA Attachments 4. PIEE 5. Geo code waiver memo</td>
<td></td>
</tr>
<tr>
<td>Management Reviews</td>
<td>Year 1-5 Management Review documents and Annual Progress Presentations</td>
<td></td>
</tr>
<tr>
<td>PMP</td>
<td>1. Year 3 PMP 2. Revised Year 4 PMP due to work plan revision 3. Year 4 Interim PMR</td>
<td></td>
</tr>
<tr>
<td>Quarterly and Annual Reports</td>
<td>1. First Quarter Report Oct-Dec 2012 2. Second Quarter Report Jan-Mar 2013</td>
<td>Two Quarterly Reports were submitted during the first year of the project. After that, Management Review and Results Review reports replaced quarterly and annual reports.</td>
</tr>
<tr>
<td>Document Type</td>
<td>Details</td>
<td>Notes</td>
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<td>Work plans</td>
<td>1. Combined year 1 &amp; 2 Work plan</td>
<td>Years 1 and 2 were combined into a revised, final work plan.</td>
</tr>
<tr>
<td></td>
<td>2. Year 3-5 Work plan</td>
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<td>Results Reviews</td>
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<td>Financial Reviews and</td>
<td>1. Baseline Survey Reports</td>
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<tr>
<td>Reports</td>
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<td>Project Tools and Workplan Products</td>
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<td>Technical Briefs</td>
<td>Delivery of Injectable Contraception by Drug Shop Operators in Uganda: Research and Recommendations</td>
<td>An updated Nepal brief will be available shortly.</td>
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<tr>
<td></td>
<td>Situation Analysis of Community-Based Referrals for Family Planning</td>
<td></td>
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<tr>
<td></td>
<td>Nepal’s Community-based Health System Model: Structure, Strategies, and Learning</td>
<td></td>
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<td></td>
<td>Faith Matters: A Christian Approach to Engaging Youth in Family Planning</td>
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<td></td>
<td>Guidance for Integrating the Provision of Injectable Contraceptives by Community Health Workers into Family Planning/Sexual and Reproductive Health Policy</td>
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<td></td>
<td>Provision of Injectable Contraceptives within Drug Shops: A Promising Approach for Increasing Access and Method Choice</td>
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<tr>
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<td>Benin’s Community-Based Access to Injectable Contraceptives Pilot Project</td>
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<tr>
<td>Papers and Research</td>
<td>Sayana Press Research protocol and the most recent status information available</td>
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<td>Grantee Guidance Package</td>
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<tr>
<td></td>
<td>a. Subawardee Guidance for Start-Up and Workplanning</td>
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<td></td>
<td>c. Subawardee Guidance for the Performance Monitoring Plan</td>
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<td></td>
<td>d. Family Planning Compliance Monitoring Plan for Subaward Recipients</td>
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<td></td>
<td>e. Subawardee Guidance for USAID Gender Compliance</td>
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<td>f. USAID Environmental Compliance</td>
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<td>---------------</td>
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</tr>
<tr>
<td>Online Resources</td>
<td>Guidance for Subaward Recipients</td>
<td>Documents from the Catalog, YSRH Dashboard and Peace Corps Training Package are not included in the Dropbox folder, since they are intended to be used as an interactive online resource.</td>
</tr>
</tbody>
</table>

Community Health Systems Catalog
Dashboard on Youth Sexual & Reproductive Health
Peace Corps Maternal and Newborn Health Training Package (Sessions 1-13)

Community Health Worker Provision of Injectable Contraceptives Toolkit
  a. Introduction to the Package  
b. Provision of Injectable Contraceptives by Community Health Workers  
c. Initiation and Continuation of Injectable Contraceptives by Community Health Workers  
d. Community-Based Access to Injectable Contraception: Radical Common Sense  
e. WHO Optimize MNH Guidance: Recommendations on CHW Provision of Injectable Contraceptives (2012)  
f. Conclusions from the WHO Technical Consultation on Expanding Access to Injectable Contraception (2009)  
g. Guide to Resources in the Online CBA2I Toolkit  
h. Key Actions for CBA2I Advocacy
ANNEX A (to SOW)
APC LOGIC MODEL

Logic model for Advancing Partners & Communities

Goal: To advance and support community programs that seek to improve the overall health of communities, especially in relationship to family planning

Inputs
- JSI & FHI 360 staff expertise, skills, and experience
- Sub-awardees and partners (PVOs, NGOs, MOH, other CAs, etc.) expertise, skills, and experience
- Existing community-based health best practices, tools, & materials
- Existing capacity building best practices, tools, & materials
- International and regional partners
- Financial resources

Activities
- G/T, advocacy, technical assistance, collaboration, and support for CBFP, including the design and documentation of country-level CBFP programs
- Solicitation, management, and monitoring of sub-awards for innovative PVO/NGO community-based health programs
- Capacity building and development of resources to support PVOs/NGOs in the implementation and management of community-based health programs

Outputs
- Technical assistance provided to countries, partners, or programs on CBFP, CBAD, and other innovations
- Materials and resources developed to strengthen and support CBFP
- Innovative CBFP approaches assessed, documented, and shared
- Sub-awards issued and successfully managed
- Capacity building provided to sub-awardees and other partners

Outcomes
- CBFP & related innovations introduced, advanced, and scaled up
- Sub-awards lead to improved measures of performance in community-based health programs
- Organizational capacity to implement and manage quality community health programs improved

Impact
- Increased quality of access to, and demand for family planning services within communities
- Decreased unmet need for family planning
- Other health impact measures, particularly those related to community-based health programs improved
- Strong PVOs/NGOs implementing quality, innovative community-based health programs with sound management and limited external support

Feedback
APC role diminishes as one moves to long-term impact
Community Health & Service Delivery

- **Child Blindness Prevention & Treatment**: Bangladesh, Cambodia, Burma, Nepal, Philippines, Thailand, Vietnam
- **Ebola Prevention & Recovery**: Cote d'Ivoire, Guinea, Liberia, Sierra Leone
- **Families, Orphans & Vulnerable Children**: Burundi, Cambodia, Moldova, Uganda
- **Family Planning**: Benin, Central Asia Regional, Ghana, Liberia, Senegal, Tanzania, Uganda, Zambia
- **Family Planning Integration**: Ethiopia, Kenya, Nepal, Tanzania, Uganda
- **Gender**: South Africa
- **Health Systems**: Sierra Leone, Sub-Saharan Africa Regional, Tanzania
- **HIV**: Botswana, Dominican Republic, Ghana, Guinea, Guyana, Haiti, Tanzania
- **HMIS**: Ethiopia
- **MCH**: Ethiopia, Sierra Leone
- **Mental Health**: Ukraine
- **Programs for Persons with Disabilities & Service Providers**: Colombia, Democratic Republic of the Congo, El Salvador, India, Kenya, Laos, Nicaragua, Romania, Ukraine
- **WASH**: Africa Regional
- **Policy, Advocacy, Information & Tools**:  
  - **Community Health**: Burkina Faso
  - **Female Genital Cutting/Mutilation**: Kenya
- **HIV**: Botswana, Cameroon, Dominican Republic, Ghana, Guyana, India, Papua New Guinea, Suriname, Trinidad & Tobago, Uganda, Zimbabwe
- **Social Behavior Change & Communication**: India
- **Youth**: Asia & Middle East Regional
- **Research, Surveys, Evaluation & Data**:  
  - **Community Health**: Nepal
  - **Evaluation**: Madagascar
  - **Family Planning**: Malawi
Main data sources to be used by the consultants may include, but not be limited to:

- Key informant interviews (KII) with USAID staff in Washington and in Missions;
- In-country leadership and stakeholders;
- APC project staff in headquarters and in the field;
- International partners (Peace Corp, WHO, etc.);
- Field visits;
- Project documents listed in “Section XX: Other Reference Materials”
- Annual Core funding levels
- APC self-assessment
- Funding disbursements, as needed
- Grant Matrix
- Percentage of sub-grants to total amount of money amount set aside to support the sub-awards and management of the sub-awards (do not include technical support and oversight or and capacity building), available from the Finance and Grants team

The following Key Informant Interview (KII) list is preliminary and the evaluation team should add stakeholders, partners and staff to this list as necessary.

Key informants can include, but not be limited to:

- APC project staff from both JSI and FHI 360: a) Project Director; b) Technical leads; c) Finance & Grants team
- APC staff at local field offices including: Dominican Republic, Ethiopia, Guyana, Haiti, Uganda and Zambia
- USAID/APC project management staff: AOR; Technical Advisor; Program Analyst
- USAID/Washington partner staff in: Office of HIV/AIDs; Office of Maternal, Child and Newborn Health; Office of Population and Reproductive Health Commodities, Security and Logistics Division; Research, Technology and Utilization Division; Policy, Evaluation and Communications Division; and the Service Delivery Improvement Division (names provided upon request)
- USAID Missions, in countries in which APC works or collects data (full list in Annex B: Country Activities)
- APC in-country sub-awardees/partners, including public sector and NGO/FBO entities (contact list to be provided by APC Grants Management team)
- Beneficiary partners (church parishioners, clients served by community health workers, etc.)
- Experts with a variety of perspectives on CBFP programs, including:
  - Children’s Investment Fund Foundation (CIFF);
  - PATH
ANNEX II. DATA COLLECTION TOOLS

Advancing Partners and Community Grantees
On-Line Survey using SurveyMonkey

Grant Number and Location of Grant Implementation: APC-GM-0038 Zambia

Brief introduction and explanation: This is a voluntary, confidential and anonymous survey. It is intended for all grantees in the Advancing Partners and Community (APC) Grant process.

You were listed as the contact person, responsible for the overall application for this grant. We are contacting you based on your prior APC grant application, which is either completed or still ongoing.

We hope that you will participate, as we are very interested in your experience with the APC grant process.

Please fill in the form on SurveyMonkey by five days from the date of receipt of this request. Your answers will be kept private and will only be summarized in anonymous format to protect the confidentiality of all the respondents.

Informed Consent: Provide informed consent before asking any questions. No signature is required.

Hello. Our names are Sam Clark and M.E. Khan. We are from the Global Health Program Improvement Project (GH Pro). We are conducting an evaluation of the Advancing Partners and Community (APC) Project and we would like you to participate.

• We would like to ask you some questions about your APC grant.
• Our evaluation is intended to assess the extent to which APC has achieved its objectives.

Summary of ground rules for the SurveyMonkey questionnaire

• This questionnaire is confidential and voluntary.
• Your name will not be linked to any of the findings.
• You can end the interview at any time and have no obligation to answer any questions asked.

We hope that you will participate nonetheless, as your answers are extremely important.

I, _____________________, agree to participate with the understandings listed above.

First Name Last Name

General background
1. Your country________
2. Name of your organization_____________
3. Name of Person Responsible for Advancing Partners and Community Grant _______________
   and Grant Number (as available from APC listing): _______________
4. Broad Grant category (Check one from the following menu):
   1. HIV/AIDS
   2. FP/RH
3. Post-Ebola
4. MCH
5. Other: Please specify ____________

5. In which of the following technical areas do you provide services under your APC grant project(s)? If you do provide services, give the name of one or more grant categories listed below (Check as many as apply from the following menu).

1. Family Planning (excluding population health and environment work)
2. Wheelchairs, Prosthetics & Orthotics
3. Child Blindness
4. Gender
5. Health Systems Strengthening
6. HIV/AIDS
7. Maternal and Child Health (excluding orphans and vulnerable children work)
8. Mental Health (excluding orphans and vulnerable children work)
9. Orphans & Vulnerable Children
10. Population, Health, and Environment
11. Post-Ebola Response & Recovery
12. Supply Chain Management
13. Water, Sanitation, & Hygiene (WASH)
14. Other: Please specify_________________________

6. Status of your APC grant: Check one but if you have received more than one APC grant you could fill both (answer as applicable):

1. Completed___ 2. In progress____

7. Approximate size of your APC grant: Check one:

1. $100 k or less
2. $101 k - 250 k
3. $251 k - 500 k
4. $501 k - 1 million k
5. More than $1 million

8. Nature of grant: (Project implementation refers to performance of program activities, while technical assistance/capacity building refers to the strengthening of an agency/institution, not to an actual program activity.) Check one:

1. Project Implementation.
2. Technical Assistance/Capacity Building only
3. Both 1 & 2
9. Please briefly describe your role in the implementation of the APC/JSI/FHI grant or grants:
Open-ended comment for this question.

__________________________________________________________

Financial management of grant implementation

10. Which implementing agency gave you the grant?

1. JSI  
2. FHI360  
3. Other (Please specify) __________________________

11.a With regard to the timely release of funds from APC/JSI/FHI, was it:

1. Mostly on time  
2. Sometimes Delayed  
3. Mostly delayed.

11.b Generally the delays were of what duration? Give an example of the longest delay in months

________Months

11.c. If you indicated 2 or 3 above, what type of difficulties did you face in implementing the project due to delay in release of payment? Open-ended comment for this question.

__________________________________________________________

12 a. Did you receive any assistance or orientation from APC/JSI/FHI360 on how to follow the procedures for financial management or financial reporting? 1. Yes  2. No

12 b. If yes, was the assistance/orientation sufficient, somewhat or insufficient

1. Sufficient  
2. Somewhat sufficient  
3. Insufficient?

Training, orientation and technical assistance in basic organizational management

13. During the APC supported project implementation, did you or staff of your organization receive any training, orientation or technical assistance from APC / JSI/ FHI?

1. Yes  2. No

14. What types of training/ orientation or technical assistance did you or your colleagues receive from APC or its implementing agencies JSI/ FHI360? (Use drop menu and check as many as apply)

Instruction: Circle as many as applicable for you/ your organization

01. Branding Plan.
02. FP compliance monitory tool.
03. FP compliance follow up report.
04. Governance and/or oversight strengthening.
05. Grant making.
06. M&E.
07. PSM.
08. Financial management.
09. Dash board.
10. Other, please specify: ____________________________
15. On average, the training and support your organization received in project management provided sufficient knowledge and skills for your staff to make improvements in overseeing grant management? (Check one)


Technical and substantive training

16. Did APC or its implementing agencies JSI/ FHI360 build your organizational capacity in technical skills and technical matters like establishing CBFP, quality of service, monitoring of program etc. If yes, what topics.

Instruction: Use drop menu and check as many as applicable for you/ your organization

01. Establishing Community Based Family Planning (CBFP)
02. Integration of FP with other services
03. Integration of services
04. Quality of services
05. Monitoring quality of services
06. Monitoring and evaluation
07. Contraceptive technology update
08. Sayana Press
09. CBA2I
10. Community Health Systems
11. Contraceptive security and cold chain
12. HIV/AIDS indicators for performance measure
77. Other, please specify

17. In general, do you think that the number of days or sessions for technical/ substantive training on specific topics by APC resource persons was just required, shorter than required or longer than required

(Circle one)

1. Just as required 2. Shorter than required 3. Longer than required 4. Other view specify

Please comment:

18.a Would you say the amount of ongoing technical support provided by APC resource persons during the implementation of the project was: (Check one)

1. Just as required 2. Shorter than required 3. Longer than required 4. Other view specify

18.b Open-ended comment under this question.

______________________________________________________________________________

______________________________________________________________________________
19. On average, the technical training and support your agency received provided sufficient technical knowledge and skills for your staff to make **improvements in the program implementation and/or outcome of the project** (Check one)


Generally, to measure improved performance, what do you monitor for the project funded by ACP/JSI/FHI360?

20. Please rate each of the following statements based on your experience of technical assistance during your most recent project activities supported by APC.

(a). 1 Topics of the technical assistance were responsive to the **needs of your** organization?


(b). 2 Open-ended comment under this question.

_____________________________________________________________________________

_____________________________________________________________________________

(c). The TA from APC and its implementing agencies like JSI/FHI360 was provided using **participatory training approaches**.


(d). The APC supported trainers and resource persons are **competent** (have good knowledge of the subject) to provide technical support?


(e). The technical support significantly increased the grantees knowledge and understanding of USAID and APC policies, procedures, and processes.


**Feedback on substantive / technical and management monitoring**

21.a Did APC or its partner provide feedback from their monitoring data/results to you or your organization?

   (i) Technical /substantive aspects of project   1. Yes   2. No

   (ii) Management and financial aspects of project   1. Yes   2. No

21.b Please give an example of how you used monitoring data / results provided were used

   (i) to improve substantive /technical aspects of the project

   (ii) to improve management aspects of the project

22.a Do you consider the results of the technical assistance and support provided by APC or its partners to be generally sustainable (i.e., strengthened your organization’s long-term institutional ability to deliver quality technical results, manage programs or reduce your dependency on outside donated technical support? Or strengthened your ability to know when/how to hire/collaborate with partners to correct your gaps?)

22.b Open ended comment under this question.
______________________________________________________________________________
______________________________________________________________________________

23.a What do you consider the two most important areas where TA from APC has made significant improvements in your organization’s functional/management or technical capabilities?

23.b Functional/management areas

1st Most important functional area.
Write example here:__________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

23.c Technical areas

1st Most important technical/substantive area.
Write example here:
______________________________________________________________________________
______________________________________________________________________________

24.a What do you consider APC’s and/or its implementing agencies JSI/FHI360 most important strength in providing technical/substantive assistance?

24.b Write example here: _______________________________________________________
______________________________________________________________________________
______________________________________________________________________________

25.a What do you consider the single greatest shortcoming/weakness in APC/implementing agencies technical support?

25.b Write example here:
______________________________________________________________________________
______________________________________________________________________________

26.a What alternative ways of providing APC technical support would you suggest for ensuring sustainability of outcomes (i.e., for achieving longer term institutional capacity building to get new funding from USAID and/or other donors)?

26.b Write example here:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
27.a Over the next two years, what are your highest priority technical support needs in the areas of CBFP and integration of FP with other health or non-health services. (You can indicate more than one area of technical/substantive support if there are multiple needs).

27.b Write example here:

_______________________________________________________________________

_______________________________________________________________________

28. How likely would you be to recommend the APC Project for getting technical assistance?


29.a As a result of APC technical assistance and capacity building, are you able to get new funding either from USAID or other donors? Check one: 1. Yes  2. No

29.b If yes, how many grants/funding have you obtained since the APC technical assistance?

Enter number of grants obtained here: _______
Advancing Partners and Community Survey of participating USAID Missions
On-Line Survey using SurveyMonkey

Brief introduction and explanation: This is a voluntary, confidential and anonymous survey. It is intended for all USAID Missions cooperating in the Advancing Partners and Community (APC) Grant process.

You were listed as a USAID Mission contact person, partly responsible for this grant. We are contacting you based on your experience with an APC grant application, which is either completed or still ongoing.

We hope that you will participate as we are very interested in your experience with the APC grant process.

Please fill in the form on SurveyMonkey by five days from the date of receipt of this request. Your answers will be kept private and will only be summarized in anonymous format to protect the confidentiality of all the respondents.

Informed Consent: Provide informed consent before asking any questions. No signature is required.

Hello. Our names are Sam Clark and M.E. Khan. We are from the Global Health Program Improvement Project (GH Pro). We are conducting an evaluation of the Advancing Partners and Community (APC) Project and we would like you to participate.

• We would like to ask you some questions about your mission participation in the APC grant process.
• Our evaluation is intended to assess the extent to which APC has achieved its objectives.

Summary of ground rules for the SurveyMonkey questionnaire
• This questionnaire is confidential and voluntary.
• Your name will not be linked to any of the findings.
• You can end the interview at any time and have no obligation to answer any questions asked.

We hope that you will participate nonetheless, as your answers are extremely important.

I, ____________ ___________ agree to participate with the understandings listed above.

First Name Last Name

1. Please indicate your Mission Country: _________
2. How long you have been working in this Mission? (Circle the answer below)
   1 or less years 2 3 4 5 >5 years
3. How familiar are you with the Advancing Partners and Communities (APC) project and its technical support for your mission? APC is a global initiative funded by USAID to promote community-based FP and providing technical assistance to strengthen capability of NGOs and their sustainability?
4. What type of involvement have you had with the APC? Describe type of involvement in the space provided here:
5. a) Has your Mission given any buy-in to APC or its implementing partners JSI / FHI360?  
   1. Yes.    2. No    3. Not sure

5. b) If yes, since how many years has your Mission been using them? Number of years:

5. c) What is the total approximate value of the buy-in US Dollars? $: ______________

5. d) What activities are APC or its partners currently implementing or have implemented during the last five years in this country using field support? Describe the type of activities here:
_______________________________________________________________________
_______________________________________________________________________

5. e) What were the activities where APC has helped the mission in this country using buy-in support?  
Add drop box here:
   1. FP and Reproductive Health
   2. HIV/AIDS
   3. Ebola or post Ebola
   4. Technical assistance to NGO/Private sector
   5. Technical assistance to Public Sector
   6. Other: Please specify:

6. We are reviewing the overall performance of the APC Project. In your view, how was the overall performance of APC in your mission country?  
Excellent    2. Good      3. Average      4. Poor      5. Very poor

Please explain:
_______________________________________________________________________
_______________________________________________________________________

7. How helpful have APC grant staff been in fulfilling your Mission’s procurement needs? In other words, has APC helped your Mission to get the funding to the right partners as sub-grantees?  

Please explain:
_______________________________________________________________________
_______________________________________________________________________

8. In general, have APC or its implementing partners JSI / FHI360 responded to your Mission’s inquiries in a timely manner?  

Please explain:

_______________________________________________________________________
_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________
9. Has APC enabled your program to engage local organizations and other groups that you otherwise would not have been able to engage?


Please explain:

10. How would you grade APC project’s contribution to achieving your Mission’s in-country health goals?


Please explain:

11. Based on your experience with APC technical support since October 2012, how would you describe the quality of the technical assistance provided by APC or its implementing partners JSI / FHI360?

   Excellent   2. Good   3. Average   4. Poor   5. Very poor   8.DK

Please explain:

12. Based on your experience with APC technical support since October 2012, how would you grade APC performance in your country with respect to the following broad functional areas?

   a) Understanding of your country’s health needs

   Excellent   2. Good   3. Average   4. Poor   5. Very poor   8.DK

   b) Collaboration with MOH and response to their request for support?


   c) Contributing to policy change that supports or encourages provision of FP services through Community-Based Family Planning?

d) **Providing leadership** to MOH/NGOs/other partners for developing Community Based Family Planning projects?

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Very poor</th>
<th>DK</th>
</tr>
</thead>
</table>

e) Providing leadership to MOH/NGO/other partners for **integrating FP with other health services**?

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Very poor</th>
<th>DK</th>
</tr>
</thead>
</table>

f) Helping NGOs to develop and implement **community-based FP**?

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Very poor</th>
<th>DK</th>
</tr>
</thead>
</table>

g) Building capacity of local NGO and partners (for example, in areas such as *project planning, implementation, monitoring, and scaling up* their programs)?

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Very poor</th>
<th>DK</th>
</tr>
</thead>
</table>

h) Building capacity of the local NGO and partners to provide **improved quality of services**.

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Very poor</th>
<th>DK</th>
</tr>
</thead>
</table>

13. Apart from deliverables and immediate outputs achieved by the end of the APC assignment(s) in your country, did the APC or its or its implementing partners JSI/FHI360 provision of technical assistance achieve any **longer-term** outcomes such as:

**Item A. Policy change**?

<table>
<thead>
<tr>
<th></th>
<th>Definitely Yes</th>
<th>Yes</th>
<th>Not sure/depends</th>
<th>No</th>
<th>Definitely No</th>
</tr>
</thead>
</table>

Please explain:

_______________________________________________________________________
_______________________________________________________________________

**Item B. Establishing networks** of NGOs and institutions to support CBFP?

<table>
<thead>
<tr>
<th></th>
<th>Definitely Yes</th>
<th>Yes</th>
<th>Not sure / depends</th>
<th>No</th>
<th>Definitely No</th>
</tr>
</thead>
</table>

Please explain:

_______________________________________________________________________
_______________________________________________________________________

**Item C. Capacity building** of NGOs in project management and improved grant implementation and performance?

<table>
<thead>
<tr>
<th></th>
<th>Definitely Yes</th>
<th>Yes</th>
<th>Not sure / depends</th>
<th>No</th>
<th>Definitely No</th>
</tr>
</thead>
</table>

Please explain:

_______________________________________________________________________
_______________________________________________________________________

_______________________________________________________________________
Item D. Were there any other longer-term outcomes? Yes or No?
Please explain:
_______________________________________________________________________
_______________________________________________________________________

14. Do you feel that the results of APC advocacy and technical assistance will be sustainable? In other words, will APC’s capacity building for NGOs and other institutions enable them to manage and implement their projects with no or very limited technical assistance?

1. Yes  2. Not sure  3. No

15. How likely would you be to recommend the APC Project to another office within your mission or to another mission colleague?


Please explain:
_______________________________________________________________________
_______________________________________________________________________
GH PRO 445 APC
PERFORMANCE EVALUATION

DATA COLLECTION TOOLS AND INSTRUMENTS

Key Informant Interview (KII) Guide

This KII questionnaire is intended for a wide range of respondents:
(Implementing partners, Donors, NGOs, Community Service Agencies)

NB: Cover page provides additional confidentiality for respondents.
Instructions prior to beginning interview: (5 MINUTES)

- **Eligibility:** Determine respondent’s position, how long employed in position, what type of institution, and which APC Result (R1, R2, R3) respondent has been primarily involved in.
- If respondent has no knowledge of APC they can still be interviewed as long as they are employed in RH/FP related activities. But, if respondent has no knowledge of APC and is not involved in any pertinent activity, do not proceed.
  1. Unique ID number: ____, ___, __
  2. Name of interviewer ________________________
  3. Name of note taker ________________________
  4. Name of translator ________________________
  5. Date: ___Day___Mo___Year
  6. Respondent name:
  7. Respondent Sex:
  8. Position:
  9. Organization:
  10. Number of years has worked in this position: _________ Years (or months)
  11. Region: _________
  12. District: _____________________
  13. Facility Name: _______________
  14. Type of facility: _______________ (Public/ Private/ FBO etc.)
  15. Knowledge of APC: **NB: Be sure they know that JSI or FHI360 is a funder of APC.**
     a) Are you aware of the APC project, which is implemented by JSI and FHI360?
        Yes or No. (circle one)
     b) Can you tell me how you have been involved in the APC Project?

**INSTRUCTION:** Confirm whether the respondent knows what the APC Project is, that is involves funding by JSI or FHI360, and what it has done in at least one of the three Result areas shown below. Validate this by asking them to briefly describe the APC Results they are most familiar with and any examples of specific activities APC is supporting in this area.

1. We would like to talk with you about the work APC has been doing since 2012. The APC has been working on three areas (Refer to the list of Result 1, Result 2, Result 3 below). We would like you to participate in conversation on the work APC has been doing in these areas. APC has been supporting:

2. **Global leadership and advocacy for CBFP?** *Familiar with Result 1? Yes or No. Y/N*

3. **Sub-grant program to expand/strengthen PVO/NGO CBFP programs?** *Familiar with Result 2? Y/N*
4. Capacity building/resources to support PVOs/NGO CBFP programs? Familiar with Result 3? Y/N

5. Not familiar with any the three Results.

6. Familiar with all three Results

NB: Have a list of all agencies funded by APC in the two countries. Keep in mind that they may not be aware of the three results 1, 2 or 3.

NB: Be sure that this instrument is not read verbatim. Do your best to use a conversational approach.
Informed Consent: Provide informed consent before asking any questions.

Oral Informed Consent Statement – no signature is required

- Hello. Our names are________________names of interviewers________________. We are from GH Pro and we are conducting an evaluation of the APC Project and we would like you to participate.
- We would like to ask you some questions about the APC since it started in 2012.
- Our evaluation is intended to assess the extent to which APC has achieved its objectives.
- A secondary purpose of this evaluation is to identify community-based family planning activities that may warrant future investment and to better understand the roles of the partners.
- Participation in this evaluation is voluntary and you may decide not to answer any of the questions. However, we hope that you will participate in this evaluation since your answers are very useful to us.
- Do you have any questions for us about the evaluation?

Summary of Ground Rules for the interview:

1. This interview is confidential and voluntary.
2. Your name will not be linked to any of the findings.
3. If you are willing to be quoted, this is appreciated. But no interview quotes will be associated with your name unless cleared in advance by you.
4. You can end the interview at any time and have no obligation to answer any questions asked.

May we begin the interview on this basis? Can we proceed? Yes or No. (circle one)

NB: No signature required: Verbal consent is sufficient.
Result 1: Global leadership and advocacy for CBFP (15 MINUTES)

**Result 1:** Has APC provided global / country leadership and advocacy for CBFP? Yes, or No.
If YES, how?
Identify key successes and missed opportunities?
What were key lessons learned?

**Operational Definition of selected words:**

**Technical leadership** refers to leadership for a specific innovation related to a novel form of technology. For example, Sayana Press or an approach like innovation of forming CBH system and or delivery of services, involving religious group in delivery of FP

**Advocacy** refers to the generation of support for a particular type of effort. A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.

**Technical assistance** is any form of support that could be provided to country, program or system etc. to learn and implement innovation in technology or technique, or approaches like CBFP

**Scale-up:** To introduce a system/technology, method or approach for delivery services covering larger areas or in a number of institutions.

**Item 1.1** One of the important objectives of APC project implemented by JSI/ FHI was to provide global/country level leadership to popularize the CBFP strategy. Could you broadly tell me what were the key components of the strategy that APC/JSI/FHI followed to achieve this objective of providing Global/Country level leadership for CBFP?

**Item 1.2**

a. Please provide concrete examples of APC/JSI/FHI global/country level technical leadership provided for including/ expanding CBFP, CBA2I, Community Health Systems (CHS) and other innovations?

b. What were successes (provide concrete examples)?

**Further probe:** What was the data collection method (MEL — Monitoring, evaluation, and learning) that are used to determine whether an innovation is “effective”?

c. Do you think there were challenges and difficulties in implementing the program?

If YES, what? (Ask for elaborate their answers with specific examples)?

d. In your view, what are the key lessons learned in providing global or country levels CBFP or CB Health services?

**Item 1.3**

a. Please provide specific examples of APC/JSI/ FHI global/country advocacy provided for use of CBFP or changing of global/country environment in favour of CBFP and or CB Health Service?

b. What are some examples of successes?

c. What were the challenges or difficulties faced in perusing advocacy at Global or country level to achieve the project objectives?

d. How were they addressed?

e. In your view, what are key lessons learned from organizing such advocacy for CBFP and related innovation?

**Item 1.4**

a. Did ACP JSI/ FHI 360 develop materials and/or resources materials to strengthen and support CBFP implementation? Yes or No.
b. If YES, please give examples. What materials have been developed in relation to CBFP?

c. **Probe:** If they provide examples, ask who is using it.

d. **Probe:** Is this being used in your country, by government program or NGOs implementing CBFP or CB Health services?

e. **Probe:** If the informant is an NGO / PVO: Are you using this material for your program? If so, what are they used for and how are they used?

**Item 1.5** Did ACP assist/support PVOs/NGOs to use and adapt resources developed to implement their CBFP program efficiently?

**Item 1.6a.** Did APC/ JSI/FHI360 introduce, advance and **scale up** CBFP and related innovations?  
Yes No  
b. If YES, please describe what has been scaled up and where? Has it been introduced and scaled up in your country?  
c. How APC/JSI/FHI360 has scaled up CBFP or related innovations globally/ in country?

**Item 1.7** How do you measure global leadership or leadership within a country for success in achieving its goal. Take for example leadership in expanding CBFP and or CB Health services. What **key parameters** have you been tracking?

**Item 1.8** How it is decided that a technology like Sayana Press or an approach like CBFP or use of religious leadership **worth expanding or scaling up**?  
What parameters or indicators are considered before deciding to **scale up a technology or approach**?  

**Further Probe:** Are there additional data collection processes implemented (such as costs; relative gain; feasibility; etc.) to determine this?  

**Further Probe:** What parameters or indicators are considered before deciding to **scale up a technology or approach**?  
Could you give examples?

**Item 1.10a.** In your view did the APC Project achieve its stated objectives for providing global / country leadership and advocacy for CBFP? Yes No  
b. Elaborate your answer.
Result 2: Sub-grant program to expand/strengthen PVO/NGO CBFP programs (15 MINUTES)

Result 2: Has APC’s sub-grant program expanded and strengthened innovative PVO/NGO CBFP community programs?
b. Identify and get details

Operational Definition of selected words:

Program management: Refers to management of specific aspects of projects that need to be implemented irrespective of program activities, such as governance and/or oversight strengthening, grant making Monitoring and evaluation (M&E) of the program activities, Procurement Supply Management, Financial management.

Program implementation: Refers to the details of project activities, irrespective of ongoing program management, such as contraceptive technical updates, improving quality of care, organizing CBFP, and instituting Sayana Press.

Organizational development: Organization development is dedicated to expanding the knowledge and effectiveness of people to accomplish more successful organizational change and performance. For example, better administration, better monitoring systems, better financial systems.

Technical capability on certain subjects: Indicators for technical capability on certain substantive subjects, which would include specific activities, items such as contraceptive technical updates, improving quality of care, organizing CBFP, and instituting Sayana Press.

Technical capacity: Indicators for technical capacity would include inputs that would improve success of a CBD program, such as appropriate training of CHWs, supply chain, timely compensation / payments and monitoring and feedback.

Organizational capacity: Indicators of organizational capacity could be tracking of timely implementation of activities, improved finance management, tracking expenditure, tracking timely reporting etc.

Item 2.1a. Has the APC sub-grant program implemented innovative PVO/NGO CBFP community programs?

Yes        No

2.1b. If YES. Why do you consider that CBFP community program as innovative?

2.1c. Probe: Did the program use a new method or a new delivery approach or something else?

Elaborate your answer

Item 2.2a. Have the APC/ JSI/FHI360 sub-grant/sub-awards programs improved the performance of CBFP and or community-based health program/ system?   Yes       No

2.2b. If, YES ask. Could you provide specific examples of improved program performance by an APC sub-grantee?

2.2c. What indicators were used to measure improved performance of the program?

Item 2.3a Has the APC sub-grant program contributed to the implementation of PRH priorities? In particular,

(a) Choice of contraceptive method, it means that clients have choice of different contraceptive methods and she/he could take an informed choice at the time of accepting a FP method

PERFORMANCE (ENDLINE) EVALUATION OF THE APC PROJECT / 78
(b) **Youth** (men and women in the age of 14-24 / 14-29 are considered youth. Programs need different strategy to reach them and meet their FP and RH information and service needs)

(c) **Social behaviour change (SBC)**: It refers to communication strategy to reach the targeted audience with messages, delivered in a culturally sensitive manner to bring about desired behaviour change. It uses diverse communication approaches including interpersonal communication.

(d) **FP workforce** include all level of FP providers including front line workers and CHW providing FP and primary health services.

(d) **Gender** refers to the state of being male or female but typically used with reference to social cultural and psychological differences between the rather than biological one. It is accrued traits in a given cultural context rather than biologically determined.

2.3b. If YES, name the specific area(s) and give examples what contribution the sub–award made in these priority areas

(INSTRUCTION: ASK THIS QUESTION FOR EACH AREA THE INFORMANT MENTIONS)
Instruction: The following questions (2.4–2.12) in box are applicable only to Grantees. These questions will be also asked to few key persons at JSI and FHI in a different section.

<table>
<thead>
<tr>
<th>Item 2.4a. Were there difficulties with the timely release of funds from APC?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NO – mostly release of fund was timely</td>
</tr>
<tr>
<td>2. Sometimes release was delayed</td>
</tr>
<tr>
<td>3. Release of fund was mostly delayed</td>
</tr>
</tbody>
</table>

2.4b. If the answer is either 2 or 3, **PROBE**: what were the reasons of such delays?

Item 2.5. Did APC/JSI/FHI provide you or your concerned staff any assistance to explain and follow procedures for financial reporting? **Yes** **No**

Do you feel it was sufficient to improve financial reporting?

Item 2.6a. Did APC/ JSI/ FHI360 provide feedback from monitoring data and help you understand how to use the results to strengthen your program(s) activities? **Yes** **No**

2.6b If YES, can you give a specific example of how you used monitoring data to improve programming?

Item 2.7a. During the APC / JSI/ FHI 360 supported project implementation, did you or the staff of your organization receive any technical assistance (TA) from APC /JSI/FHI360 to strengthen program management and implementation? **Yes** **No**

2.7b. If YES, what types of TA did you or your colleagues receive from APC / JSI/ FHI 360 to strengthen your program management capacity (Check as many as apply)

01. Branding plan
02. FP compliance monitoring tools
03. FP compliance follow-up reports
04. Governance and/or oversight strengthening
05. Grant making
06. Monitoring and evaluation (M&E) of the program activities
07. Procurement Supply Management
08. Financial management
09. Dash board
10. Other, please specify:
2.8.a Did APC or its partners like JSI or FHI360 help in **organizational development** as part of sub-grant activity?
Yes           No

2.8. b If YES give examples.

2.9. Did APC and partners like JSI and FHI 360 help you to build **technical capability on certain subjects** such as: contraceptive technical update, improving quality of care, organizing CBFP, Sayana Press, etc.
Yes   No
If yes, give a specific example of such training attended either by you or some other person of your organization and monitoring its work.

3.0 In your view to what extent have APC and its partners like JSI / FHI 360 succeeded in strengthening and expanding PVO/NGOs through sub-grants and their capability to get grants from USAID and other donors?
Elaborate your answer with examples.

---

**Substantive training and technical (for grantees only)**

3.1. Did APC build your organizational capacity in technical skills and technical matters like establishing CBFP, quality of service, monitoring of program, etc. If yes, what topics (**use drop menu and check as many as applicable for you/your organization**)

01. Establishing CBFP/ Advantages of CBFP
02. Integration of services / Integration of FP with other services
03. Quality of services
04. Monitoring quality of services
05. Monitoring and evaluation
06. Contraceptive technology update
07. Sayana Press
08. CBA2I
09. Community Health Systems
10. Contraceptive security
11. Cold chain
12. Other specify

3.2. In general, do you think that the **number of days** or sessions for **technical/substantive training** on specific topics-by APC resource persons was: (Check one)

1. Just as required   2. Shorter than required   3. Longer than required

3.3. Would you say the amount of **ongoing technical support** provided by APC resource persons during the implementation of the project was: (Check one)

1. Just as required   2. Shorter than required   3. Longer than required

3.3. On average, the technical training and support your agency received provided sufficient technical knowledge and skills for your staff to make **improvements in the program implementation and or outcome of the project** (Check one)

**Result 3. Capacity building to support PVOs/NGO CBFP programs (15 MINUTES)**

**Reminder:** Result 3: PVO/NGOs prepared to receive USAID funds and implement effective community-based programs, especially family planning. Per the APC logic model and PMP, Result 3 refers to capacity building and development of resources to support PVOs/NGOs in the implementation and management of community-based health programs.

**Item 3.1a.** Has APC implemented by JSI / FHI360 helped capacity building strengthened PVOs/NGOs to implement effective community-based programs, especially family planning?

Yes No.

3.1b. If YES, give examples of these capacity building efforts by APC / JSI/ FHI360.

If No, why not? Elaborate your answer. Why do you feel so?

**Item 3.2.** What methods has APC/ JSI/FHI360 used to strengthen the technical and organizational capacity of sub-grantees for the implementation and management of community-based health programs?

3.2.a. Can you give examples of methods used by APC to strengthen technical capacity?

**INSTRUCTION:** If spontaneous answers are not given, consider giving one or two examples to stimulate an answer; for example, inputs that would improve success of a CBD program, such as appropriate training of CHWs, supply chain, timely compensation / payments and monitoring and feedback.

3.2.b. Can you give examples of methods used by APC to strengthen organizational capacity?

**INSTRUCTION:** If spontaneous answers are not given, consider giving one or two examples to stimulate an answer; for example, indicators of organizational capacity could be tracking of timely implementation of activities, improved finance management, tracking expenditure, tracking timely reporting, etc.

3.2.c. Can you give examples of methods used by APC to strengthen PVO/NGOs ability to receive funds from USAID or grants from other donors?

**Item 3.3.** Are there any technical support activities that APC could have been eliminated or reduced, while achieving the same level of program success? Yes or no. Please elaborate.
Section 4. PARTNER COOPERATION: APPLICABLE ONLY TO SENIOR STAFF JSI AND FHI360 [TEN MINUTES]

THIS SECTION IS APPLICABLE TO ONLY SELECTED SENIOR STAFF OF JSI AND FHI360

Item 4.1. What has been the role of the prime (JSI) and the partner (FHI360) in advancing the implementation of the APC project? **Paraphrase:** Please describe the current working relationship between JSI as prime and FHI360 as partner to implement the APC project.

**Item 4.2a.** Can you provide any examples of how JSI and FHI360 collaborate in the APC program?

**b. Probe:** How does this collaboration ensure the production of quality deliverables?

**c. Probe:** Have there been any challenges in the collaboration of JSI and FHI in the production of quality deliverables?

d. How it is resolved?

**Item 4.3.** Are there any issues or challenges that have emerged while implementing the shared responsibility assigned to JSI and FHI360 for the APC project?

**Probe:** For example, some of the areas of possible challenges might include: issues in financial arrangements, disbursements, staffing, challenges in interagency communications, transparency, priorities, setting agenda, developing work plans. Has any of these or more issues caused challenges in collaboration?

**Item 4.4.** Among all the challenges we discussed, what is the biggest challenge in the working relationship between JSI and FHI for APC?

Do you think that some of the challenges or tension is due to undefined responsibility or ambiguity in defining the responsibilities?

How could those issues be resolved or have been resolved?

**Item 4.5.** What would you do to improve the working relationship between JSI and FHI360 for APC?
Section 5. OPTIONAL FINAL QUESTIONS: RECOMMENDATIONS FOR FUTURE PROGRAMMING?

INSTRUCTION: Applicable only to selected senior staff of JSI, FHI, USAID MOH and few CAs donors who are aware of APC activities

Item 5.1. What do you recommend for the next two years of the extended period of APC to make the program more effective and more useful? Which aspects of APC do you feel have been most effective: R1, R2, R3? How would they be best continued? Which would be essential in order to meet FP2020 goals.

Item 5.2. What aspects of APC do you recommend be considered for future programming?

Item 5.3. What do you see as emerging themes, opportunities and activities in community-based family planning? Which aspects are best suited for USAID to continue, versus alternate donor support?

Item 5.4. How will you value the following themes or issues of APC for future USAID programming?

|------------------|-----------------------------|------------|---------------|------------|

Item 5.5. What do you see as the benefits of the sub-award program implemented by APC to USAID/Washington and Missions?

Item 5.6. What aspects of the sub-award program should be maintained, changed, or eliminated? This refers to the process of funding and procurement.

Item 5.7a. What aspects of CBFP are absolutely essential for meeting FP2020?

B. What could be essential to fund by USAID and what aspects or themes could be left for other donors?

Item 5.8. To what extent has the cross-sectoral nature of funding facilitated results that benefit various health elements?

Probe: For example, when an FP program funding mechanism is used to support post-Ebola activities or HIV/AIDS, are there any unanticipated benefits?

6. Evaluation questions for key grants management team members

Finance Director JSI

Grants and Operations Manager, JSI
Finance and Operations Manager JSI
Financial Analyst, Research Utilization, Program Sciences at FHI360

1. How would you describe the grant process that you have developed for APC?

2. What is the overall goal of the grant making process?

3. How does your grant process proceed? What are the main components for a given grant?

4. How does your grant file data get configured over time?

5. How does your grants program interact with JSI internal grants management database?

6. What are the biggest challenges for your grant making process?

7. What are the expected outcomes for your grant process?

8. How would you describe the grant process that you have developed for APC?

9. What is the overall goal of the grant making process?

10. How does your grant process proceed? What are the main components for a given grant?

11. How does your grant file data get configured over time?

12. How does your grants program interact with JSI internal grants management database?

13. What are the biggest challenges for your grant making process?

14. What are the expected outcomes for your grant process?
Points of discussion for informal interviews with CHWs

We are trying to understand how CHWs are contributing in improving community health. We want to learn who are contributing to empowering CHWs with correct knowledge about health and family planning so that they can disseminate it among community members.

This discussion is voluntary and confidential. There are no correct or wrong answers. None of the information provided by you will be cited or quoted in any way by name. May we begin on this basis? Yes or No.

1. Your name                      age                  sex                   education

2. For how long have you been serving as a CHW?

3. What promoted/motivated you to become a CHW?

4. Could you provide me in detail how you do the motivational and educational work as CHW?

NB: Probe and encourage getting more clear information in the process of his/her working in the community

5. Who trained you to work as a CHW? Which NGO, or staff of the agencies like PSI, JSI, FHI or government health staff? If more than one agency, name all of them.

6a. We will like to know details around each aspect of the training that you have received. Let me ask one by one a few questions on the training.

   How long was the training in number of days: __________days

6b. Was it a full time or part time training? Indicate the type of training schedule:

   Full time         2. Part time

6c. What topics were covered in the training. Probe for all topics taught

6d. Was any test was done before or after training about the knowledge gained on the topics that were covered in the training? 1. Yes                 2. No

6e. If NO, how was it assessed whether the training led to an increased level of knowledge and expertise to work as CHWs?
7. Do you feel the training was well organized, the trainers had knowledge and were helpful in imparting the required knowledge?

7b. Would you say that the duration of training was less than the required length, just as required or longer than required.
   1. Less than required length   2. Just as required   3. Longer than required.

7c. Do you need additional training on any subject that is required to meet community inquires and provide services?

7d. On what topics would you like to get more training?

8. How is your work monitored and how do you know that you are doing good work? What types of data is collected to measure your performance and who does it?

9a. What type of challenges do you face in doing your work as a CHW? Give specific examples of some of the main challenges

9b. How could it be resolved or how has it been resolved?

10. How do you rank self-performance as CHW — very successful, successful, average, poor and very poor
    1. Very successful   2. Successful   3 Average   4 Poor   5 Very poor
The following question is applicable only in the DMPA-SC area

11. How many days training did you receive in DMPA-SC before you were allowed to provide this method to women?

11b. How many practical cases you were asked to perform during the training period?

12. Do you feel confident in injecting DMPA-SC?

13. What is the reaction of women about DMPA-SC? Why are more women easily adopting it as compared to other contraceptive methods?

14a. What are the advantages of DMPA-SC?

14b. What are its disadvantages?

15. In these days in some countries, women are injecting DMPA-SC themselves. Do you think it is a good idea to allow women to inject DMPA-SC themselves and not depend on any health worker?

(Please explain the reasons of your answer)
### ANNEX III. LIST OF PERSONS INTERVIEWED

KIs for APC Evaluation in United States, Ghana, and South Sudan (31 Total)

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<thead>
<tr>
<th>Interview No.</th>
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<td>1</td>
<td>Joy Cunningham</td>
<td>Senior Technical Officer (Gender and Youth)</td>
<td>FHI 360</td>
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<td>2</td>
<td>Dawn Chin-Quee</td>
<td>Scientist</td>
<td>FHI 360</td>
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<td>3</td>
<td>Christy Creekmur</td>
<td>Financial Analyst</td>
<td>FHI 360</td>
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<td>Tracy Orr</td>
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<td>John Stanback</td>
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<td>6</td>
<td>Holly Burke</td>
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<td>7</td>
<td>Amita Mehrotra</td>
<td>Program Manager</td>
<td>FHI 360</td>
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<td>8</td>
<td>Leigh Wynne</td>
<td>Senior Technical Officer (CBFP)</td>
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<td>Jessica Posner</td>
<td>M&amp;E Advisor</td>
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<td>Olga Cojocari</td>
<td>Grants and Operations Manager</td>
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<td>Tanvi Pandit-Rajani</td>
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<td>Walter Proper</td>
<td>Director of Country Field Support</td>
<td>JSI</td>
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<td>Katie Cook</td>
<td>Senior Knowledge Management Strategist</td>
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<td>Chamberlain Diala</td>
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<td>Bonnie Keith</td>
<td>Senior Policy and Program Officer, Advocacy and Public Policy Program</td>
<td>PATH</td>
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<td>Tishina Okegbe</td>
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<td>21</td>
<td>Daniel Mensah</td>
<td>Executive Director</td>
<td>Health Keepers Network</td>
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<td>22</td>
<td>Mona Bormet</td>
<td>Program Director</td>
<td>Christian Connections for International Health</td>
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<td>23</td>
<td>Sara Tifft</td>
<td>Project Director</td>
<td>PATH</td>
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<td>Victoria Graham</td>
<td>Former AOR, APC</td>
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<td>Maggwa Baker</td>
<td>Senior Technical Advisor</td>
<td>Office and PRH Research Division, USAID</td>
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<td>25</td>
<td>Jeff Sanderson</td>
<td>Senior Technical Advisor, Team Leader for West Africa Post-Ebola Program</td>
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<td>Dr. Melissa Freeman</td>
<td>RH/FP Advisor and AOR for APC</td>
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<td>Michal Avni and Afeefa Abdur-Rahman</td>
<td>Senior Gender Advisor in Health at USAID/Washington Gender Office</td>
<td>USAID PRH</td>
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<td>Laura Sanka</td>
<td>International Program Director</td>
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<td>29</td>
<td>Cathy Savino</td>
<td>Senior DCHA Advisor</td>
<td>Empowerment and Inclusion Division of DRG, USAID</td>
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## Benin KII and Other Interviews (49 Total)

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<td>Athanase Hounnankan, USAID/Benin</td>
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<td>Dr. Didier Agossadou, General Secretary, MOH</td>
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<td>Dr. Franck Robert Zannou-Director, DSME</td>
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<td>Dr. Gaston, AHOUNOU-Deputy of FP/DSME</td>
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<td>Dr. Dennis Sossa, MCH, DSME</td>
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<td>Mr. Martin Edjitche, PIHI-Project Director for BUPDOS</td>
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<td>Mr. Salomon Balogou, Executive Director, PIHI-Com Project</td>
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<td>Mr. Mose Chabi Issiah, information, education, and communication, MOH</td>
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<td>Mr. Taufic Yacoubou &amp; Dr. Dadda Donatien, Coordinating Doctor</td>
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<td>Mr. Rogcent Expedie Ewassadja, Nurse for Community Clinic</td>
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<td>Ms. Allicoura Assibi &amp; Mr. Maret, CHWs in village</td>
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<td>Mr. Guaessere Sidi, CHW in village</td>
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<td>Mr. Sournon Bouko, Mayor of Chiao City, Supporter of PIHI</td>
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<td>Dr. Cyriaque AFFOUKOU, Coordinating Doctor, Calavi health zone</td>
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<td>Mr. Houngbegnon, Asst. M&amp;E and Planning PIHI, BUPDOS NGO</td>
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<td>Dr. Yves Sossou, Supervisor and Trainer of Trainers for DMPA-SC, IPPF</td>
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<td>Mr. Christian Sonakpo, Project Manager PIHI, Sian’son NGO</td>
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<td>Dr. Yves Sossou, Executive Director, ABPF/IPPF</td>
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<td>Ms. Victorine AHOUANGAN, FP Specialist, ABPF/IPPF</td>
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<td>Mr. Faustin Onikpo, Manager in Charge, ARM3</td>
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| Grand Total | 57 | 39 | 96 |
# ANNEX IV. LIST OF DOCUMENTS REVIEWED

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ANNEX V. STATEMENT OF DIFFERENCES

The Advancing Partners & Communities Project (APC) is a five-year project (with a two-year extension — 2012–2019) funded by the U.S. Agency for International Development (USAID) and implemented by John Snow Research & Training Institute and partner, FHI 360. The overarching goal of the APC Project is to advance and support community programs that improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning (FP).

The Final Evaluation Report on the USAID APC Project was prepared by and submitted to USAID by the Global Health Program Cycle Improvement Project (GH Pro; USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment Number: 445). After completing a careful review of the draft report, the agreement officer’s representative (AOR) and APC team differ with several of the findings and conclusions of the report. These differences lie primarily in the conclusion regarding monitoring and evaluation (M&E) and the findings for the strategy for global leadership.

Background

Donors and partners alike agree that the community health space is complex and fragmented. There is a large number of stakeholders involved, with competing interests. This is compounded by the intersections with health systems strengthening, health workforce planning, and the competing concerns of different health programs (HIV, tuberculosis, FP, maternal and child health, etc.). It is not a surprise that the evaluators found “most APC informants could not answer if they had visualized a clear pathway that could lead to global acceptance of CBFP [community-based family planning] as an effective way to deliver contraceptive services at the community level.” The AOR and APC team disagree that this is an appropriate measure of APC’s strategy for global leadership, which has focused on leveraging opportunities to harmonize approaches and provide strong country demonstrations.

APC needed to promote CBFP in several different ways during the life of the project — one was to ensure that CBFP was effectively incorporated into Community Health Systems (CHS) across the board — advocating for the inclusion of community-based systems in broader conversations about the health system, while advocating for CBFP in FP programs and, specifically, for CBFP to be a key and core component of CHS. Different countries were at different points in the continuum of welcoming or accepting CBFP within their CHS. APC sought to work through (or tried to work through) these challenges by partnering and collaborating with local civil society organizations. We do not believe that the evaluators appreciated the different terrains that we navigated in efforts to complete our work.

CHS activities were purposefully and strategically designed to support global priorities and shifts towards "harmonized" community health programming. Based on “problem identification,” we developed activities that would be responsive and provide solutions to meet the needs of donors, policymakers, and others to help guide their investments in community health at a global level. APC is proud of its work to advance CBFP through a broader platform of CHS. APC developed several tools and approaches to: fill global knowledge gaps in community health policy (CHS Catalog); assist countries to develop community health policy and guidance, creating links to FP through human-centered design (HCD), a participatory approach that engaged frontline health workers and other health system actors in the policy process; and raise awareness of the interconnections between FP, health systems, and policy (Community Health Policy Matters Video). The project believes the CHS portfolio has advanced global knowledge through the use of its tools and approaches, now being adopted by other implementers and initiatives at the country and global levels. This is one measure of demonstrated global leadership.
Monitoring and Evaluation

The APC project disagrees with the conclusion by the evaluators regarding M&E, (i.e., that M&E was “neglected” or “not done”). Every FP small grant had an M&E plan and system in place. Ample documentation of this was provided to the evaluators regarding the M&E process undertaken with the core grantees, such as Performance Monitoring Plans (PMPs) with indicators standardized across the grantees, spreadsheets with compiled results, performance monitoring reports, and quarterly reports with data. The project used custom indicators, such as “number of community health workers (CHWs) and/or other health providers trained or supported,” as well as service indicators, such as “number of acceptors new to modern contraception; methods distributed (to calculate CYP [couple-years of protection]),” which were selected to measure achievements according to the workplan of each grantee. The project also shared the overall project PMP and performance monitoring reports with the evaluators. These indicators are aggregated, shared, and reviewed with USAID on an annual basis.

A misunderstanding of the project may explain the evaluators’ findings regarding the lack of scientific rigor. After many iterations of the evaluation report, the small core-funded grants were still referred to as “research” even though it was clear that the small projects were neither research nor studies. This is important as it affected their expectations for M&E and led to the incorrect comparison between the small grants and the randomized controlled trial on self-injection of DMPA-SC that was conducted in Malawi.

Contrary to the evaluators’ statements that no documentation on processes, challenges, and lessons learned was done, the APC project provided many examples of such documentation:

- APC documented WellShare’s counseling, testing outreach, and emergency contraception qualitative outcomes and quantitative outputs in these posts on the APC website:
  https://www.advancingpartners.org/about-us/success-stories/accelerating-family-planning-uptake-through-integrated-hiv-counseling-and

- APC documented Salvation Army’s integration of FP addressing misconceptions and unmet need for FP in this post, detailing qualitative and quantitative outcomes:

- APC documented the Uganda Protestant Medical Bureau’s training of religious leaders as FP advocates in this post, detailing qualitative and quantitative outcomes:

- The technical brief on integration covers in-depth processes, challenges, and lessons learned from seven grantees:
  https://www.advancingpartners.org/resources/technical-briefs/integrating-family-planning-into-community-based-services

APC agrees that a higher allocation of travel funds for M&E technical assistance (TA) would have been beneficial. M&E TA to grantees was provided remotely, as in-person TA was not possible due to budgetary constraints. While it would have been ideal to conduct TA on-site, it was also not prioritized since the grantee organizations, especially ADRA, Pathfinder, WellShare, and World Vision were experienced and well versed in M&E and had their own dedicated M&E staff that provided relevant support to the grants.
It was noted during the evaluation that small grants not funded with FP funding were not able to demonstrate FP outcomes because they did not include FP indicators. It is possible that the evaluators confused the differences in M&E between the small grants receiving funding from other sources. In order to assess whether providing these grants under an FP-focused mechanism helped advance FP activities or awareness within those activities, FP indicators need to be included across those non-FP projects. The APC team and AOR feel strongly that this should be considered in future projects where combined funding occurs and thus agrees that M&E for a similar grants project could be improved.

Given the impact of the Malawi self-injection study in advancing global leadership for CBFP, the AOR and APC team would agree with the recommendation that future programming consider several rigorous studies like the self-injection research in Malawi that can provide the evidence to significantly move the field forward, in addition to the learning from small grants. However, studies of that kind are costly and must be carefully considered within existing resource envelopes.

Initiative for Global Leadership

In their report, the evaluators acknowledged APC’s work at both the global and country levels to increase CBFP. There is, however, a discrepancy in their finding that APC’s “performance at the country level was much more focused and strategically planned, particularly in working with Ministries of Health (MOH) and networking with local partners to influence policy change to support CBFP locally rather than through global leadership” despite evaluator acknowledgements that APC’s tools, approaches, and technical assistance advance CBFP at the global level. It is the view of the AOR and the APC team that the evaluators did not recognize the link between advancing country-level work as an advocacy tool to advance the global progress on CBFP. Although CBFP (especially CBA2I) has been successfully demonstrated in Asia, there have not been corresponding demonstrations in the challenging Sub-Saharan African context. Based on the APC team’s experience, it was felt that significant progress for CBFP would need to be demonstrated in a few sub-Saharan countries in order to lead globally. Although the evaluators state the global “activities and initiatives were often ad hoc,” they were designed to address problems that arose in the global community as barriers to implementation of CBFP and to address concerns of key stakeholders. These were paired with focused and strategic country-level efforts as a multipronged effort to advance CBFP.

Unfortunately, the timing of the evaluation meant that several key outcomes for global leadership occurred or will occur after the evaluation work was completed. For example, donors and country teams held a regional meeting on DMPA-SC in May 2018, where the results from the APC study on self-injection of DMPA-SC was instrumental in convincing country leadership in Zambia, Uganda, and Benin (among others) to begin shifting policies and programs towards delivery of self-injected DMPA-SC. Anticipated this fall is WHO’s revised CHW guidelines, which will potentially show results of APC’s advocacy for CBFP.
ANNEX VI. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

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

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

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

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature:  
Date: 3 May 2017

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature ___________________________ Date ____________

Adewole FALADES

Name Translator/Interpreter

Title
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.

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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date

Hamba Luso

Title M&E Consultant

Page 114 of 131
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ANNEX VII. SUMMARY BIOS OF EVALUATION TEAM MEMBERS

Sam Clark, Team Lead/Evaluation Expert. Sam Clark has held senior positions and consultancies in the design, implementation, and monitoring and evaluation (M&E) of gender-equitable sexual and reproductive health programs (maternal, newborn and child health [MNCH], family planning [FP] and the prevention of HIV/AIDS). He has been Team Leader on 10 evaluations on MNCH, FP, and HIV/AIDS for USAID, UNFPA, UNICEF, and WHO since 2011. Sam Clark holds a Doctorate (Sc.D.) and Master’s with Honors (Sc.M.) from the Johns Hopkins University School of Hygiene and Public Health. In addition to his extensive experience in applied qualitative and quantitative M&E to assess public health programs and in program management and budget monitoring, he has diverse in-depth computer skills using SPSS, SAS, Epi-Info, and MS Office.

M.E. Khan, International FP/RH Expert. M E Khan is internationally recognized for implementation research in reproductive health and family planning. Presently he is president of the Center for Operations Research and Training (CORT), New Delhi, India and also works as an independent health consultant. His areas of interest include operations research, monitoring and evaluation, community mobilization, behavior change communication, gender-based violence, and capacity building of young researchers and program managers. Dr. Khan has contributed more than 60 papers to international fora and written several books.

Linda Sussman, Senior Technical and Research Specialist/Advisor (USAID). Linda Sussman is a senior research advisor at USAID in the Bureau of Global Health, Office of Population and Reproductive Health, in the Research, Technology, and Utilization Division, where her primary focus is on social and behavioral science research related to sexual and reproductive health, including research related to youth, gender, scale-up, and integration of family planning in multi-sectoral efforts. She leads the USAID management team for the Passages Project, which conducts research and provides global leadership on community-level interventions focusing on normative change with adolescents, their families, and their communities.

Alanna White, Program Analyst (USAID). Alanna White is a Program Analyst at USAID in the Bureau of Global Health, Office of Population and Reproductive Health, in the Service Delivery Improvement (SDI) Division. She obtained her MPH from the University of Hawaii at Manoa with a specialization in Social and Behavioral Health Sciences and focus on Disaster Management and Humanitarian Assistance. She has worked on several SDI-housed project USAID Management teams, in topic areas ranging from post-abortion care and fistula, to community-based family planning.
For more information, please visit
http://ghpro.dexisonline.com/reports-publications