MIDTERM PERFORMANCE EVALUATION OF USAID’S HEALTH POLICY PLUS (HP+) PROJECT

May 2019

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DISCLAIMER

The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
ABSTRACT

This is a Midterm Performance Evaluation of the Health Policy Plus (HP+) Project. The purpose of the evaluation is to provide an independent assessment of HP+ progress toward achieving project goals and objectives. Evaluation questions focus on: a) the extent to which HP+ technical approaches have enabled achievement of project objectives and met indicators; b) the current level of satisfaction of USAID and other partners with project progress to date; and c) emerging trends and needs in health policy that might be addressed in this or future projects. Methods included review of background documents, review of a midterm self-assessment and other information provided by Palladium based on questions posed by the team, detailed interviews with knowledgeable informants, and an online e-survey. Findings and conclusions were that HP+ progress in achieving program results in its four main technical areas (policy, advocacy, health financing, and accountability/governance) is on track; demand for HP+ in health financing has increased rapidly, indicative both of growing need for this assistance and satisfaction with work completed so far; on the whole, stakeholders say they are very satisfied with results being achieved; there remain some challenges and areas for improvement going forward; and there are a number of important emerging policy needs that could be addressed in this or future projects.
ACKNOWLEDGMENTS

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Next, the team thanks all those from Global Health Program Cycle Improvement Project (GH Pro), USAID, and Palladium who helped with the administrative, implementation, and logistical support for this evaluation, including scheduling and tracking of interviews, travel arrangements, reserving meeting rooms, and more. Kate Bartram and Laura Mansilla (GH Pro), Kelly Thomas (USAID), and Kelly Carrera (Palladium) were especially helpful.

The team also owes thanks to Linda Cahaelen, the Agreement Officer’s Representative (AOR) for the HP+ Project, and all the members of her AOR team for their good work in developing the scope of work for this evaluation and their guidance and assistance throughout the evaluation process.
# CONTENTS

Abstract ........................................................................................................................................................................ iii
Acknowledgments ............................................................................................................................................................ iv
Acronyms ................................................................................................................................................................... vii
Executive Summary ........................................................................................................................................................ x

I. Introduction ..................................................................................................................................................................... 1
   Evaluation Purpose ........................................................................................................................................................ 1
   Evaluation Questions .................................................................................................................................................... 1

II. Project Background ...................................................................................................................................................... 2
   Prior USAID/GH Investment in Health Policy Work .......................................................................................... 2
   Design of the Health Policy Plus (HP+) Project .................................................................................................... 2

III. Evaluation Methods and Limitations ...................................................................................................................... 4

IV. Findings ........................................................................................................................................................................... 7
   Evaluation Question 1 .................................................................................................................................................. 7
   Evaluation Question 2 ................................................................................................................................................ 32
   Evaluation Question 3 ................................................................................................................................................ 40

V. Conclusions and Recommendations ...................................................................................................................... 44
   Conclusion 1: HP+ Management Structure and Systems .................................................................................. 44
   Conclusion 2: Project Technical Approaches ...................................................................................................... 44
   Conclusion 3: Achieving Progress on Cross-Cutting Principles ........................................................................ 45
   Conclusion 4: Country Office Staffing ................................................................................................................... 45
   Conclusion 5: The Rise of HF Work ....................................................................................................................... 46
   Conclusion 6: Core Activity Implementation ...................................................................................................... 48
   Conclusion 7: Global Technical Leadership ....................................................................................................... 49
   Conclusion 8: Models And Tools ............................................................................................................................ 49
   Conclusion 9: Future Trends ................................................................................................................................... 50

Annex I. Scope of Work ................................................................................................................................................ 51
Annex II. Evaluation/Analytic Methods and Limitations .......................................................................................... 73
Annex III. Key Informant Interview Guide ................................................................................................................ 74
Annex IV. HP+ Self-Assessment Guide ...................................................................................................................... 78
Annex V. E-Survey Interview Guide ............................................................................................................................ 80
Annex VI. E-Survey Summary Tables .......................................................................................................................... 87
Annex VII. Sources of Information .............................................................................................................................. 99
Annex VIII. HP+ Midterm Evaluation List of Emerging Issues ............................................................................ 100
Annex IX. HP+ Results Framework .......................................................................................................................... 105
Annex X. HP+ Organigram ......................................................................................................................................... 106
Annex XI. List of HP+ Models/Tools .......................................................................................................................... 107
Annex XII. Disclosure of Any Conflicts of Interest .................................................................................................. 120
Annex XIII. Summary Bios of Evaluation Team ...................................................................................................... 123

Tables
Table 1. Number of PEPFAR Staff Trained in GSD, by Year and Location ............................................................... 28
## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AMO</td>
<td>Assurance Maladie Obligatoire</td>
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<td>AOR</td>
<td>Agreement Officer’s Representative</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ATF</td>
<td>AIDS Trust Fund</td>
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<td>CA</td>
<td>Cooperative Agreement</td>
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<td>CANAM</td>
<td>Mali’s National Health Insurance Fund</td>
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<td>CD</td>
<td>Capacity development</td>
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<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
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<td>CHMT</td>
<td>County’s Health Management Team</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CIP</td>
<td>Costed Implementation Plan</td>
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<td>CLA</td>
<td>Collaborating, Learning, and Adapting</td>
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<td>CNSS</td>
<td>Caisse Nationale de Solidarité en Santé</td>
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<td>CSCom</td>
<td>Community Health Centers</td>
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<td>CSO</td>
<td>Civil Society Organizations</td>
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<td>DEC</td>
<td>Development Experience Clearinghouse</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DPS</td>
<td>Department of Population Studies</td>
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<td>DRM</td>
<td>Domestic Resource Mobilization</td>
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<td>EQUIST</td>
<td>Equitable Impact Sensitive Tool</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FP2020</td>
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<td>FPAWG</td>
<td>Family Planning Advocacy Working Group</td>
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<td>FS</td>
<td>Field support</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GF</td>
<td>Global Fund</td>
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<td>GH</td>
<td>USAID Bureau for Global Health</td>
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<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<td>GSD</td>
<td>Gender and Sexual Diversity</td>
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<td>HEP+</td>
<td>Health and Education Policy+ Project (i.e., the HP+ Project/Office in Guatemala)</td>
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<td>HF</td>
<td>Health financing</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HOP</td>
<td>Headquarters’ Operational Plan</td>
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<td>HP+</td>
<td>Health Policy Plus</td>
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<td>HPI</td>
<td>Health Policy Initiative</td>
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<td>HPP</td>
<td>Health Policy Project</td>
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HQ Headquarters
IAWG-C Interagency Working Group on Costing
IR Intermediate Result
JKN Jaminan Kesehatan Nasional (National Health Insurance, Indonesia)
KII Key Informant Interviews
LOE Level of effort
LTWA Long-term technical assistance
M&E Monitoring and evaluation
MANASO Malawi Network of AIDS Service Organisations
MCH Maternal and Child Health
MCHN Maternal and Child Health and Nutrition
MGDS Midterm Growth and Development Strategy
MNH Maternal and Newborn Health
MoFEDP Ministry of Finance and Economic Development
MOH Ministry of Health
MoHP Ministry of Health and Population
NACOPHA National Council of People Living with HIV/AIDS
NGO Nongovernmental organization
OGAC Office of the Global AIDS Coordinator
OHA Office of HIV/AIDS
OHT OneHealth Tool
OSAR Observatorio en Salud Sexual y Reproductiva
PAD Project Appraisal Document
PBB Program-Based Budgeting
PEC Policy, Evaluation and Communication (Division)
PEPFAR U.S. President's Emergency Plan for AIDS Relief
PHDP Positive Health, Dignity, and Prevention
PLT Project Leadership Team
PMP Performance Monitoring Plan
PPD ARO Partners in Population and Development Africa Regional Office
PRB Population Reference Bureau
PRH Office of Population and Reproductive Health
RAPID Resources for the Awareness of Population Impacts on Development
RFA Request for Application
RH Reproductive health
S&D Stigma and discrimination
SEC Essential Community Healthcare
SFI Sustainable Financing Initiative
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>SOW</td>
<td>Scope of work</td>
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<td>STTA</td>
<td>Short-term technical assistance</td>
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<td>TA</td>
<td>Technical assistance</td>
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<td>TLT</td>
<td>Technical Leadership Team</td>
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<td>TMA</td>
<td>Total Market Approach</td>
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<td>TNP2K</td>
<td>National Team for the Acceleration of Poverty Reduction</td>
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<td>TOM+</td>
<td>Technical Oversight and Management+</td>
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<tr>
<td>ToT</td>
<td>Training of trainers</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USAID/W</td>
<td>USAID/Washington</td>
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<td>WG</td>
<td>Working Group</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WRA</td>
<td>White Ribbon Alliance</td>
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EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTION

The purpose of this midterm performance evaluation is to provide the United States Agency for International Development (USAID) an independent assessment of USAID’s Health Policy Plus (HP+) Project Cooperative Agreement (CA) and its progress toward achieving project goals and objectives. The evaluation questions from the evaluation statement of work are as follows:

1. **HP+ Technical Approach:** To what extent have the current mix of HP+ technical assistance (TA) and capacity development (CD) approaches, including long-term technical assistance (LTTA), short-term technical assistance (STTA), training, organizational development, monitoring and evaluation (M&E), and communications, enabled the achievement of the project’s objectives, and met indicators as outlined in the project Performance Monitoring Plan (PMP) and Field Activity PMP?

2. **Stakeholder Satisfaction:** What is the current level of satisfaction of USAID missions and other partners with the inputs and progress toward project goals to date?

3. **Future Trends:** What are the emerging trends and needs in health policy, advocacy, health financing (HF), and governance that might be addressed in the current or future project?

PROJECT BACKGROUND

HP+ is a global cross-bureau project launched on August 28, 2015. As the flagship policy and financing project, HP+ works with missions to strengthen in-country approaches in policy, sustainable financing, accountability/governance, and advocacy. The HP+ Project is a five-year CA with a $185 million funding ceiling. In Years One to Three of the project (8/28/15 to 9/30/18), HP+ has received core funding support of $28.6 million and field support funding of $64.6 million, and has operations in more than 17 countries. Expanding the efforts of prior USAID investments from the Health Policy Project (HPP), HP+ focuses on strengthening and advancing health policy priorities in family planning (FP)/reproductive health (RH), HIV/AIDS, and maternal and newborn health. It aims to improve the enabling environment for equitable and sustainable health services, supplies, and delivery systems through policy development and implementation, with an emphasis on voluntary health programs, and by strengthening in-country partners’ capacity to navigate complex environments for effective policy design, implementation, and financing.

EVALUATION METHODS AND LIMITATIONS

The methods employed were semi-structured interviews with key informants and surveys, supplemented by document review. The HP+ evaluation team reviewed the PMP, workplans, annual reports, as well as project products, reports, presentations, and publications, for a total of more than 70 project documents.

The project documents were used to understand the scope of the project, help develop the interview guides, and corroborate information obtained from the key informant interviews (KIs). Field visits were used to understand the context in which the project activities are implemented. The field visits were to

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1 Budget table provided by Suneeta Sharma, HP+, June 27, 2018.
Guatemala, Kenya, Malawi, and Tanzania, as requested by the Agreement Officer’s Representative (AOR). Interviews also took place with key informants in Washington, D.C., including donors based in Washington, D.C., the AOR team, other USAID staff that work with the project, the HP+ Project Leadership Team, and key HP+ staff.

For another eight countries, the evaluation team conducted phone-based interviews with USAID mission staff, HP+ Country Office staff, and host country partners. An online survey was sent out to 143 remaining knowledgeable individuals, mainly from the mission, donor, and host country partners stakeholder groups.

**FINDINGS**

**Evaluation Question 1**

The HP+ management structure was conceptualized during Palladium’s response to USAID’s request for application (RFA) for the project. The management structure was tailored to be responsive to both USAID and partner countries’ needs. Overall, responses were favorable across all stakeholder groups, although there were some useful suggestions on areas for improvement, both on staffing and systems/communication.

HP+ technical approaches include LTTA, STTA, and other CD approaches. All these technical approaches are contributing in different ways to achieving results. Seconding—i.e., HP+ hiring of full-time advisors to be placed to work in host country partners organizations—is one method that supports sustainable, tailored CD to staff and organizational processes while promoting institutional change. For field activities, using field-based technical staff and local consultants is HP+’s default standard, and most missions and host country partners confirmed that they also prefer local TA because local staff know the country context better, and are less costly. CD is happening in many areas of work, but more CD inputs are needed.

For Result 1 (Policy Development): Since 2015, HP+ facilitated the design, adoption, and/or implementation of 65 health policies, plans, and laws/regulations. These results were achieved using a country-led, collaborative approach that facilitates country ownership of the process and results.

For Result 2 (HF): By the midterm of the project, HP+ built an impressive staff capacity in health economics and financing at headquarters (HQ) and in the Country Offices. It deployed that capacity strategically to respond to countries’ requests for TA to improve the sustainability, equity, and efficiency of their health services sectors, with a focus on FP and HIV. Missions’ requests for HF assistance on behalf of countries have outstripped expectations. Given the wide range of issues competently addressed by the HF team globally, HP+ is well positioned to take on the future challenges that development assistance in HF will present.

Through a combination of STTA and training, HP+ enabled civil society organizations (CSO) to use evidence in their advocacy efforts to increase health sector budget allocations and/or budget execution at national and subnational levels of government.
For Result 3 (Stewardship, Accountability, and Transparency): HP+ worked with government partners to improve stewardship, accountability, and transparency. Much of this work entailed health systems strengthening and policy reform strategies that improved efficiency. By helping put strong structures and processes in place, HP+ helped local governments take on new responsibilities and give citizens a greater opportunity to influence health and development policy decisions.

For Result 4 (Global Leadership and Advocacy): HP+ helped to translate global initiative goals into national-level planning and implementation, and ensured that local solutions fed into global policy dialogue. Additionally, HP+ promoted and strengthened the global thought leadership and advocacy agenda for equitable, sustainable health policies at all levels of government.

Achieving Cross-Cutting Principles: The HP+ Project scope of work (SOW) identifies four cross-cutting principles that are meant to be at the heart of the project’s mandate: gender equality, health equity, CD, and sustainability. HP+ has worked to institutionalize all four themes into planning, implementation, and results by: a) appointing a technical lead for each of the cross-cutting themes to provide technical leadership; b) requiring that all core and field workplans include a description of how each theme is being integrated or addressed; c) advancing specific topics through design and use of innovative tools and approaches; d) providing targeted STTA to field programs; and e) capturing how the respective themes were advanced with every project result report.

Use of Models and Tools: HP+ has effectively used models and tools to generate evidence helpful across all four Intermediate Results (IRs) in multiple countries. For example, some models simulate the social and economic consequences of different rates of fertility and population growth in countries, reflecting the historical focus of USAID’s policy projects on FP programs. Models used in HF focus on estimating the costs, cost effectiveness/benefit, cost savings, effect on health outcomes, in varying detail, of providing specific services to defined populations, considering different levels of use and expected health outcomes.

Evaluation Question 2

Communication with USAID: Virtually all respondents that regularly communicate with USAID (AOR team and missions) stated that they were highly satisfied with USAID’s responsiveness. The AOR and her team were especially praised for their helpfulness.

Contributions and Challenges of Implementing Core Activities: HP+ has used core activities for innovative work and promoting of global learning. Often, these core activities produce knowledge that can also be applied in field activities. With core activities, mission directors must give prior written approval before any HP+ core activity can be implemented in-country. In some cases, this approval process can be lengthy.

Stakeholders Satisfaction with HP+ Results: Missions and host country partners expressed appreciation that HP+ aligns its work priorities with the in-country priorities of the mission and the Ministry of Health (MOH). Stakeholders could provide several examples of important results across all of the IRs.

With few exceptions, stakeholders also gave high marks to the work products of the HP+ HF team, and for its execution of workplans and its flexibility in adapting solutions to local conditions. Satisfaction with HP+-provided HF support is reflected in the increasing and widespread demand for its services from USAID missions. Interviews revealed that all country partners, across HP+ funding streams, realize that donor support is declining. The message has been sent and received that countries need to move
toward sustaining their health sector programs with their own finances, public and private, rather than those of external donors.

**Evaluation Question 3**

The evaluation team asked all stakeholders to state what they thought were the most important future trends or emerging issues in areas: FP, HIV/AIDS, and maternal and child health (MCH), and across these health elements in HF. This report indicates the 10 to 12 most often mentioned issues for each of these four areas, and notes the common themes among these, namely:

- Widespread acknowledgment that donor funding is declining, and increasing mobilization of domestic resources needs to be a priority.
- Universal health coverage (UHC) is a long-term goal that depends on moving toward sustainable HF.
- A clear map for moving forward is needed, and HP+ is well positioned to provide this type of support.
- More advocacy work is needed to increase demand for FP and HIV/AIDS services, improve the quality of services, and extend the reach of health services, especially to groups that are underserved (e.g., adolescents, men, key populations, etc.).

**RECOMMENDATIONS**

Based on findings, the report offered conclusions and 14 corresponding recommendations that were grouped by nine major evaluation theme areas.

1. **HP+ Management Structure and Systems**
   
   **Recommendation 1:** HP+ should continue to implement a management structure that addresses all key elements of the project scope, and is responsive to changing client needs, while always looking for ways to improve its generally well-functioning management operations systems.

2. **Project Technical Approaches**
   
   **Recommendation 2a:** HP+ should continue using a strategic approach for deployment of embedded staff where their impact will be greatest, and be prepared for an increase in requests for embedded staff.

   **Recommendation 2b:** In the interest of empowering Country Office technical staff to do their jobs most effectively, HP+ should consider circulating and updating a listing of HQ staff capabilities to help country offices know their options for STTA requests from HQ; and consider extended TDYs by HQ experts to assist and mentor technical staff in Country Offices, if requested.

   **Recommendation 2c:** Consistent with its policy to use country sources of TA as their default, HP+ should consider using qualified local trainers to conduct gender and sexual diversity (GSD) and/or other on-site trainings in the future.
3. **Achieving Progress on Cross-Cutting Principles**

**Recommendation 3:** HP+ should continue to give priority to the cross-cutting theme areas of gender equality, health equity, CD, and sustainability, using all available approaches, especially within the context of HP+ field activities.

4. **Country Office Staffing**

**Recommendation 4a:** In instances where HP+ Country Offices are adversely affected by U.S. Government political or fiscal requirements, the AOR, relevant USAID missions, and HP+ HQ should continue to determine what positive steps, if any, can be taken to mitigate the adverse impacts of those requirements on HP+ country funding and/or operations.

**Recommendation 4b:** HP+ should consider additional staffing requests based on their merits and available funding, and take appropriate actions.

5. **The Rise of HF Work**

**Recommendation 5a:** HP+ should increase emphasis on building health economics and financing capacity in government ministries, at national and subnational levels, and CSOs. HP+ should increase involvement of its Consortium partners in its capacity-building efforts.

**Recommendation 5b:** HP+ should make every effort to link HF analytic work to implementation of recommendations and keep USAID informed of its progress in doing so. HP+ should also adhere as closely as possible to health teams’ expectations for periodic reporting of progress against results for HF activities.

6. **Core Activity Implementation**

**Recommendation 6:** HP+ and USAID should continue to be open to a shared management role between the AOR and the mission regarding core activities operating in-country. The mission should have a role in core activity day-to-day decisions in-country, if it so desires, the details of which should be negotiated with the AOR.

7. **Global Technical Leadership**

**Recommendation 7:** HP+ should confirm that country results and publications are always shared promptly with the local USAID mission in print and electronic form. All publications should also be accessible on the HP+ website, and on HP+ Country Office webpages, should be provided to the USAID Development Experience Clearinghouse (DEC), and disseminated widely to the relevant host country and international partners. HP+ Country Office leadership also should take the initiative to regularly offer to do presentations in-person and through webinars (or other electronic means) for USAID health team staff when major new publications or work products are released.

8. **Models and Tools**

**Recommendation 8:** HP+ should mobilize HP+ staff and consortium partners involved in modeling activities to optimize efforts to deliver all work products on time. HP+ should always fully engage CSO and government partners at each stage of model/tool development and application. HP+ also should make every effort to publish reports that are accessible to all relevant audiences, from the national to local levels, and include clear policy and program implications.
9. Emerging Issues

**Recommendation 9:** Few of the emerging issues reported here are brand new to HP+. Still, USAID’s Bureau for Global Health should consider how these emerging issues may offer new insights or approaches, particularly on transition issues, sustainable HF, and improvement of adolescents’ access to FP and HIV test/treatment services.
I. INTRODUCTION

EVALUATION PURPOSE
The purpose of this midterm performance evaluation is to provide the United States Agency for International Development’s (USAID) Bureau for Global Health (GH)/Office of Population and Reproductive Health (PRH)/Policy, Evaluation and Communication (PEC) Division, Office of HIV/AIDS (OHA), and Office of Maternal and Child Health and Nutrition (MCHN) an independent assessment of USAID’s Health Policy Plus (HP+) Cooperative Agreement (CA) and its progress toward achieving project goals and objectives. As outlined in the USAID project appraisal document (PAD) under which this project falls, this evaluation serves to accomplish the following:

1. Assess how the following have affected or influenced overall project performance: the quality of the project’s technical approach, its current and/or altered staffing and management structure, and its progress in achieving the four Intermediate Results (IRs). Identify current and emerging trends in policy, advocacy, financing, and governance.

2. Measure satisfaction of GH offices, missions, regional bureaus, country government partners, as well as other stakeholders and partners in project performance and its ability to achieve key benchmarks. Provide feasible recommendations to be incorporated into the management and conduct of future projects. Assess options for implementing the highest-priority recommendations.

EVALUATION QUESTIONS
The evaluation team was asked to address the following questions:

1. **HP+ Technical Approach:** To what extent have the current mix of HP+ technical assistance (TA) and capacity development (CD) approaches, including long-term technical assistance (LTTA), short-term technical assistance (STTA) training, organizational development, monitoring and evaluation (M&E), and communications, enabled the achievement of the project’s objectives, and met indicators as outlined in the project Performance Monitoring Plan (PMP) and Field Activity PMP?

2. **Stakeholder Satisfaction:** What is the current level of satisfaction of USAID missions and other partners with the inputs and progress toward project goals to date?

3. **Future Trends:** What are the emerging trends and needs in health policy, advocacy, health financing (HF), and governance that might be addressed in the current or future project?
II. PROJECT BACKGROUND

PRIOR USAID/GH INVESTMENT IN HEALTH POLICY WORK
USAID has invested in centrally managed projects related to health policy for 40 years. Predecessor policy projects included Resources for the Awareness of Population Impacts on Development (RAPID) I–IV (Fiscal Year [FY]78–95), OPTIONS I and II (FY86–95), POLICY III (FY95–05), and the Health Policy Initiative (HPI) (FY06–10), which all provided TA for formulating policies related to family planning (FP), maternal health, and later HIV/AIDS.

HP+’s immediate predecessor, the Health Policy Project (HPP) was competitively awarded as a CA late in 2010. This five-year project had a project ceiling of $250 million and a life-of-project funding total of $153 million. The prime awardee was The Futures Group but the award also included a consortium of partners: Plan International (formerly known as the Centre for Development and Population Activities [CEDPA]); the Population Reference Bureau (PRB); RTI International, Futures Institute; White Ribbon Alliance (WRA); and Partners in Population and Development Africa Regional Office (PPD ARO). The majority of funding came from mission field support (FS); the rest from GH, USAID Regional Bureaus, and Office of the Global AIDS Coordinator (OGAC). HPP carried forward most of the essential technical contents of the HPI, but with much more emphasis on capacity-building.

DESIGN OF THE HEALTH POLICY PLUS (HP+) PROJECT
HP+ is a global cross-bureau project launched on August 28, 2015. As the flagship policy and financing project, HP+ works with missions to strengthen in-country approaches in policy, sustainable financing, accountability/governance, and advocacy. The HP+ Project is a five-year CA (AID-OAA-A-15-00051) with a $185 million ceiling, with end of Year Three funding support of $28.6 million in core funds, field support funding of $64.6 million in 17 countries, and presence in 42 countries. Expanding the efforts of prior USAID investments from HPP, HP+ focuses on strengthening and advancing health policy priorities across health elements, with a focus on FP/reproductive health (RH), HIV/AIDS, and maternal health. HP+ is implemented by Palladium and a team of partners that includes Avenir Health, Plan International, PRB, RTI International, WRA, and ThinkWell. HP+ aims to improve the enabling environment for equitable and sustainable health services, supplies, and delivery systems through policy development and implementation by strengthening in-country partners’ capacity to navigate complex environments for effective policy design, implementation, and financing. By working on evidence-based and inclusive policy, sustainable financing, improved governance, and strong advocacy, HP+ offers creative strategies to strengthen the capacity of in-country partners when navigating complex political and financial environments.

This project supports key stakeholders and governments to ensure that global, national, and decentralized policies and resources prioritize and support health systems to improve health outcomes. Substantive changes in policy are required to support rapid and substantial increases in financial and human resources for successful transition. Financing and domestic resource developments are required to assure broad and critical health policy implementation; new economic approaches are needed as countries seek to improve health systems and health outcomes. As decision-making and economic power devolve to the local level, improved approaches for accountability and transparency are critical. New processes for health planning and policy

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2 USAID, Health Policy Project Midterm Evaluation, March 2014, p. 3.
development and implementation are essential, and building capacity across a range of analytic, advocacy and negotiation skills is necessary.³

III. EVALUATION METHODS AND LIMITATIONS

This is a midterm performance evaluation. As such, its purpose is to provide USAID “an independent assessment of USAID’s HP+ CA and its progress toward achieving project goals and objectives.” The evaluation was asked to focus on the three key evaluation questions, which are provided in the Introduction.

Data Sources: The evaluation team utilized several data sources for gathering the data necessary to address the evaluation questions. The team began by reviewing several key background documents, such as the HP+ Request for Applications (RFA) and the Technical Application submitted by Palladium, to gain a fuller understanding of the USAID project design, goals and objectives, and technical approaches proposed by the successful applicant (i.e., Palladium and its consortium partners). In addition, the team reviewed annual workplans and progress reports available to date, and had access to PMP data, HP+ publications, work products, and numerous other technical reports and presentations.

A second data source was a Midterm Self-Assessment report prepared by Palladium, in response to a series of questions our team posed to them. The team followed up with a few additional questions that surfaced during data collection. Palladium provided a very thoughtful and detailed response to all of the questions. This self-assessment provided a valuable description of their management structure, the rationale for the technical approaches Palladium has adopted for HP+, the implementation challenges they have addressed, and some of the main results they have achieved.

A third data source was in-depth key informant interviews (KIs), representing eight stakeholder groups: Agreement Officer’s Representative (AOR) team, other USAID/Washington (USAID/W), missions, HP+ leadership and other Palladium staff, consortium partners, HP+ Country Offices, host country partners, and donors. Based closely on the evaluation questions and related areas to consider in the scope of work (SOW), the evaluation team developed a master questionnaire and determined which questions were appropriate for each stakeholder group; they then developed a version of the questionnaire appropriate for each stakeholder group. Face-to-face interviews were completed in Washington, D.C., and in four site visit countries (Guatemala, Kenya, Malawi, and Tanzania). The team also completed phone interviews with additional key informants in eight other countries (Jamaica, Indonesia, Madagascar, Cambodia, Mali, Ghana/West Africa, Togo, and Niger).

A fourth data source was an online e-survey that was sent to an additional 143 key informants, including USAID health staff in missions, governmental and nongovernmental organization (NGO) implementing

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOR Team</td>
<td>11</td>
</tr>
<tr>
<td>Consortium Partners</td>
<td>6</td>
</tr>
<tr>
<td>Donors/International Organizations</td>
<td>12</td>
</tr>
<tr>
<td>HP+ Country Offices</td>
<td>33</td>
</tr>
<tr>
<td>Host Country Partners</td>
<td>95</td>
</tr>
<tr>
<td>HP+ Palladium (Headquarters)</td>
<td>11</td>
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<tr>
<td>USAID Missions</td>
<td>43</td>
</tr>
<tr>
<td>USAID/Washington</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>214</td>
</tr>
</tbody>
</table>

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5 See Annex IV: HP+ Self-Assessment Guide.
6 See Annex III: Key Informant Interview Guide.
partners, and other donors in all the remaining countries that are collaborating with the HP+ Project. All informants were given two to three weeks to respond, with a due date of October 5, 2018. Despite email reminders to solicit timely responses, the response rate for this e-survey was a somewhat disappointing 26 percent (37/143).

**Analytical Approach:** The team adopted a mainly qualitative analytical approach, drawing on data and information from all four data sources to develop evidence-based findings that directly address the three main evaluation questions of this HP+ midterm evaluation. This approach is appropriate because each of the evaluation questions is somewhat subjective in nature, requiring judgments on the linkages between technical approaches and the implementation of project objectives, or the level of stakeholder satisfaction with HP+ inputs and progress to date, or which are the most important emerging trends and issues relating to health policy and financing. Where the team saw quantifiable results, it tried to include those in the findings, but many of the findings stem from more qualitative analysis.

**Qualitative Methods Used**

1. **Compilation and Organization of KII and e-survey qualitative data.** In KIIs, one team member conducted the interview and all team members in attendance wrote notes on responses in blank spaces on hard copies of the questionnaire. This was done for two reasons: a) in an interview, different team members may sometimes highlight different points in their notes; and b) if a team member is later unsure about a statement in their notes, they can triangulate with other team members to get their interpretation of the statement. Each team member was responsible for typing up and saving their notes, question by question, in a standard format as soon as possible after every interview, and each team member named and stored their interview notes in a single file folder to facilitate storage and retrieval of the interview files.

   After the data collection phase of the evaluation was completed, the first step in data compilation was to create a shared Google spreadsheet upon which to array all qualitative data from KIIs and e-surveys. Data from each interview file by each team member was transferred onto a unique row in the spreadsheet. Identifiers captured on each row of the spreadsheet included the name of respondent, job title, organization, country, stakeholder group, and name of team member providing the notes. The remaining cells on each row included one cell for any background information provided by the respondent, followed by his/her responses to each question asked (one cell per question).

2. **Identification of common themes, patterns, and connections.** Once the data compilation was complete, spreadsheet data organization functionalities facilitated analysis in many ways. For example:
   a. The team sorted by name of respondent to group all the team members’ notes together on each respondent, to get the fullest picture of what each respondent said on key questions.
   b. The team sorted by stakeholder group to discern similar themes or patterns of response within that stakeholder group, and differences in responses among stakeholder groups.
   c. Similarly, the team sorted by country to analyze similarities and differences among country organizations on issues like satisfaction with HP+ performance, or future policy trends/issues.
When the team saw that there were a large number of similar responses in the interviews regarding results, accomplishments, or satisfaction with performance within and across countries on a particular theme or IR, it considered those as potential findings subject to discussion within the team and cross-validation with other sources as needed.

3. **Formation of thematic conclusions and recommendations related to the three main evaluation questions.** During its analysis and report-writing, the team developed high-level conclusions and recommendations on nine major themes. The team views these themes as central to the three main HP+ evaluation questions. The Conclusions and Recommendations are fully supported by the data and other evidence analyzed by the team.

In any evaluation there are bound to be some issues or areas for improvement that arise during the course of the evaluation, and the HP+ evaluation is no exception. In this report, mention of these issues or areas for improvement are found in the relevant sections of the Findings, but many are also noted in the Conclusions and Recommendations. This is not to suggest that the team regards every issue or area for improvement as high importance. Rather, the intent was simply to ensure that issues or area for improvement are not missed in the text, but instead are duly noted, assessed, and acted on as appropriate.

**Limitations:** There are some limitations inherent to some of the data sources. For example, HP+’s Midterm Self-Assessment, which was based on questions the team posed to HP+, while thorough and highly relevant, still has the possibility of bias inherent to self-assessments.

The in-depth qualitative interviews, though extremely valuable, presented some challenges as well. The team opted not to record its interviews, so one potential limitation is the loss or distortion of information that can occur as interviewers are taking notes. The team guarded against that in two ways: a) by asking for clarifications if any team member was not clear on the point being made; and b) by having two or more team members take notes in most cases so the team could compare notes as needed. Another potential limitation was that some interviews were done in French or Spanish. For the Spanish interviews in Guatemala, the team had a good translator who supplied earpieces to all present, and did simultaneous translation of the English questions into Spanish, and the Spanish responses into English. As there was one team member who was fluent in Spanish, she did solo interviews with stakeholders in Spanish while the English-only team members were doing their interviews using the translator. For the French phone interviews, the team had an excellent translator who read our questions in French, and then summarized the responses in English for the team. Because this may have resulted in some lost information, the team asked the translator to also share her notes with us, for a fuller picture of the responses from the knowledgeable informant. Another recurring problem in the international phone interviews was the poor phone connection in some countries. The team quickly learned where it was better to use Skype or another technology.

The main limitation of the e-survey concerned response rates. Only 37 respondents of the 143 requests to complete the survey completed it. An additional limitation was that the respondents’ stakeholder group is not clearly evident in the survey responses, although in some cases that could be gleaned from the respondents’ open-ended comments. Although the e-survey had several questions that included scaled response categories, the team opted not to undertake a separate quantitative analysis of the e-survey data as it had hoped, due to the small number of respondents. However, the qualitative comments from the e-survey were added to the compiled responses from the in-depth qualitative interviews to inform our findings for the three main evaluation questions.
IV. FINDINGS

EVALUATION QUESTION 1

HP+ Technical Approach: To what extent have the current mix of HP+ TA and CD approaches, including LTTA, STTA, training, organizational development, M&E, and communications, enabled the achievement of the project’s objectives, and met indicators as outlined in the project PMP and Field Activity PMP?

This evaluation will begin answering Evaluation Question 1 with an examination of the organization, management structure, staffing, and systems of the HP+ Project, and whether these have been optimized to achieve full and successful implementation of HP+ Project activities and objectives. Next, the evaluation will assess the extent to which the TA and CD approaches used by HP+ are proving effective in delivering TA when and where it is needed to achieve high-quality results and promote CD. Finally, the evaluation will share key results, organized by IR, to indicate the progress made to date in achieving project objectives.

A. HP+ Organization, Management Structure, Staff, and Systems

1. How is HP+ Organized?

The HP+ management structure was conceptualized during Palladium’s response to USAID’s RFA for the project. It was modeled on Palladium’s decades of experience managing and implementing GH programs in health policy, and the specific design features of the HP+ project, for example:

- Core funding streams from three Offices in the Global Health Bureau, representing three program areas: FP/RH, HIV/AIDS, and maternal and newborn health (MNH) as well as FS funds from USAID missions from these same programs.
- The integration of partner organizations into a consortium with Palladium, each bringing a specialized technical focus to the project.
- The critical importance of strong USAID collaboration.

HP+ created a management structure tailored to be responsive to both USAID and partner countries’ needs. This overarching management structure has been in place since the beginning of the HP+ CA, but it has adapted to changing needs (e.g., re-establishment of the Technical Leadership Team [TLT]).

While overall management of HP+ resides with the Project Leadership Team (PLT), appropriate layers of technical leads and managing personnel at headquarters (HQ) and in-country comprise a framework of focused and effective project delivery. The organizational chart in Annex X shows the entire HP+ management structure. An overview of this structure is as follows:

- **Project Leadership Team.** HP+ is led by a PLT that includes the project director and four deputies leading FP/RH, HIV, FS, and finance and operations. This five-person team is ultimately responsible for the technical delivery of all core and field activities, the efficient use of U.S. Government funds, and transparent communication and coordination with the USAID AOR team. The PLT works in close collaboration with IR Leads (policy, financing, transparency and accountability, and global leadership), the cross-cutting theme advisors (gender, equity, sustainability, and CD), the monitoring, evaluation, and learning advisor, and
the communications director to ensure high-quality and effective technical delivery. The PLT meets weekly to discuss management needs, activity staffing, USAID priorities, and portfolio updates.

- **Technical Leadership Team.** The TLT, which consists of Palladium and consortium staff, maintains and communicates current guidance, innovations, and cutting-edge approaches to ensure high-quality technical work across the project. Due to its technical expertise, this team is responsible for supporting workplan design. Members of the TLT are critical contributors to core and field activities that have a workplan focus in their area of expertise. The TLT, which was initially formed in Year One but was not active in Year Two, is being reinstated in Year Three in a modified format to more effectively inform workplanning. Through a variety of regular forums—semi-annual HP+ partner meetings, country activity manager/activity manager meetings, quarterly HP+ Partner calls, monthly expanded PLT meetings, and collaborating, learning, and adapting (CLA) working group (WG) meetings—technical leadership from across the project meets quarterly to discuss processes related to workplan development and implementation and to ensure the project’s technical approaches are innovative and responsive to local needs.

- **Country Directors.** HP+ country directors are located in field offices and provide overall technical direction and implementation oversight for country programs. FS programs are supported by U.S.-based country activity managers who are responsible for coordinating all aspects of workplan development and implementation in conjunction with field-based country directors and their teams. HP+’s field work comprises 66 percent of the project funding; as such, HP+ country directors are at the center of supporting country stakeholders and mission requests. HP+ convenes a quarterly country directors’ call with the PLT, providing an opportunity for exchange among and between the country directors as well as a forum for discussion among the full project leadership representing HQ and country offices.

- **“Triangle of Trust.”** HP+ follows Palladium’s “Triangle of Trust” model to ensure high-quality technical execution, effective financial monitoring, and timely operational support for the project. At the project level, this triangle comprises the project director and the deputies for field programs and finance and operations. To ensure agility throughout the entire project, HP+ cascades the model to its field programs, drawing on country directors, operations managers, and country activity managers. The finance and operations team is staffed by full-time experienced managers, assigned to specific countries and core programs. This flexible management structure allows HP+ to easily expand in response to increased FS.

- **Management Meetings.** In addition to the management structures, HP+ is engaged in several regularly scheduled meetings to advance project needs and priorities. These include FP/RH, HIV, FS, and management meetings with the AOR team (monthly). Internally, HP+ convenes country activity manager (field activities)/activity manager (core activities) team meetings (monthly); and CLA WG meetings (quarterly); convenes all-project HP+ breakfast briefings held monthly.

2. **How Well is the HP+ Organizational Structure Meeting Project Objectives?**

In the KIIIs, respondents were asked to comment on whether the current staffing structure was helpful or unhelpful to project implementation, and whether they had suggestions for improvement. As shown below, the responses on these points were mostly favorable across all stakeholder
groups, although there were some useful suggestions on areas for improvement, both on staffing and systems/communication. Below is a summary of findings along with representative examples of KII responses for each major stakeholder group:

**a) AOR Team**

AOR team advisors stated that they were generally pleased with the responsiveness of the HP+ HQ management structure and staff, and with the solid working relationships between HP+ and host country government partners, missions, and NGO implementing partners. For example, AOR team members noted that HP+ management also took positive action to replace a Country Director in Cambodia in close collaboration with the USAID AOR team and mission activity manager. However, AOR team members also suggested a number of specific improvements: involve fewer people in the review process for work products; avoid delays in completion of modeling activities; and give missions ample notice on travel whenever possible.

Comments from the AOR team included:

“HP+ has been very responsive to HIV requests. Sometimes it seems as though there are too many hands in the pot worrying about too many details, which causes delays in work products.”

“Largely good. Happy with staff and HP+ is well positioned to respond. Management is working well for program. There have been specific issues with local staffing where the hiring choice for the Chief of Party was a poor fit. However, HP+ quickly responded and addressed the complaint.”

“Good interactions with HP+ staff. Senior people are fully engaged, and lend support to junior members. Management works well. No issues.”

“HP+ mixes HQ and country office for TA. Staffing in HF is solid. Increasingly, modeling work is being done by Palladium staff instead of Avenir. Not having enough HP+ modeling people available for TA when needed has been frustrating, so the activities have lagged. HP+ does use the field offices when they can.”

“There has been some disconnect between HQ and Country Teams. The AOR provided more guidance, and we’ve seen improvement in the past two years in communication flow.”

“Yes, the management structure has been helpful. I talk often with senior staff at HP+ and they are pretty solid people.”

**b) HP+ Country Offices**

The team found that Country Offices have very good technical staff that are able to handle most of the HP+ TA needs, and who also appreciated that TA is available from HQ when needed to fill gaps. Other stakeholders’ groups (e.g., Palladium, host country partners, missions) confirmed that Country Offices (where they exist) are and ought to be the main “face of HP+” in day-to-day collaborations with local implementing partners. It seemed that host country partners, in particular, appreciated collaborating with Country Office staff because they are available when needed, highly skilled technically, responsive, and speak the language and know the local culture because, for the most part, they are native to the country.

However, a few Country Offices also indicated they were concerned about keeping key staff or had to reduce staff due to reduction of activities (Tanzania), or due to long delays in receiving their USAID funding (Guatemala), or due to the ongoing USAID suspension of engagement with
MOH (Kenya). Several Country Offices also spoke of specific needs for hiring additional staff.\textsuperscript{7} All of these country concerns (Tanzania, Guatemala, Kenya) are related to U.S. Government funding decisions and are beyond the control of HP+.

Comments from Country Offices staff included:

“We have very solid people technically, with broad experience. Also, HQ [is] able to fill gaps. We are also collaborating with other partners on some of our work. Working to harmonize logistics planning with partners on county work.”

“There has been a reduction in staff due to the late delivery of funds. If we were to look for other capacities needed, we would want someone to handle the communications, but we don’t have the resources for it. The technical capacities remain strong, and we are collaborating more with other USAID organizations to leverage additional technical expertise. Expectations for the project are high, so we are trying to do the same level of work with fewer people.”

“We have a good team; there’s individual capacity and skills that complement each other. People outside recognize our experience and capacity of these topics. We can improve integration as a team – we have a common agenda but everyone has specific scopes. We may need to organize better to not duplicate efforts. Some teams may be siloed.”

“Several HP+ country staff are co-located in government or NGO offices. Only the County Director and two other staff work in the office. HQ assistance for analysis and report writing is very helpful. The country office also hires local short-term consultants as needed. However, the workload for the Country Office continues to increase. May need to hire another management assistant to help handle communications with clients and partners.”

c) Donors

Our team found that donors greatly value the work of HP+. Donors spoke highly of HP+ expertise at HQ and at the country level, and of their technical leadership in international conferences. At the country level, local donor representatives characterized HP+ as a leading partner on health policy and financing due to the breadth of their operations and expertise. Donors also seemed to appreciate that the work of HP+ is aimed at achieving common objectives in health policy and financing that they also support.

Typical comments from donors included:

“Excellent team at HQ and country level. Know the country context very well. Know the policy landscape. Great contacts on the ground. Excellent grasp of the local scene.”

“The technical expertise that was on display (at the FP2020 [Family Planning 2020] meeting) in Ghana was very impressive.”

“They are reliable and credible partners in the area of FP Financing. Process of HF reform is so complex with many moving parts. HP+ has been able to contribute enriching discussion.”

“Know their technical expertise through their presentations and publications. Know senior staff well and know their Consortium partners too. HP+ is a respected partner.”

\textsuperscript{7} The team appreciates that needs for additional staffing may be raised when an evaluation team comes to town but such requests need to be made to and considered by the appropriate decision-makers.
“Some of the technical staff used to work for UNICEF. They have a lot of expertise in MCH [maternal and child health]. They have worked very collaboratively, and their technical approaches have been sound. They also are innovative. In their analyses of financing needs for MCH and adolescent health they had good expertise in-country, but also access additional experts from HP+ HQ. They freely share their technical approaches with their United Nations partners and others so that all can benefit from their information.”

“Their resource mapping was helpful. The technical approach is high level, as is their in-country expertise. People like them because they support structures in place. They do work quickly and are responsive.”

d) E-survey

The analysis of the e-survey responses concluded that there were mixed reviews on adequacy of local staff deployment—some respondents are happy with the status quo, while others are calling for more local staff to be hired in-country, with less dependence on HQ for all in-country TA. The team was told by HP+ HQ that the country staffing levels and organization can differ from country to country, depending partly on the size and complexity of the HP+ portfolio and level of USAID buy-in funding. That said, it may be inevitable that local and HQ stakeholders differ in their views on the numbers of local HP+ staffing needed. These are matters that can be and often are discussed during phone/Skype meetings between local and HQ stakeholders and/or during annual country workplan development.

Typical comments included:

“The in-country staff complement could be bolstered with a focal point on sustainable health financing and community engagement.”

“The team hired in my country was very helpful, supportive and always available.”

“We’ve had a few snafus with logistics and planning when countries were selected [for recruitment of local staff] based on HP+ footprint in country.”

“At this point, HP+ has not deployed any local consultants. All assistance has been emanating from HQ. We would like very much to see HP+ engage more local consultants. Also limit home office travel to the country to what is essential.”

“HP+ was fortunate to garner high quality, experienced professionals as its team members as well as its consultants. The project also received excellent technical support from HQ from a number of individuals.”

e) Host Country Partners

In this evaluation, host country partners include government ministries, NGOs, universities, or other local institutions that are either directly involved with HP+ as implementing or collaborating partners, or indirectly involved with HP+, e.g., as interested parties or frequent users of HP+ information or products.

Based on our analysis of the KII data, our team found that the large majority of respondents from host country partners rated HP+ technical expertise and depth very highly. As noted by other stakeholders, there are some Country Offices that may lack technical depth in certain skill areas, but in those cases, host country partners stated that HQ technical assistance was able to
fill those needs. It was also clear that there is high demand for HP+ to transfer skills to host government staff, and much appreciation for HP+ efforts to do so.

Representative comments from host country partners included:

“HP+ technical approaches are excellent, and they have a very high level of technical expertise.”

“Very capable expertise. Not sure about the depth of technical expertise and surge capacity. We may need some TA from HP+/HQ to move forward with the design of the activities.”

“HP+ has a unique combination of skills; technical, practical, with good command of national policy priorities. High technical capacity.”

“HP+ has a high level of capacity in their staff. He has known some of them for a long time, and their support has been timely.”

“HP+ has very deep technical competencies in their disciplines. They also are very responsive to the Host Government, and are careful to engage them at every step of program implementation.”

“The technical approaches and project expertise has been very good. Before HP+ eventually ends, our organization needs more help with capacity-building from HP.”

**B. HP+ Technical Assistance and CD Approaches**

Evaluation Question 1 asks to what extent the mix of TA and CD approaches are helping to achieve project objectives. Based on the analysis of all the evidence, the short answer is that all these technical approaches described below are contributing in significant ways to achieving results.

1. **LTTA:** HP+ has learned by experience that improving national and subnational capacities of partner staff, organizations, governments, and systems calls for methods beyond the traditional default of conducting training events and providing STTA. Seconding technical advisors, i.e., HP+ hiring of full-time advisors to be placed to work in host country partners organizations, is one oft-requested method that supports sustainable, tailored CD to staff and organizational processes while promoting institutional change.

As of November 2018, HP+ has employed the seconding of 23 part-time and full-time technical advisors in six countries (Cambodia, Indonesia, Kenya, Malawi, Mali, and Mozambique). As secondments are customized to each country’s unique context and project objectives, the way these secondments are negotiated and the scope and expectations of each one is different. In a typical scenario, a seconded staff person reports to work at a host organization while employed by HP+.⁸

While the aim of a secondment can be for the host organization to eventually absorb the secondee —and thereby bolster their staff and expertise—if the SOW is properly structured, the secondment itself (whether or not staff are permanently transferred to the host) may have benefits at individual, institutional, and systemic levels. HP+ strives for secondees to fulfill technical expertise needs at the targeted organization and strengthen staff competencies and organizational norms and systems as they work.

In Kenya, HP+ is seconding economists to six county governments to support planning and budgeting processes, working closely with the counties to ensure they create permanent

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⁸ Communication from Suneeta Sharma (Palladium/HP+), November 21, 2018.
positions for the secondees after one year. HP+ has negotiated and signed memoranda of understanding with the counties to ensure clarity and understanding in the limits of HP+ support, and counties have pledged to allocate funding and create these new positions within the counties’ teams.

2. **STTA**: For field activities, the team learned that TA requirements normally are determined during the preparation of annual workplans, after consultations with missions, host country partners, and HQ. HP+’s default standard is to use field-based technical staff and local consultants, except in cases where fully qualified candidates are not available in the local labor force. In addition, most missions and host country partners confirmed that they also prefer local TA because local staff know the country context better and are less costly. This rationale also contributes to long-term sustainability—fostering the advancement of local solutions to local issues. HP+ is increasingly deploying HP+ country staff to provide TA to other HP+ countries, based on their expertise and experience working in country- and culture-specific contexts, thereby promoting and supporting south-to-south TA. However, if additional and/or specific expertise is needed, US-based TA is mobilized.

Overall, Country Offices are the largest provider of TA in HP+, accounting for 60 percent of the level of effort (LOE) for TA in the past 12 months. HP+ HQ provides STTA for filling expertise gaps and/or providing surge capacity in specific technical areas (e.g., HF, models); Palladium HQ currently provides 29 percent of the LOE for TA, with the remaining 11 percent of TA being provided by consortium partners and consultants.  

3. **Other CD Approaches**: In addition to LTTA and STTA, the team found that HP+ uses multiple approaches to CD, including: conducting workshops, training local trainers, co-creating and sharing tools and models, and south-to-south learning. CD is happening in many areas of work, but the team feels more CD inputs are needed, especially in countries that are decentralizing healthcare funding and management. For more discussion of results achieved by HP+ on CD, see Section D below, Achievements in Addressing Cross-Cutting Principles.

**C. HP+ Key Results Achieved by IR**

HP+ activities and results are measured through advances in the following areas, which correspond to the four main IRs and corresponding sub-results from the HP+ results framework: (IR-1) health policy; (IR-2) sustainable financing; (IR-3) stewardship, transparency, and accountability; and (IR-4) global leadership and advocacy. To date, the project has implemented core and field activities in 42 countries; collaborated with 626 government, development, nongovernmental, and civil society organizations (CSOs).

Results reported herein come from a variety of sources, including the Palladium/HP+ Midterm Self-Assessment, HP+ Semi Annual Reports, Palladium written responses to specific questions posed by the evaluation team, data from the HP+ results database, compiled responses from our in-depth KII s, and e-survey responses.

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9 HP+ Midterm Self-Assessment, Palladium, August 2018, Table 4.  
10 See Annex IX: HP+ Results Framework.  
11 See HP+ Midterm Self-Assessment, p. 6.
Result 1: Health policies are developed, adopted, implemented, and monitored that improve equity, access, availability, affordability, and acceptability of quality health services, supplies, and information.

Laws and policies, and their implementation, provide the foundation for enabling equitable health service coverage and quality, especially among underserved and vulnerable populations. They also obligate resources and actions, regulate the quality of services across sectors (public and private), and help to ensure continuity of health programs, even as individual political leadership ebbs and flows. HP+ facilitates inclusive, country-led policymaking that values diverse voices and legitimizes difficult strategic choices through deliberative, evidence-based, and transparent processes. Working with partners to assess the needs of each country at the national and subnational levels, HP+ informs policy and resource mobilization decision-making processes and addresses operational barriers to policy reform and implementation along the way.

Since 2015, HP+ has facilitated the design, adoption, and/or implementation of 65 health policies, plans, and laws/regulations. The examples given below under each sub-IR testify not only to the impressive results achieved, but also to the country-led, collaborative approach that facilitates country ownership of the process and results.

Sub-IR 1.1: Individual and institutional capacity to develop, implement, monitor, and evaluate legal and regulatory frameworks, macro-level policies, and operational policies is strengthened.

Jamaica: HP+ has created an enabling environment for moving forward with important new policies. The project has also engaged well at the facility level to improve local capacity and the standards of care. There has been excellent work on stigma and discrimination (S&D), including improving the capacity of NGOs to engage in S&D activities. HP+ has provided excellent advice on needs for policy change and facilitated processes for making those policy changes.

Kenya: The suspension of activity with the MOH for nearly two years halted most HP+ work with the national-level MOH. Before that suspension, HP+ was working on health planning and financing reform with the MOH to increase its focus on universal primary healthcare, preventive primary healthcare, preventive vs. curative care, strategic planning, and evidence-driven decision-making. Under the suspension, HP+/Kenya focused mostly on its substantial policy development and capacity-building work at the county level, and in collaboration with other implementing partners. Fortunately, this suspension was lifted as of November 8, 2018.

Madagascar: HP+ helped the MOH develop their National Health Strategy for community health, and to implement the strategy. Madagascar signed on to FP2020, and honoring its commitments is a priority of MOH and USAID. For example, HP+ was very engaged with the MOH and other partners in an 18-month effort to help update Madagascar’s FP/RH law in line with its FP2020 commitments. USAID was pleased that the old law from 1920 was replaced by a new law. HP+ also engaged with many partners and worked together to put universal health coverage (UHC) in place in Madagascar, and advocated for necessary budget resources to ensure adequate support for the most vulnerable populations.

Malawi: HP+ country office staff reported that all their work is aligned with country and mission priorities and strategies. For example, HP+ worked on monitoring and reporting on the country’s achievement of the millennium development goals and setting its sustainable
development goals. The country office also recruited a Ugandan economist to guide the formulation and help write sections of the midterm growth and development strategy (MGDS III), 2017-2022, which integrates population considerations. HP+ contributed text and annexes to the MGDS II as well. The work of HP+ on this strategy has been so useful that the Government of Malawi is now looking to HP+ to assist in preparing its new population policy.

HP+ has helped in the development of the health information system (HIS) strategy, policy development, and research for the national health policy, and annual reports on health.

HP+ assisted a team at the MOH to produce a Condom Strategy, and organized workshops to review the strategy and prepared a final draft. HP+ helped the MOH present the strategy to MOH senior management for final approval. HP+ is working with CSOs to disseminate the new policy in zones and districts. HP+ is also assisting with the M&E component, and has helped follow through with action plans to implement the new policy. The MOH team is very satisfied with HP+’s work. This example illustrates that HP+ provides assistance at all stages of the policy development process, from conceptualization through implementation.

Togo: HP+ helped the MOH with revision of the current strategic plan for FP, and is working with them on a new FP strategic plan that will guide the government in their efforts to further improve access to quality voluntary FP services, and build on recent increases in contraceptive prevalence rates. HP+ assistance with these strategic plans has been MOH-led, and is improving MOH capacity to develop and implement sound strategic plans.

Sub-IR 1.2: Sustainable policies and strategies that address health equity, support non-discrimination and human rights for poor, marginalized, and vulnerable populations are developed, adopted, implemented, and monitored.

Jamaica: HP+ worked on the national HIV/AIDS policy for Jamaica. HP+ has helped Jamaica significantly, through work on the positive health, dignity, and prevention (PHDP) training on leadership for people living with AIDS, technical support, training of healthcare providers, and gender-based violence (GBV). They have helped the Jamaican government in terms of test and treatment, toward the 90-90-90 targets.

HP+ tries to be responsive to priorities the mission identifies. Major accomplishments include helping to develop the National Strategic Plan for HIV and FP. HP+ has done extensive work on community health through building capacity of NGOs to support people living with HIV and key populations. HP+ also has been the lead partner working on S&D training for healthcare workers, aiming for a total facility approach. So far about 320 have received the training.

Kenya: One goal of HP+ work in Kenya is to increase access to health services. For example, Linda Mama is a Government of Kenya program that HP+ supports. It aims to reduce maternal mortality by providing every pregnant woman with an insurance card she can use for up to one year after birth. As a result, access to an improved package of maternal and neonatal healthcare has expanded, regardless of women’s ability to pay. Linda Mama achieves both equity and access objectives. HP+ provided assistance to Kenya’s MOH and the National Health Insurance Fund to redesign the program and to cost the benefits package, ensuring that the government allocated adequate resources. Results from that analysis informed the program’s reimbursement rates for faith-based and private sector facilities. HP+ will continue providing implementation support for this program.
Malawi: There have been many HP+ results, including successful advocacy for an FP line item in the Malawi budget from 2013 onward, which has increased to $82 million in 2018 to 2019; funding thematic review meetings and a symposium on youth; and helping to draft the Youth Friendly Health Services Strategy to extend better access to FP, HIV prevention, and other services.

Mali: The workplan is based on national government priorities. HP+ wants government partners to address high-impact activities. HP+ already has done good work in advocacy and completion of a costed implementation plans (CIP) for FP in Mali. HP+ also is working with Mali on strategies to improve the sustainability of investments in Mali's FP program. In addition, they are working to help the MOH develop related policies that will support these strategies. Currently, top health priorities include ending forced marriages and creation of more FP demand through introduction of new FP methods (especially Sayana Press).

West Africa: HP+ work is very much aligned with the priorities of countries in the region. For example, HP+ is assisting countries to reform RH laws to improve access to FP. HP+ has facilitated formulation of CIP in many countries to guide their allocation of domestic resources for FP/RH services. FP is now gaining more acceptance in West Africa: For example, the contraceptive prevalence rate is 30 percent in Burkina Faso and 24 percent in Senegal, nearly doubling over the past decade (World Bank tables). HP+ has been working on task-sharing to allow community health workers (CHWs) to deliver Depo-Provera at the community level. Togo was the pilot project, and Cote d'Ivoire plans to initiate a pilot test soon. If these go well, HP+ will help plan for ramping up these programs. Per the Dakar Declaration, HP+ is urging government leaders to improve HIV outreach to key populations, and also advocating for community-based delivery of MCH services and antiretroviral (ARV) drugs.

Sub-IR 1.3: Individual and institutional capacity to effectively advocate for health policies is strengthened.

Guatemala: FP funding appropriations and programs are culturally sensitive and carry certain political risk among conservative members of Guatemalan Congress. The Health and Education Policy+ (HEP+; i.e., the HP+ office in Guatemala)12 has been extremely helpful with models and tools for advocacy and making the case for investment in FP. These have been most helpful in keeping the program moving forward. HEP+ also has helped the ministry of public health to apply knowledge to make policy based on evidence, and develop tools for monitoring performance and impact.

Regarding access of youth to FP/RH, HEP+ efforts are tied to the priority to reduce teen pregnancies and sexual violence. Not everyone favors allowing teens to access FP/RH services. HEP+ led efforts to gain support by showing an analysis of the legal rights and needs of youth. Now the MOH has official policy guidelines. On another issue, HEP+ developed guidelines for the best use of beverage tax funds for FP commodities and better procurement mechanisms. HEP+ has been key in developing policy. Their work with civil societies is a model,13 and the mission is very satisfied because the CSOs have contributed to important proposals and changes.

12 The HP+ program in Guatemala includes a component that is supported with USAID/Guatemala funding from the education account. As a result, the Country Office in Guatemala is referred to as HEP+.

13 Harry E. Cross, Marisela De La Cruz, and Juan Dent “Government Stewardship and Primary Health Care in Guatemala since 1996,” Public Administration and Development (John Wiley and Sons), July 2018. Also see “Empowering CSO Champions for Health: Spotlight on Guatemala” underneath Sub-IR 3.3 (p.
of law. For example, with HEP+ support, a law was passed to increase the age of marriage, partly due to Observatorio en Salud Sexual y Reproductiva (Reproductive Health Observatories or OSAR) constantly putting data in front of lawmakers until they act. OSAR was also involved in the immunization law. Currently, the Red Nacional de Hombres is working on a paternity leave policy. However, the sustainability of this work by CSOs in Guatemala is a challenge, due to recent reductions in funding.

Malawi: HP+ is helping the MOH to implement the CIP for FP. It is working in four districts (Mchinji, Machinga, Nkhata Bay, and Lilongwe) to align program activities for the implementation of the CIP. HP+ also trained 61 civil society representatives in a budget advocacy workshop. It is working on an initiative to equip and train religious leaders to advocate for FP/RH.

Mali: HP+ collaborated with the Health and Social Development Committee of the National Assembly and the Association of Municipalities of Mali to facilitate an advocacy session to sensitize key decision-makers on the importance of increased investment in CHWs for sustainability. Advocacy recommendations were based on findings from a series of HP+ costing studies.

Sub-IR 1.4: Multi-sectoral policies with a focus on the integral links between FP/RH, health and other development sectors, are developed, adopted, implemented, and monitored.

Guatemala: The “E” in Health and Education Policy+ stands for education because HEP+ works on multisectoral policy activities that cut across the health and education sectors. A good example is HEP+ work with the ministry of education on providing comprehensive sexual education, including sexual and RH, FP methods, information given to adolescents to prevent pregnancies of children under 14, etc. There is a technical oversight group on how to work with adolescents on GBV. The ministry is monitoring programs and did the baseline and intervention with technical support from HEP+.

HEP+ has contributed to many priority programs in the MOH. For example, MCH and maternal health have improved partly because HEP+ has highlighted the problems in these areas and stirred the government to action. Policies are not enough, however; policies need to be implemented fully and successfully. To that end, HEP+ helped form a multi-sectoral coordinating committee to help push the action forward.

Kenya: HP+ work is aligned with Kenya’s national agenda: Vision 2030: The “Big Four” of the Kenyan President (UHC, manufacturing, affordable housing, food security). HP+ helped with a five-year development plan that includes budget review and projections, sector reports, fiscal strategy (medium-term expenditure framework), and costing. HP+ also is assisting counties with integrated development plans, annual development plans, and budget planning. Counties must have an integrated plan tied to national agenda.

HP+ helped design the County Integrated Development Plan. HP+ also organized a public/private forum to plan how to operationalize UHC.

Malawi: According to a host country partner, HP+ has done important work in policy development, notably, a National Condom Strategy. HP+ is working to empower districts to manage the condom supply chain, and there are quarterly meetings to coordinate condom supplies. Unfortunately, Malawi recently had a condom stockout created by an unplanned drawdown of
condoms without proper coordination. HP+ has been redoubling efforts to coordinate with all condom providers to plan for and meet their condom needs.

HP+ is contributing to policy development in programs aimed at reducing child mortality and unwanted fertility. HP+ was responsible for the topic of population and development featured in the Medium-Term Development Strategy. The government leads the policy process, but HP+ has an opportunity to help shape policies and their implementation. HP+ is active with the parliamentary caucus on population and development. It is also active with the Malawi Network of AIDS Service Organisations (MANASO), civil society, and faith-based organizations.

Result 2: Sustainable, predictable, and adequate financing for programs and health policy implementation is increased.

By the midterm of the project, HP+ built an impressive staff capacity in health economics and financing at HQ and in the Country Offices. It deployed that capacity strategically to respond to countries’ requests for TA to improve the sustainability, equity, and efficiency of their health services sectors, with a focus on FP and HIV. Missions’ requests for HF assistance on behalf of countries have outstripped expectations. Given the wide range of issues competently addressed by the HF team globally, HP+ is well positioned to take on the future challenges that development assistance in HF will present.

Sub-IR 2.1: Domestic resources for health services, supplies, and delivery systems are increased.

Through a combination of STTA and training of CSOs, HP+ enabled local organizations to use evidence in their advocacy efforts to increase health sector budget allocations and/or budget execution at national and subnational levels of government. In the majority of cases identified, the allocations affected were for specific program budgets, namely FP and HIV/AIDS, and line items within those program budgets, namely commodities (contraceptives and ARVs). At the national level, this was the case in Burkina Faso (2017–2018), Kenya (2017–2018), and Tanzania (2016–2017). In Tanzania, line item budgets for essential commodities and medicines also increased. In Nigeria, line items increased for staff training and CIP implementation (2017) in three state budgets; in the following year, in these same states, budget line items for FP increased again by far larger amounts.

Burkina Faso: The government repositioned FP as a national priority via the adoption of the National Health Development Plan 2011–2020. This national priority did not translate into a concrete budgetary commitment until key health sector stakeholders, assisted by HP+, undertook focused actions to make it so (namely, the West African Health Organization’s Network of Champions, Agir PF, United Nations Population Fund, and the Ouagadougou Partnership). HP+ built the capacity of NGOs, FP networks, and national “champions” to make their case to government officials and parliamentarians to increase funding for FP. The culmination of these advocacy efforts occurred in September 2017, when the president of Burkina Faso increased the FY 2018 budget for purchasing contraceptives from 500 million to 1.3 billion CFA (from $860,000 to $2,236,000).

Kenya: At the county level, where direct HP+ TA has concentrated its efforts since the state department suspended USAID’s work at the national government level, overall health sector budget allocations increased in 26 counties. HP+ provided STTA and training in program-based budgeting (PBB) to county health directors, staff, and “champion” advocates (see Result 2.2). County health officials in turn, are using the PBB methodology to make evidence-based cases to
budgetary authorities to increase county health budgets. In at least one county, health officials are also using PBB to reallocate their budgets to improve internal efficiencies and reallocate resources to more productive uses (see Result 2.1.3). The sharing of best practices among the 26 HP+-assisted county health departments is likely to spread the uptake of this practice elsewhere in the counties.

Kenya: In 2018, Nyeri County, one of the 26 counties assisted by HP+, the county’s health management team (CHMT) applied evidence to improve operational efficiency and use the resulting savings to fund essential services delivery. The evidence used by the CHMT came from previously produced public expenditure reviews that HP+ had assisted counties to produce, through STTA and training in PBB (see Sub-IR 2.1). Specifically, the CHMT reduced funding for wages, the largest budget category in most of the health sectors, by switching medical staff to contracts. Not only did this reduce expenditures on wages, but it also increased their productivity by deploying them to areas where services demand was the greatest.

Kenya and Mozambique: In both countries, HP+ provided STTA to the governments to develop and submit successful GF applications (2018 to 2020). In Kenya, HP+ assisted the MOH to secure three years of medicines and drugs. In Mozambique, HP+ provided cost estimates of “test and start” scale up to develop the HIV section of the GF submission.

In 2017, in Mozambique, HP+ produced a costing analysis and worked with MOH staff to develop an “investment case” demonstrating the benefits of increasing reproductive, maternal, neonatal, child and adolescent health services. Based on the merits of the case made, the World Bank approved $105 million in non-reimbursable grants to strengthen the government’s primary healthcare program.

Malawi: HP+ seconded a senior staff to the Ministry of Finance to provide long-term technical support to the government to apply for GF grants and provide guidance in the use of awards. In January 2018, the GF and the Government of Malawi signed three-year (2018–2022) grant agreements for $525 million to address HIV, TB, and malaria.

Mali: In 2018, HP+ collaborated with partners in the national assembly and the Association of Municipalities of Mali to host an advocacy session to promote domestic resource mobilization (DRM) to extend essential community healthcare (SEC). In the rural, underserved areas of the country, SEC is delivered by CHWs, a cadre which historically has been supported by donors, rather than by either the national or local governments. Some 132 Malian decision-makers attended the advocacy session, reflecting their awareness of the importance of identifying sustainable financing for CHWs in the face of declining donor support.

To date, there has been no national budgetary allocation to support CHWs. The sensitization of decision-makers to what is at stake and an understanding of their choices is a precondition to their making the budgetary decision, but not a guarantee that they will. Nonetheless, HP+-assisted advocacy efforts have resulted in 150 mayors signing commitments to use local resources to implement SEC in their municipalities. HP+ has since continued its STTA to support advocacy for financially supporting SEC expansion through CHWs by producing an advocacy tool available through its website.

Nigeria: HP+ training and TA realized budgetary results in Bauchi, Sokoto, and Ebonyi states. In 2017–2018, HP+ helped establish and then trained family planning advocacy working groups.
(FPAWGs) in advocacy, accountability, and finance for key FP initiatives, including staff training and CIP implementation in these states; training in leadership was also given to selected women. FPAWG members were drawn from a wide swath of groups, including academia, state government and civil society, religious groups, and the media. Together, the groups developed and implemented advocacy workplans aimed at increasing funding for FP in their respective states.

With HP+ support in each state, in 2018, the FPAWGs successfully influenced government authorities to establish FP budget line items and increase FP appropriations. Going forward, without HP+ support, the FPAWGs are continuing their advocacy efforts, developing new workplans to expand FP programs and their funding.

Tanzania: Prior to the Parliament acting to increase budgetary allocations for essential commodities and medicines in 2016, HP+ provided significant STTA to generate evidence for budget advocacy and to bring together international donors and other partners to formulate a budget advocacy strategy for DRM. HP+ also facilitated meetings between CSOs and parliamentary committees for this same purpose. Such advocacy was consequential in increasing line-item allocations in the 2016–2017 budget by $59 million for the purchase of ARVs, essential commodities, and medicines. In preparation for the 2017–2018 budget, HP+ again coordinated budget advocacy "asks" among partners.

Sub-IR 2.2: Individual and institutional capacity to efficiently and effectively prioritize, deploy, and manage resources for health services and supplies is strengthened.

In consultation with missions and host countries, HP+ was able to identify and target assistance to key areas of countries’ health program operations that are critical to expanding and increasing the efficiency and effectiveness of their domestic resource allocations. HP+ targeted such assistance to county governments in Kenya; to the national health insurance programs in Indonesia and Mali; and to 13 different public and private organizations throughout West Africa.

Kenya: The Financial Management Act requires the use of the PBB methodology by public sector program managers and financial analysts yet offered no practical means to put it into practice. Particularly at county levels, capacity was weak to non-existent when the act was put in place. The HP+ Country Office recognized this weakness as an important impediment in pursuit of DRM in the health sector, and ultimately UHC, one of the president of Kenya’s "Big Four" agenda items.

HP+ addressed this lack of capacity in counties by partnering with the Kenya School of Government, a public institution charged with upgrading the skills of public sector employees, to produce a PBB curriculum and manual. HP+ and school staff and consultants phased in introducing these materials to 26 counties. They designed and conducted PBB workshops for the training of trainers (ToT) in the 26 HP+-assisted counties, emphasizing planning, budgeting and advocacy approaches that increase domestic resources for health, prioritizing HIV/AIDS as a subprogram. Following the ToTs, HP+ provided STTA support for the training of county health department directors, staff, and advocacy champions.

The combination of STTA, ToT, training of county officials and champions, and funding for the training resulted in an increase from 23.4 percent to 27 percent in the overall percentage of budgetary allocations made to health programs across the 26 counties in two years and the
creation of a line item for HIV/AIDS programs in those budgets. In one year, 26 counties doubled their allocations to HIV/AIDS programs from $2 to $4 million. Training using the PBB manual and curriculum is being extended to additional counties through other implementing partners and adopted by the National Treasury.

Using evidence generated by HP+ and contained in each county's health accounts, health departments prepared the health sections of their respective county's integrated development plan for 2018–2022, which prioritized allocations and spending over this five-year period.

Indonesia: The HP+ team partnered with the National Team for the Acceleration of Poverty Reduction (TNP2K) to conduct a comprehensive assessment of the national health insurance, Jaminan Kesehatan Nasional (National Health Insurance, Indonesia; JKN). The assessment was a key part of the Government of Indonesia's effort to extend financially sustainable coverage nationally. HP+ provided the tools and analytics for this assessment, and technical advisors to work with TNP2K staff and be physically present while the work was being done. HP+ technical experts were not seconded to TNP2K, but worked in TNP2K offices for months.

HP+ customized a computer-based tool for this assessment to achieve a primary objective of generating alternatives to present to the ministry of finance for plugging JKN's ongoing financial deficit and enabling an expansion to be financially sustainable. While capacity-building of TNP2K staff was not an objective of the assessment, the support and technical assistance that HP+ provided resulted in doing just that. At the conclusion of the assessment, the TNP2K staff alone presented the findings to the ministry of finance. Later, these staff conducted further analyses using the model and presented these findings at the annual meeting and international conference of the Indonesian Health Economics Association.

Mali: In 2017, with STTA and financial support from HP+, Mali's National Health Insurance Fund (CANAM) developed an operational plan to extend provision of obligatory health insurance (Assurance Maladie Obligatoire or AMO) to community health centers (CSCom). This extension supports the Government of Mali's goal of scaling up health services at the community level in a financially sustainable way while also minimizing out of pocket expenses for Malians using these services.

Only 4 percent of Mali's 979 CSComs offer AMO services despite CANAM's efforts. Current enrollees are primarily drawn from the government's workforce and formal sector employees, located in Bamako. HP+ facilitated working meetings with key stakeholders, including CANAM and the National Federation of Community Health Associations, to identify the challenges and alternative ways to strengthen and expand AMO coverage in the CSComs. HP+ produced a working paper that served to guide stakeholders to assess AMO implementation, identify weaknesses, and formulate an action plan to re-launch AMO in the CSComs. HP+ supported the stakeholders to develop a strategy toward this end with specific intervention areas, a short-to long-term timetable and a budget. HP+ also developed tools for local agents to administer AMO benefits in CSComs.

West Africa: In 2017, HP+ HQ organized a regional meeting in Sub-Sahara Africa to advance strategic, country-led financing solutions for FP. In January 2018, stakeholders from 13 national level governments, civil society, the private sector, USAID, and other development partner organizations met for five days in Accra, Ghana, to share country experiences and learn about
effective approaches and tools. HP+ technical advisors participated in discussions about ways to quantify need, mobilize resources, and engage the private sector. Country representatives left the meeting with specific action plans to finance FP programs, reflecting their strengthened capacity to analyze and use data.

**Sub-IR 2.3: Optimal range of public and private financing markets and mechanisms is developed and utilized.**

HP+ has appropriately deployed public and private sector financing experts to assist missions and countries to expand overall fiscal space, allocative efficiency, and health program coverage. HP+ has responded to requests to rationalize the commercial sectors’ participation in the sales and distribution of health products and services in demand and to governments’ embrace of decentralization reforms to expand transparency and citizen participation at regional and local levels.

Guatemala: In 2017, the president of the country approved the National Decentralization Agenda, operationalizing an economy wide law that had been enacted years beforehand. The HEP+ country office took the initiative to advocate for this agenda to the president. HEP+ staff then produced for the Government of Guatemala the key document that now specifies the actions needed to operationalize it, namely, by promoting local development, resource efficiency, citizen participation, and transparency.

HEP+ supported the Ministry of Public Health and Social Assistance to comply with a new procurement law by updating its guidelines to be more efficient and transparent in the procurement choices it makes among international vendors.

Malawi, Uganda and Nepal: HP+ applied the Total Market Approach (TMA) through STTA to expand access to FP commodities in the private sector in these countries. In Malawi, HP+ worked with the MOH to develop the National Condom Strategy, emphasizing the TMA; the MOH adopted the strategy in 2017. In Uganda (2017) and Nepal (2018), HP+ applied the TMA projection tool to inform the countries about the size and potential of their commercial sectors for selling FP commodities and to assist them in goal setting.

**Result 3: Policy environment for public stewardship, accountability, and transparency is improved.**

Analysis of the evidence showed that HP+ works with government partners to improve stewardship, accountability, and transparency. Much of this work entails health systems strengthening and policy reform strategies that improve efficiency and strengthen democracy. By helping put strong structures and processes in place, HP+ helps local governments take on new responsibilities and give citizens a greater opportunity to influence health and development policy decisions.

**Sub-IR 3.1: Policies and regulatory frameworks that support accountable and transparent stewardship for health are developed, adopted, implemented, and monitored.**

Guatemala, Madagascar, and Pakistan: HP+ promoted health sector reform by conducting legal and political environment analysis to identify obstacles and opportunities in planning.

Malawi: HP+ has made impacts on governance and policy leadership by working on several government WGs, including the Population and Development WG, Key Populations WG, Hip Condoms WG, HIV Prevention WG, and Women Leaders WG.
HP+ played an important role on the MOH’s Youth Friendly Health Strategy, which has resulted in youth having better access to FP services and commodities. HP+ is also helping develop an action plan to ensure that the strategy is being implemented. FP now has a line item in the MOH budget for commodities, and several host country partners stated that this likely would not have occurred without the efforts of HP+.

**Sub-IR 3.2: Local leaders and technical experts in public and private institutions employ effective and transparent management and monitoring of health budgets and systems.**

E-survey Respondent: HP+ is a great support for capacity-building and technical learning in advocacy and leadership skills. Their leadership workshops are worth participating in.

Ghana, Jamaica, and Tanzania: Improved the HIV treatment cascade by using adaptable tools to conduct baseline assessments, design facility-based S&D reduction interventions, and develop S&D reduction plans with a newly developed end-line assessment to evaluate progress based on data.

Guatemala: An NGO provider of FP/RH services stated that HP+ has worked with his organization at the national- and department levels, providing TA and sharing models and tools for advocating for improved FP services. HP+ works on interagency committees relating to FP. Perhaps the most important work of HP+ is the TA with use of a tool for monitoring of insurance for FP, which resulted in enhancing commitment, increasing the reach of the program, improving the information, education, and communication materials, and leading to increased use of FP. Improved data allow his organization to follow-up on further data and act based on indicators.

Guatemala: HP+ has given TA and logistic support, especially on development of a management information system to track performance indicators. HP+ has applied specialized knowledge to help solve issues when the ministry is implementing systems specifically for development of information systems.

Guatemala, Kenya, Malawi, and Pakistan: HP+ supported government decentralization by translating national policies for devolution of health services into actionable regional- and county-level implementation plans. These implementation plans helped clarify what roles, responsibilities, and budgets would remain at the federal level of the MOH, and what would devolve to the province, state, or county level.

**Sub-IR 3.3: Civil society is empowered and engaged in participatory processes for policy advocacy, implementation, monitoring, reform, and fiduciary transparency.**

Guatemala: HP+ is a pioneer in engaging and equipping CSO partners to do effective advocacy monitoring of program performance and budget expenditures information to hold government officials at all levels accountable (see “Empowering CSO Champions for Health: Spotlight on Guatemala” below).

With HP+ technical and financial support, CSO networks have worked on the national level with the MOH and Secretary of Nutrition, Congress, the Network of Indigenous Women, etc. OSAR worked to raise the age of marriage. There have been changes in healthcare services—for example, they are motivating indigenous women to give birth at facilities to reduce maternal mortality. Monitoring showed an increase in births at facilities due to a change in how the MOH is providing counseling.
HEP+ also engages in dialogue with committees in the Congress on health needs for indigenous people and for children. HEP+ also has improved networks using performance monitoring data to exert pressure at all levels of government to get results. The various CSO networks also help each other be more effective. For example, the ALIMISAR requested a report on marriages in Guatemala, and the men’s network had the report and shared it with ALIMISAR. HEP+ also worked for improvement in the proper use of micronutrients for infants, which had an impact on reducing infant mortality. This led to an increase in resources for micronutrients due to local advocacy by the CSO networks.

Guatemala, Mali, Nigeria, Pakistan, Uganda, and West Africa: HP+ has strengthened the capacity of civil society in these countries to track commitments and hold governments accountable for resource allocation and policy implementation.

Result 4. Sustainable development goals are advanced through global leadership and advocacy.

Effective leadership and advocacy empower countries to translate their commitments to global health priorities—such as the sustainable development goals, Joint United Nations Programme on HIV/AIDS’ (UNAIDS)’ 90-90-90 goals, preventing child and maternal deaths, and FP2020—into actionable policies and programs. HP+ helps translate global initiative goals into national-level planning and implementation, and ensure that local solutions feed into global policy dialogue. The project aids local stakeholders in generating essential evidence, effectively planning for policy implementation, advocating for domestic resources and political commitment, and pushing accountability to promote the structures and practices for domesticating global commitments and more effective management of health resources. Additionally, HP+ promotes and strengthens the global thought leadership and advocacy agenda for equitable, sustainable health policies at all levels of government.
Sub-IR 4.1: Best practices in health policy, financing, and governance are advanced.

HP+ has contributed to the global knowledge base by documenting and sharing best practices and lessons learned: Twenty-seven peer-reviewed journal articles have been produced, more than 63,000 project publications have been downloaded through the HP+ website, and HP+ actively participates in global forums.

HP+ participated in the October 2017 World Health Organization (WHO) Symposium on Financing for Universal Health Coverage, an invite-only meeting that engages health and finance authorities on best practices to design and implement HF strategies geared toward attaining UHC.

HP+ played a key role in the three 2017 to 2018 regional FP2020 focal point workshops, presenting to country teams on best practices in CIP execution and rights-based FP.

Guatemala: With HEP+ support, CSO networks advocated to reduce youth pregnancies, and reduce GBV against women and girls. They encourage/teach youth to form a “Life Plan” that includes education, a good way to decrease pregnancies among youth. The networks are also teaching young people about their right not to be sexually violated, and what this means. This extends to sex education for young people, taught by a young person in their own village, using the local language (not Spanish). This is much needed since they reported that last year alone, 13 young girls committed suicide in the municipality because they became pregnant.

HEP+ has helped CSOs look for pertinent ways to advance a new cultural perspective on masculinities and women’s rights, and show the negative consequences of traditional negative/harmful behaviors toward women.

Malawi: Consortium partner WRA is having a big impact on advancing respectful maternity care in Malawi: It established a Safe Motherhood Committee in Ministry of Health and Population (MoHP) and a technical working group (TWG), and sought policy to formally recognize midwives as a profession in Malawi, starting with their roles in hospitals and eventually extending elsewhere. This move recognizes midwives as the core providers of maternal care and reproductive care in the country. WRA conducted the first baseline survey of midwives to find out the numbers of those practicing. Then WRA did advocacy work through using this baseline survey.

Sub-IR 4.2: The evidence-base for decision-making in health services, supplies, and delivery systems is strengthened.

HP+ participated in the November 2017 Marshalling the Evidence for Health Governance WG, which is jointly led by USAID and WHO. HP+ served as co-chair of the TWG for policy and regulation and presented its work on “Do Better Laws and Regulations Promote Universal Health Coverage?”

HP+ has developed customizable models, tools, and curricula for stakeholders to strengthen skills and answer pressing policy and program questions in their contexts, including One Health, RAPID, and DemDiv that generate evidence to demonstrate how health investments help nations achieve development goals.¹⁴

¹⁴ See Annex XI for more information on these models and tools.
HP+ West Africa collaborated with the Ouagadougou Partnership though organizing sessions at their annual meetings on the 2017 Economic Community of West African States Task Shifting declaration, engaging religious leaders on FP, and strengthening capacity of youth to advocate for CIP funding for youth program efforts.

Malawi: HP+ does grassroots work with districts trying to empower youth in communities to understand policies. Government creates policies and the communities can do advocacy to hold the government accountable. A CSO youth leader stated that she appreciated the fact that the HP+ approach is evidence-based programming. Their efforts in supporting youth are creating leaders for tomorrow. HP+ also is advancing efforts for HIV prevention among youth. HP+ helped draft a Youth Friendly Health Services Policy, and has helped the civil society sector get engaged in support of health services. HP+ forged closer collaboration with the Christian Health Association of Malawi, and enlisted their support for advocacy on behalf of MCH, HIV, and FP/RH programming.

Sub-IR 4.3: Global advocacy agendas for equitable and sustainable health policy implementation are advanced.

Malawi: HP+ has had a productive collaboration with the Family Planning Association of Malawi, the leading NGO provider of FP in Malawi. For example, HP+ (through partner PRB): worked on an activity for radio broadcasts on population growth and advocacy for FP; worked with religious and traditional leaders (tribal chiefs) to gain support for birth spacing; held Members of Parliament accountable for spending allocated funds for FP; did a presentation of DemDiv model to a youth network; and completed a CIP for FP.

Malawi, Nigeria, Pakistan, and Uganda: HP+ is strengthening the capacity of civil society, including women leaders, to promote government accountability for their FP2020 commitments and their full implementation to improve access to and quality of FP services.

HP+ is contributing to global agenda-setting through active participation and support for the efforts of the U.S. Government Pediatric and Adolescent Care and Treatment TWG to advance new approaches and a USAID and WHO-led WG on HF and universal health access.

Togo: HP+ is engaging in advocacy with government to increase its contributions for FP. HP+ also worked with civil society (e.g., religious leaders) to mobilize their support for FP. HP+ has worked with other partners to educate religious leaders that proper birth spacing is a necessary health measure for mothers, and FP is not abortion.

D. Achievements in Addressing Cross-Cutting Principles
The HP+ Project SOW identifies four cross-cutting principles that are meant to be at the heart of the project’s mandate: gender equality, health equity, CD, and sustainability. Each of these cross-cutting principles deals with issues that affect health outcomes and access to healthcare, based on a complex set of cultural beliefs and traditions, gender relations, economic inequalities, and resources and power dynamics that influence the priorities and capacities of actors across the health system. USAID has chosen not to allocate any funding to address each of these four issues head-on; rather, it sees these as issues that should be considered and integrated into the activities of HP+.

HP+’s approach has been to institutionalize all four themes into planning, implementation, and results by:

- Appointing a technical lead for each of the cross-cutting themes to provide technical leadership
• Requiring all core- and field workplans include a description of how each theme is being integrated or addressed
• Advancing specific topics through design and use of innovative tools and approaches
• Providing targeted STTA to field programs
• Capturing how the respective themes were advanced with every project result report

Ultimately, HP+ also hopes to address inequities and promote sustainability on a large scale through its country-level support for robust policies, effective implementation, HF and accountability systems, and through global dissemination of products.

The following sections provide examples of how HP+ is advancing and achieving cross-cutting results.

**Gender Equality.** HP+’s Gender Strategy outlines how to promote gender integration under each of the project’s four IRs.

For example, at the country level:

• In Guatemala, local advocacy organizations, with support from HEP+, called for and successfully closed a loophole in the marriage law that can lead to the end of child marriage. HEP+ is collaborating with the ministry of education on age-appropriate school curricula on gender roles and sexual health education, including trainings to increase the capacity of young women to prevent pregnancies. They encourage young men to give up their “machismo” side, treat women as equals, and become more engaged in the care of children.

• In Mali, HP+ generated evidence to support gender-responsive health laws and policies. Mali launched the advocacy model RAPID Women, which examines the links between FP, women’s empowerment and education, and demonstrates the impacts that these investments in women and girls have on social and economic development. At its launch, the Ministers of Human Rights and Promotion of Women, Children, and Families signed formal agreements to invest in the health, education, and empowerment of women and girls.

At the global level:

HP+ has worked to advance global leadership and local advocacy for “respectful maternity care” in health facilities to reform the existing standards of practice arising from harmful gender norms and improve quality of care and health outcomes.

In addition, the Gender and Sexual Diversity (GSD) blended learning package institutionalizes, within U.S. President's Emergency Plan for AIDS Relief (PEPFAR) programs, a methodology that challenges internal bias to improve HIV programming. PEPFAR has mandated that all staff complete the course and introduced it into Country Operational Plan 16 guidance. As of July 2018, HP+ has trained 661 PEPFAR staff in-person, and an additional 1,554 PEPFAR staff have completed the online version of the Gender and Sexual Diversity package, for a total of 2,215 trained (see Table 1 below). HP+ also created with local partners country-specific modules for Jamaica and Kenya—training local champions who then deliver the training to additional audiences.
Table 1. Number of PEPFAR Staff Trained in GSD, by Year and Location

<table>
<thead>
<tr>
<th>Location</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>54</td>
<td></td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>Cambodia</td>
<td></td>
<td>59</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>CDC</td>
<td>36</td>
<td>33</td>
<td>19</td>
<td>88</td>
</tr>
<tr>
<td>Ghana</td>
<td></td>
<td>56</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Jamaica</td>
<td>65</td>
<td></td>
<td></td>
<td>65</td>
</tr>
<tr>
<td>Kenya</td>
<td>50</td>
<td>21</td>
<td></td>
<td>71</td>
</tr>
<tr>
<td>Mali</td>
<td></td>
<td>20</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Nigeria</td>
<td></td>
<td>52</td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>OHA</td>
<td>41</td>
<td>11</td>
<td>15</td>
<td>67</td>
</tr>
<tr>
<td>OGAC</td>
<td>33</td>
<td>11</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td>Tanzania</td>
<td></td>
<td>73</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>164</strong></td>
<td><strong>170</strong></td>
<td><strong>327</strong></td>
<td><strong>661</strong></td>
</tr>
<tr>
<td>Online (as of 07/18)</td>
<td></td>
<td></td>
<td>1,554</td>
<td>1,554</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>2,215</strong></td>
</tr>
</tbody>
</table>

Source: Nicole Judice, Palladium/HP+

**Health Equity.** For health equity to prevail, individuals must have equal access to essential health services, regardless of wealth, geographic location, gender, sexual identity, or ethnic group. HP+’s approach to health equity centers around three areas:

- Using analytics to assess and understand equity issues to identify barriers to access, and then use the information to estimate the resources required to reach vulnerable populations and help reduce out-of-pocket costs.
- Contributing to pro-equity health sector reform by working with governments and stakeholders to identify, frame, and act on health equity issues across and within countries and to integrate equity goals in development strategies and policies.
- Developing pro-equity standards by understanding and reducing systemic barriers—like S&D—that marginalized populations face in accessing high-quality healthcare.

HP+ has achieved significant results in health equity. For example:

- In Guatemala, HEP+ conducted a catastrophic health expenditure analysis to assess whether certain individuals or subpopulations face financial hardship when accessing healthcare services, over time, across wealth quintiles, and among populations (rural vs. urban).
- In Kenya, Mombasa County made strategic shifts in its HF, increasing its health allocation to 27 percent in 2017–2018 (up from 12 percent in 2014–2015), and developing a social protection policy to support payment of the National Hospital Insurance Fund for the elderly, poor, and disabled. These moves came after HP+ worked with Mombasa CHMT to generate critical evidence for advocacy. As a result, the county has reduced out-of-pocket costs to 34 percent of total health expenditures (down from 41 percent in 2014–2015) and it is reporting increased enrollment in the National Hospital Insurance Fund—from 3 percent in 2014–2015 to 7 percent in 2016–2017.
In Togo and Guatemala, HP+ has supported policy efforts to improve access to FP/RH services for youth that are sexually active.

The RTI International-led total facility approach to addressing S&D, being implemented in sites in three countries (Ghana, Jamaica, and Tanzania) is innovative, participatory, locally owned, and comprehensive in involving all levels of staff. It fills a global evidence gap through including baseline data to understand the impact of S&D on accessing services, stakeholders’ use of data to design facility-tailored S&D-reduction activities for a sustained response, and end-line data to evaluate the impact of stigma reduction on service delivery. In applications in Ghana and Jamaica, HP+ incorporated key-population stigma into the measurement and intervention approaches, and in Tanzania, they included a focus on S&D faced by youth in seeking HIV and/or RH services.

HP+ is doing benefit incidence analysis to guide equitable expenditure of AIDS funds. HP+ activities relate to efforts to improve sustainability whenever possible. HP+ is also actively seeking to improve CD in local country settings, with a focus on equity, quality, and protection of the poor from catastrophic expenditures.

**Capacity Development.** HP+ uses multiple approaches to CD, including embedding staff in host country partner agencies, conducting workshops, training local trainers, co-creating tools and models, and south-to-south learning. HP+ marks capacity achievements by HP+ partners’ achievement of performance benchmarks, not by its interventions.

To date, HP+ has achieved some excellent results that demonstrate increased capacity for specific components of policy, advocacy, finance, and governance. For example:

- In Guatemala, HEP+ helped improve the National Social Information System platform that now incorporates 16 institutions. Public access to this system, which includes Ministry of Finance data, allows CSOs to monitor what is happening with the funds collected from the alcoholic beverage tax, which is meant to go for FP commodities costs.

- In Kenya, working with HP+, the Health Economics Unit at the University of Nairobi now incorporates policy analysis and policy communications courses into its graduate degree programs. In Jamaica, the PHDP curriculum is fully supported by the government.

- In Madagascar, HP+ has developed capacity within the National Solidarity Fund for Health. They have worked on a health package to reinforce capacity at the district hospital level. It is too soon to talk seriously about financial sustainability in Madagascar, but gender equality and health equity are concerns that are already included in HP+ work.

- In Mozambique, there are currently 11 embedded staff doing M&E in the national planning directorate. HP+ is working to keep them focused on an enabling role, rather than gap-filling. HP+ developed a memorandum of understanding, identifying expectations and an exit strategy.

- In Uganda, HP+ supported Samasha Medical Foundation, a local NGO, to transfer skills for applying the motion tracker methodology to Zambian and Tanzanian CSOs, who successfully applied it to reach consensus on goals, roles, and tracking progress toward FP2020 commitments.

Still, there is much more work to be done in capacity-building, particularly in the areas of modeling and tools related to HF, and in governance of health services in countries that are decentralizing.
Sustainability (and Preparing for Transition). Development aid for health aims to create country health systems capable of sustaining, expanding, and adapting essential health services to meet their populations’ needs. Adequate, predictable financial resources comprise one component of sustainability, but equally important are effective governance and financial management, collaborative processes, political commitment, accountability, and program adaptability.

HP+ promotes sustainability through:

- Establishing governance, legal/policy, financing, and other systems-level arrangements to sustain access to and continuity of high-quality, responsive health services.
- CD and transfer at individual, organizational, and system levels.
- Mainstreaming of priority health interventions (e.g., FP, HIV, MNH) into broader health systems. HP+ works to ensure that all voices are engaged, placing equal attention on the needs of the poor and other underserved groups so that they do not get lost in transition.

HP+ supports partners to integrate systems thinking to make sense of the complexity of proposed health reforms, analyze system-wide effects and the potential for unintended consequences, “work with the grain” of local systems, and monitor and adapt activities. For example:

- In Jamaica, HP+ is part of a national WG planning for transition to sustainable financing for health. The next difficult step is to get government commitment for social contracting to guarantee financing for healthcare.
- In Kenya, the financial sustainability of the country’s multi-year efforts to establish national health insurance is still unclear. A major unsettled issue is how to pay for the care needed by the large numbers of poor and those working in the informal sector. On the other hand, HP+ support to county-level capacity-building in PBB is reaping results by increasing revenues for health and HIV programs: The amount raised through these efforts is $6 million.
- In Tanzania, HP+ helped the Government of Tanzania develop the AIDS Trust Fund (ATF) guiding documents, including an operations manual and mobilization strategy for the ATF. The National Coordinating Body for HIV in Tanzania has requested HP+ to assist it to identify a sustainable way to finance the ATF, using private sector funds.
- In West Africa, HP+ provided technical assistance to establish and strengthen the West Africa Health Informatics Team, a West African Health Organization-based group of software developers and informatics experts that provides on-demand informatics TA to countries throughout the region, while building local software engineering capacity to support long-term sustainability of HIS.

E. HP+ Use of Models and Tools

HP+ and its predecessor policy projects and the companies that have implemented them (originally the Futures Group and now Palladium and its consortium partners) are recognized for their development and application of computer-based simulation models. USAID first made use of these models in partner countries through the 1995 policy project. Their original purpose was to stimulate policy dialogue among high-level government decision-makers, at presidential, parliamentary and ministerial levels. Over

15 A further description of the purpose and functionalities of the models and tools discussed in this section can be found in Annex XI.
time, the models have diversified and proliferated in purpose and for intended audiences (e.g., to support advocacy at subnational levels of government by "grassroots" organizations comprised of indigenous women's groups or people living with HIV/AIDS). Palladium and Avenir Health lead the HP+ consortium in developing models; Avenir also hosts the Spectrum series of models. Spectrum includes RAPID, one of the models most widely recognized and valued by interviewees. RAPID, along with DemDiv, simulate the socioeconomic and/or health consequences of different rates of fertility and population growth in countries, reflecting the historical focus of USAID's policy projects on FP programs.

Another popular model, ImpactNow, is an Excel-based model that estimates the health and economic impacts of FP in the near term. It is designed to model the impacts of different policy scenarios, and to compare the results of those scenarios in advocacy materials.

In addition to DemDiv and ImpactNow there are other popular models and tools that have generated evidence helpful across all four IRs. For example:

- **The HIV Policy Scan and Action Plan** approach allows countries to: a) identify and prioritize HIV service gaps; b) analyze relevant policies and their implementation; and c) engage stakeholders to develop, monitor, and adapt policy, regulatory, and legal action plans to achieve HIV-related outcomes.

- **CIPs help** country programs bring together stakeholders to assess the current FP situation, identify programmatic priorities, set targets, generate cost estimates, implement the plan, and monitor progress.

- **Equitable Impact Sensitive Tool (EQUIST)** is a UNICEF web-based analysis and strategic planning tool designed to help decision-makers identify and develop equitable strategies to improve health and nutrition for the most vulnerable women and children. It was applied in Mozambique.

Models used in HF focus on estimating the costs, at varying levels of detail, of programs or specific services within programs to defined populations or subgroups, considering different levels of use and expected health outcomes. The incidence of costs borne by users of different income groups has been added in modeling exercises examining national health insurance plans. Modeling is aimed at influencing investment decisions in the sector by international donors and governments. As such, the outputs vary, for example, emphasizing national or subnational planning decisions, trade-offs among planning scenarios, health impacts, needed investments, or budgetary shortfalls. In interviews, the most often cited model or tool used by HP+ in HF work was the OneHealth Tool (OHT). A distinguishing feature of OHT is that it aims to support integrated strategic health planning, meaning across multiple health programs or interventions within programs, at national levels. Its modules use a standardized approach to costing but can also be used separately to examine single programs and interventions. Avenir worked with the Interagency Working Group on Costing (IAWG-C) to harmonize various costing tools used by planners to produce the current version. The IAWG-C, comprised UN Agencies (WHO, UNICEF, UNAIDS, UNFPA, UNDP) and the World Bank, oversees the OHT. In Kenya, a World Bank economist who was interviewed said that OHT is "used everywhere" in-country.

HP+ economists and financial analysts also developed specific models for specific uses while providing STTA in countries. These served the purpose at hand, and do not always result in definable products with immediate applications elsewhere. For example, in Indonesia, in 2017, HP+ developed a financial
sustainability model to analyze the Indonesian National Health Insurance Scheme, the JKN. Among its
other uses, it generated data that the ministry of finance used to adjust premium rates.

It was notable that USAID interviewees, both in USAID/W and in countries, considered the models to
be understandable to non-technically-inclined audiences while many times, host country partners, in
governments and CSOs did not. The modeling exercises were most appreciated and valued when HP+
made the effort (and spent the time) to explain in non-technical local language and print, what
assumptions were behind the modeling projections, how assumptions could be modified, what data were
used and the sources of the data, and how to interpret the results.

The ideal scenario is to train counterparts to identify the data needed, input the data into the models,
conduct the analyses and present the results without external support from HP+ as happened in
Indonesia. In Malawi, HP+ worked with the Population and Development Unit, Ministry of Finance,
Economic Planning and Development and the Department of Population Studies (DPS), Chancellor
College, University of Malawi, to update the RAPID model. New evidence had been identified relevant
to projecting population impacts on the country’s development sectors. HP+ developed the curriculum
and worked with DPS lecturers to train students to produce the updated projections. This curriculum
and lecturers trained in its use are now in place in DPS, capable of expanding within government and
civil society an understanding of how evidence from modeling can be used to shape policy—in this case,
population policy.

In recent years, health sector models have proliferated from a number of sources, owing in large part to
advances in computing technology and the decreasing costs of owning computers. A minority of
interviewees expressed concern that perhaps there is now an over-reliance on the use of models by
HP+ and others to influence countries’ allocation of resources. Their apprehension was that the models,
in particular the program-specific models, could have the unintended consequence of leading countries
to marginally over-invest in one program area and under-invest in others. This could result in leaving
overall investment levels constant and thereby reducing the cost-effectiveness of sector-wide spending.

**EVALUATION QUESTION 2**

**Stakeholder Satisfaction: What is the current level of satisfaction of USAID missions and
other partners with the inputs and progress toward project goals to date?**

So far, the focus of this evaluation has been to examine the extent to which the mix of technical
approaches taken by HP+ has produced results in the four key technical areas, addressed cross-cutting
principles, and looked at ways models and tools have been used. In Evaluation Question 2, the focus
turns to the level of satisfaction of stakeholders’ groups with results achieved so far, and with some
specific aspects of project operations.

**A. Communication with USAID**

Successful implementation of a complex program like HP+ depends on open lines of communication
between the AOR and HP+ HQ in Washington, D.C., and between the USAID missions and the HP+
country teams/directors and other country stakeholders in the field. Therefore, stakeholders were
asked to describe the protocols that are in place, if any, for communications with USAID counterparts,
and whether these protocols were fully meeting their needs.

Communications are happening in a variety of ways. One way is formal written communications (e.g.,
letters, memoranda) that must go through proper channels to and from the AOR and members of the
PLT in Palladium/HP+. Staff that were interviewed in Palladium, the consortium partners, and on the AOR team all knew of and said they abided by the rules for formal communications. The same was true in interviews with mission and their Country Office staffs in the field.

It also became clear that the vast majority of communications that occur between HP+ and the AOR team are informal or ad hoc communications that come in the form of emails or phone calls. Typically, these occur either in the context of ongoing efforts to plan/implement HP+ activities, or they may be ad hoc requests from a member of the AOR team for technical or budgetary information, for example. In these cases, the rules are more lax, but it is understood that participants in these informal communications have a responsibility to copy superiors and colleagues, as appropriate, to keep them in the loop.

Regular meetings are another form of communication between USAID and HP+. There are four regular technical or management meetings monthly (including FP/RH, HIV, FS, and management meetings with the AOR team) to discuss technical and management issues, or to update USAID on the status of implementation of HP+ activities and to identify/assign actions needed to keep activities on track. Similarly, in the field, mission HP+ activity managers and other members of the health team will have similar meetings (usually monthly or quarterly) with HP+ Country Office/representatives to accomplish the same objectives.

Other stakeholder groups, such as host country partners and consortium partners, often do not have the need for or access to regular communications directly with USAID. Host country implementing partners, with the exception of high-ranking government officials, told us that they normally do not discuss HP+ matters directly with the mission, but communicate directly with HP+ Country Office/representatives staff. Similarly, consortium partner staff said they funnel all communications through Palladium, except at the bi-annual HP+ partners’ meetings, where partners, Palladium PLT members, and the AOR team are all in attendance.

To sum up, USAID and HP+ have frequent communications with each other and their implementing partners via telephone, emails, and regularly scheduled meetings. Based on KII interviews, it seems that the existing communication channels are contributing to effective management of HP+. Virtually all respondents who regularly communicate with the USAID AOR team and missions stated that they were highly satisfied with the current channels of communication, and with USAID’s responsiveness. They especially praised the AOR and her team for their helpfulness.

Similarly, HP+ staff also reported that they had regular meetings with managers, and that managers were also open and available for ad hoc consultations to answer questions or provide guidance as needed. Country activity managers reported that they also have regularly scheduled phone/Skype meetings with Country Offices to get updates on planning/implementation of field activities, and address any implementation issues. Again, these communications have contributed to effective management of HP+ implementation.

B. Contributions and Challenges of Implementing Core Activities

HP+ uses core activities for innovative work and to promote global learning. Often, these core activities produce knowledge that can also be applied in field activities. At the FP financing conference, held in Ghana in January 2018, HP+ presented some important findings from its core activities.
For FP, core activities are developed collaboratively with the USAID/W AOR team and HP+, and USAID looks to HP+ to suggest ideas for core activities. Topics tend to be strategic. But for HIV/AIDS, core activities are very directive from OGAC. The replacement of HQ’s operational plan (HOP) funds with technical oversight and management+ (TOM+) also introduced some challenges, because TOM+ funds have to be spent in the same year they are received. HP+ and missions have had to be creative in putting these funds to good use.

In a number of cases, core activities have been an excellent proving ground for developing new approaches for application in countries. Some other examples include:

- **Malawi**: The FP financing roadmap tool helped identify sustainable FP financing options for achieving countries’ FP goals. Another core activity was a radio broadcast activity with PRB with regular call-in broadcasts on youth health issues. This activity was very successful, and now is being funded by mission FS in three sites in Malawi.

- **Tanzania**: The core activity on mainstreaming of HIV/AIDS results showed that integrating HIV services into the National Health Insurance Fund is feasible in the short-to-medium term. Also, the core activity on mitigating HIV/AIDS S&D showed that an all-facilities implementation of GSD training resulted in a substantial reduction of stigma attitudes and observed stigma behaviors. The S&D-reduction approach tested in Tanzania is in the process of being integrated into the national S&D-reduction curriculum and approach for Tanzania by the NACP.

- **HP+** partnered with FP2020 to apply the FP goals model as part of the CIP. (FP goals model was funded by the Bill and Melinda Gates Foundation).

- The women leads core activities in Malawi were effective in elevating women’s health and recognizing the work of women leaders.

With core activities, USAID-wide protocol requires mission director concurrence prior to implementing any core activity in-country. In a limited number of cases, this approval process can be lengthy. To minimize the possibility of disapproval, HP+ meets with the AOR team early on to identify the most appropriate countries for a given activity. Then the AOR approaches mission technical staff to get their view on how the activity fits within the mission’s objectives and work. If the activity is a good fit, then the mission technical staff offer concurrence prior to the AOR requesting approval from the mission director.

When core activities are successful in the field, countries may be interested in scaling up the activity within their country. Sometimes missions are able to take on the costs of scaling up within their budget; however, in other cases, missions don’t have the financial resources to do so.

**C. How Well Are HP+ Results Meeting Countries’ Needs?**

The HP+ Evaluation SOW identified two key areas of consideration regarding stakeholders’ satisfaction with HP+ program results:

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• In FS-funded activities, are missions [and host country government partners] satisfied that HP+ results are meeting countries’ needs?

• What has been the response of stakeholders (e.g., MOH, donors, etc.) to the technical approaches, project expertise, and results in the new (for HP+) area of HF?

b. What has been the response of stakeholders to the technical approaches, project expertise, and results in the new area of HF?

Introduction: Health sector financing TA has received more emphasis in HP+ compared to HPP or any of the previous health policy projects of GH/PRH. This aligns with and supports USAID’s current country assistance strategy, “Journey to Self-Reliance.” In addition, it recognizes the movement toward
graduation of a number of countries from lower-, lower-middle, to upper-middle income status, according to the World Bank’s classification, and thus their ability and desire to assume greater responsibility for financing their social sector programs. In these countries, particularly in Asia and East Africa, economic growth has brought with it the institutional and human resource capacity to make serious moves toward program sustainability in the social sectors, and in health in particular. HP+ has been one means by which USAID has positioned itself to collaborate with these countries to move them along the development path to self-reliance.

Overall Satisfaction of Stakeholders: With few exceptions, stakeholders gave high marks to the work of the HP+ HF team for its execution of workplans and flexibility in adapting solutions to local conditions. Given the diversity of conditions in countries and requests for TA, HP+ produced a range of results, from affecting the sector as a whole, (e.g., generating options for national health insurance expansion as a vehicle to achieve UHC, developing national health policies and strategies) to discrete parts of it (e.g., supporting advocacy efforts to increase line item budget allocations for FP and HIV commodities). Despite its successes in working with subnational levels of government and CSOs, government implementing partners, donors, and USAID missions view it primarily as a national policy-level source of TA. Over time, this perception may shift, as requests for its services and opportunities for intervening in countries’ health sectors to improve sustainability diversifies and expands.

Satisfaction with HP+-provided HF support is reflected in the increasing and widespread demand for its services from USAID missions. Interviews revealed that all country partners, across HP+ funding streams, realize that donor support is declining. The message has been sent and received that countries need to move toward sustaining their health sector programs with their own finances, public and private, rather than those of external donors. Some respondents, in countries that are just at or below low-middle income status, revealed anxiety that they will not be ready to continue on their own when the time comes. Others—those in countries approaching, or just entering, middle-high income status—revealed more resignation than alarm as to what the future may bring as donor support decreases, but still acknowledged their lack of clarity about the way forward. Given the range of responses to the current trends of international development assistance, it is clear that countries’ demands for HF TA is nowhere near saturation.

HP+ Technical Approach in HF: The technical approach of HP+ in providing HF assistance to countries is through LTTA in-country offices, and STTA provided from a pool of talent located in HP+’s Washington, D.C., offices. A highly competent and effective technical lead in HQ supports and directs the HF work worldwide. When HP+ began, most TA in HF came from this location, an exception to the way HP+ was working overall. Most HP+ staff are located in the field, working through country offices, as opposed to in the United States. For every HQ-based staff, there are 2.5 field-based staff (i.e., 80 to 200).

The decision to launch and implement HF TA in this HQ-centric way was made by default. At the time, HP+ saw it as the only way to kick off this new field of TA expeditiously and competently, given the five-year life of the project. In addition, the pool of talent working in the fields of international health economics and financing in low-income countries is relatively small compared to other technical areas of international public health, and are concentrated in the United States. Thus, retaining the large bulk of talent in one location and deploying it flexibly to respond to different requests for assistance from different countries at any time, as has transpired, made sense.
Nonetheless, relying heavily on STTA has its drawbacks and critics; HP+ leadership recognizes these and is making efforts to reduce reliance on STTA from Washington, D.C. Interviewees from governments, international organizations, and civil society expressed skepticism about the efficacy of heavy use of STTA, especially when the objective is to bring about fundamental institutional and economic reforms in countries, as the HP+ financing projects aim to do. This expressed skepticism was evident in interviews even when no criticism was leveled at the quality of the work provided by HP+ through the STTA.

The HP+ director considers the 11 Country Offices to be the “faces of HP+” and this is the role they have played implementing HF activities and projects up to the mid-point of the project. Country Offices are established and staffed when a country’s HP+ field budget is at least $1 million annually. (For historical reasons, Jamaica and Tanzania’s budgets are below this threshold.) Support from the HQ-based HF team then becomes part of the Country Offices’ workplans, decided upon in consultation with country partners and the USAID missions, and approved by the GH/PRH/AOR.

Thus, in countries with Country Offices, the HF team and the Country Office staff are structured to work as a unit, providing that singular “face” of HP+ to country partners. Interviews revealed that the HP+ country directors and staff are technically competent, respected, and personally trusted by USAID missions and country partners, in government and civil society (with one exception that was remedied expeditiously by the HP+ director). Importantly, they are able to ensure that all TA aligns with country and USAID missions’ priorities. For the reasons given, it is probable—although strictly untestable—that without the Country Offices and their long-term technical advisors in place, HP+ would not be producing the HF results it has over the past two-and-a-half years.

Midway through HP+, there were staff economists in the Country Offices of Cambodia, Guatemala, Indonesia, Kenya, Madagascar, Malawi, Mali, Mozambique, Nigeria, and Tanzania. Two of these economists are seconded to government ministries in Malawi (i.e., MoHP and Ministry of Finance and Economic Development [MoFEDP], and one in Cambodia [Ministry of Economy and Finance]). The Country Office in Kenya is planning to second up to six economists in county governments in the fiscal year beginning October 2018. In Indonesia, the HF team assigned embedded analysts to the TNP2K to assist in carrying out an important assessment of JKN, which concluded mid-2018. Support for this work came both from the HF team in Washington, D.C., and local consulting firms. In Malawi, HP+ provided supplemental medium-term assistance to the MoFEDP to develop its Third MGDS by contracting with a regionally located economist.

The HF technical lead at Palladium HQ in Washington, D.C., plays an important role in providing overall guidance and STTA to economists and analysts working in Country Offices, negotiating the methods and frequency of contacts that best suit the needs of the staff and Country Offices’ budgets. Unless the STTA is funded under a core activity or PEPFAR, the costs of these and other sources of STTA from HQ are borne by the respective Country Office’s budget. For Country Offices with tight budgets, such as in Tanzania, other less costly methods of STTA are used most frequently, such as regular Skype calls. (Budget constraints precluded the staff economist in Tanzania from receiving his preferred in-person STTA and mentoring.) In Kenya, the Country Office Director is an experienced, highly regarded economist who supervises and mentors a staff of economists and rarely asks for STTA from HQ. Instead, he prefers the low-cost ways to communicate with HQ to conserve his budget for in-country activities.
Satisfaction of Specific Stakeholder Groups:

a. USAID/W Stakeholders

These respondents included current and a few past members of the AOR team and a high-level manager in GH/PRH. The bulk of these staff are or have worked as technical health specialists in USAID health programs, even if their current positions were managerial at the time of the interviews. Only one respondent was an economist and in this professional capacity had direct experience providing STTA to HIV field programs, often alongside HP+ staff. He expressed high regard for the HP+ HF team and its work. However, he did express disappointment at the prospect of sustainable financing initiative (SFI) ending in fewer than two years, in 2020, and questioned how sustainable financing assistance to HIV programs could continue after this date.

Responses from other USAID/W interviewees to the HF work of HP+ were either positive—based on what they knew or had heard from others—or non-committal, meaning they had no opinion or could not answer.

b. Health Teams in USAID Missions (Health Teams)

With a couple of exceptions, health teams expressed a high degree of satisfaction with the HF TA provided by HP+, particularly when it was mediated through staff in Country Offices. Thirteen USAID missions bought into HP+ for TA in HF over the past two-and-a-half years, totaling approximately 25 percent of all buy-in funds. Health teams recognized and appreciated the expertise and quality of the HF work performed and its overall responsiveness to USAID and country priorities. With one exception, the health teams judged the HP+ reports and products to be of high quality and delivered on time.

A minority of health teams raised concerns about the analytic work produced by HP+ on the grounds that the recommendations did not link to or otherwise suggest a path toward implementation and/or it did not contribute to capacity-building in the partner country. These comments did not suggest that HP+ had failed to comply with the terms of any specific SOW. It is unclear why HP+ and the health teams in question did not seek resolutions to these concerns while the work was in progress or after the reports were delivered. Communications among the parties on such issues appear not to have been aligned with their respective expectations. This points to the need to perhaps review how HP+ and health teams discuss, agree on, and monitor in-country SOWs.

Other concerns regarding HF work from health teams came from two activity managers for HP+. One expressed frustration at not being able to consistently report out progress against indicators for HF activities that were being implemented, as could be done for services delivery projects. Another activity manager was impatient at the pace of HF activities and worried aloud that there was little time remaining in the life of the HP+ project to carry out the agenda proposed in the extant analyses.

c. Host Country Governments

Most government partners of HP+ were ministries of health first, and ministries of finance, second. Responses from these officials were very positive about the quality and responsiveness of TA provided in HF. In countries with Country Offices, responses were particularly laudatory of the performance of the Country Office staff. The personal characteristics of these staff (i.e., that they have been known for years, had sometimes been former employees of the respective ministry, and were trusted country nationals [in most cases]), appeared to carry almost as much weight with these officials as did their
professional competences. In more than a couple of interviews, officials asserted that they would not have been interested in working with HP+ if its TA only had been based internationally.

At the same time, some officials (e.g., Guatemala, Tanzania) stressed their need for more than STTA, even when it was provided or mediated through the Country Offices. These officials mentioned seconding as a preferred mode of TA because it would allow for both institutional capacity-building and analytic work to occur, ensuring that the latter is based on an appreciation for and understanding of the country context. The experience of HP+ in Malawi with three secondees attests to how adaptive and responsive they can be in their assignments to governments and health teams, given well-designed SOWs. In Malawi, MoHP officials compared the terms of HP+ secondees favorably to those of secondees from the Centers for Disease Control and Prevention, stating that the latter were overly structured and thus not sufficiently flexible to respond to institutional needs.

d. CSOs

HP+ provided STTA and some financial support to CSOs (primarily for trainings) in advocacy aimed at different levels of government (e.g., parliament, national, county, municipal). Those CSOs whose advocacy goals focused on budget advocacy have been playing an important role in mobilizing domestic resources for health. As with other HF projects, the foci of such advocacy have varied across CSOs and countries (i.e., ranging from increasing domestic resources for health overall for specific health programs—such as FP or HIV/AIDS—to line items within those programs—including commodities or health workers' salaries). HP+ tailored its assistance to fit the respective CSOs' objectives and capabilities, and of course, its own available budget.

CSOs interviewed placed high value on the TA and products they received from HP+ (e.g., workshops, training materials, demonstrations of policy simulations, printed briefs). This was particularly the case when HP+ made the effort to translate materials into the local language and into actionable messages suitable for CSO members and their audiences. Uniformly, CSOs' representatives emphasized the magnitude of the difference HP+ made in improving their members' understanding of government budgets and budgetary processes as well as their ability to use data to advocate for greater health allocations, expenditures, and overall budget transparency.

In Tanzania, there was a particularly vivid accounting of how TA in budget advocacy has altered the dynamics of how one CSO relates to the national legislative body. Budget advocates face a complicated journey toward increasing government spending on health: While the overall health budget in 2016–2017 increased in nominal terms, it fell as a proportion of total national spending. Nonetheless, the National Council of People Living with HIV/AIDS (NACOPHA), a CSO, now feels confident that it can meet the challenge of influencing national HIV program funding through advocacy.

HP+ built NACOPHA's advocacy abilities and confidence to apply them by generating the budgetary and expenditure data relevant to HIV program funding and showing its network members how to interpret these data. In turn, NACOPHA engaged members of parliament and government ministers in a national symposium on HIV financing and made their cases. After the event, NACOPHA members developed workplans and follow-up activities to track government responses.

Like the overwhelming majority of CSO representatives interviewed, NACOPHA's enthusiasm for continuing budget advocacy was unwavering. At the same time, these CSOs were anxious about the prospects of receiving additional TA from HP+ because they didn't believe they could sustain their
e. International Partners and Global Leadership

Responses from representatives of donors and international organizations that have partnered with the HF team acknowledged its global leadership role in the fields of international health economics and financing. As evidence, they pointed to the team’s various presentations at international meetings, published journal articles, and leadership exercised in international organizations. Additionally, economists working in the Country Offices in Cambodia, Guatemala, Kenya, Malawi, and Tanzania, and perhaps elsewhere, had also taken the initiative to form HF TWGs within ministries of health and finance to include representatives of other country donors and international organizations. These TWGs have played critical organizing and consensus-building roles within the partner governments, speaking with one voice on the direction and pace of health sector reforms. International partners interviewed acknowledged the value of participating in these TWGs and expressed appreciation for the role that HP+ staff played in their organization.

f. HP+ Consortium Partners

Representatives of consortium partners who were interviewed (Avenir representatives were not interviewed) were concerned about the “insularity” of the way the HF team operates within the project. At the same time, these representatives acknowledged the importance of providing assistance in HF to countries, especially in the face of declining support from external donors. They also acknowledged that the HF team is technically competent and performs well in countries. But at the same time, the partners believed that their respective areas of technical competence would add to the effectiveness of the HF team’s efforts to increase health sector sustainability, if done in tandem with it. At a minimum, partners asked to be brought into discussions with the HF team at the design stage of field activities, so as to be given opportunities to suggest ways their involvement could improve results. When interviewed, some partners complained that they became aware of new field work too late to be able to propose additional interventions or new approaches. Fortunately, recently redesigned work planning processes (Spring 2018), aim to redress the shortcomings cited by some partners. All partners interviewed valued their relationships with Palladium and expressed hope that they would be able to increase their participation in HF field work during the last two years of the HP+ project.

EVALUATION QUESTION 3

Future Trends: What are the emerging trends and needs in health policy, advocacy, HF, and governance that might be addressed in the current or future project?

In the course of KII interviews, the team talked with scores of experienced respondents from many countries, with wide and varying professional and life experiences. For this reason, there was a wide array of thoughtful responses when the team asked respondents to share what they consider to be the most important emerging or future trends/issues across four key health areas relevant to HP+, namely FP, HIV/AIDS, HF, and MCH. There are a number of trends that were raised by many respondents from multiple stakeholder groups. These are the emerging trends listed below. The full list of emerging issues is provided in Annex VIII.
**Family Planning**

- Expect continued declines in donor funding. How can we fill that gap? Private sector? Governments? How to plan for transition?
- How to mobilize more domestic resources for FP, starting with commodities. A related need is for better budget execution and efficiencies.
- Task shifting across health providers, encouraging private sector to play a larger role.
- Need for better access by youth to FP/RH services, in and out of schools.
- Not enough money for contraceptive supplies, training, materials, provisions of supplies in communities.
- Decentralization of health services is becoming more common. It is a complex issue that involves building capacity at local levels, planning for orderly transition of resources/management of health programming, and lots of changes in governance, investment, and capacity-building.
- Centralized vs. decentralized procurement of FP commodities.
- Need to integrate FP into UHC healthcare platform. (Many respondents mentioned this issue.)
- Continue efforts to expand coverage and reach all who need to be reached with FP services.
- Need to continue to monitor program performance and keep stakeholders informed.

**HIV/AIDS**

- Concerns about declining donor support for HIV/AIDS programs. Increased DRM, task-shifting and private sector engagement, and efficiencies are all being considered.
- Concerns that increased domestic support for HIV may take funds away from other health programs. No consistent guidance on transition from GF and PEPFAR.
- HIV+ youth and key populations face S&D and difficulty accessing ARV.
- AIDS policy agenda too driven by PEPFAR; needs to be driven more by countries.
- Concerns about PEPFAR plans to push more funds to local organization, and needs for more capacity-building at local level.
- Concerns about phaseout of SFI and impact on AID/Washington partners working on HIV/AIDS.
- How to better integrate HIV with other health services, and into UHC.
- How to get national governments to pay for ARVs. Transition planning needed.
- LBGTs and sex workers are still stigmatized and persecuted, which makes HIV prevention programs more difficult.

**Health Financing**

- UHC was one of the most often mentioned current/future priorities, usually mentioned alongside the need to establish a national health insurance program to achieve UHC. Both undertakings are massive and complex in their scope and in the resources required for long-term sustainability. Among the questions posed by respondents were the following:
  - How to pay for UHC, public and private sector responsibilities, and how much?
  - How to define insurance pools/groups?
What should be included in UHC essential care packages?
How to monitor, evaluate, and do needed risk analyses?
How to integrate FP, AIDS, or other programs that are heavily donor-funded?
How to ensure quality healthcare services on this scale?
How to do advocacy for UHC and promote the national health insurance system?
How to enroll all residents into the national health insurance system?
Costing of these initiatives, enacting enabling laws and policies, and development of national strategies for implementation.

Declining donor support and efforts to increase domestic mobilization of resources were at the heart of comments made in context of HF, as were strategies to improve efficiencies (i.e., task-shifting, and more integration of the public and private sectors in expanding health coverage).

Decentralization and all of the accompanying issues, like laws/policies defining the roles and functions of the MOH vs. local governments; and putting in all the staffing and systems related to appropriating, managing, and absorbing local and national health funding, procurement, M&E, etc.

More attention needed to strengthen governance at the subnational level. Pilot programs needed to promote more effective use of budget, better allocation, more focus on results, and better efficiency.

Need better M&E systems in place to track progress.

Maternal/Child Health

Need more training and reinforcing materials on MCH at the local facilities level.
Need to work more with ministries of finance as allies for allocating more funding for MCH.
More work is needed to improve health systems related to maternal health.
Also need more work on creating local ownership of their MCH programs.
Maternal mortality and safe motherhood are still important health issues.
More work needed to reduce early marriage and childbearing; Need to look at age of consent laws and legal/policy barriers.
Equity needs more attention. What are the vulnerabilities that affect safe motherhood (e.g., racism, HIV status, poverty)? These issues need to be looked at through a multisectoral lens.

Common Themes

1. HF: Navigating the Journey to Self-Reliance

The major trend in HF identified in stakeholder interviews, including the self-assessment from HP+, is countries’ acknowledgement that they must reduce their reliance on donors financing their health services and, instead, mobilize their own financial resources to provide population coverage. This trend was precipitated by donors and donor-funded programs, such as the GF, GAVI, and PEPFAR, making unilateral reductions in funding for development assistance programs. Today, it is unclear how low funding levels will eventually go or how donors will reprioritize sector-specific assistance once funding is stabilized.
2. Moving toward Sustainable Universal Healthcare

Interviews with government officials and donors also revealed that countries endorse the global agenda for sustainable development adopted by WHO and the UN General Assembly in 2015 in their search for financing strategies that are sustainable, equitable, and efficient. This agenda and its related guidance are relatively sound, but provide no support to countries for implementation. This presents a major challenge and an opportunity to international donors such as USAID and a project such as HP+. HP+ not only retains the 25-plus year legacy of GH/PRH’s policy projects but now also has global experience addressing a diverse range of HF issues and constraints that are keeping countries from progressing toward self-reliance in the health sector.

Achieving self-reliance in financing health services implies:

a. Increasing overall financial resources, or “fiscal space” for health, subject to macroeconomic and fiscal constraints and opportunities for catalyzing external investments
b. Using public finances efficiently and equitably through risk pooling and purchasing arrangements to prioritize population subgroups and services by income and need
c. Ensuring accountability and transparency in managing public finances at all levels of government and in partnership with civil society
d. Creating the proper regulatory structures and incentives to enable the private sector to meet the demands of higher income groups (including those in the formal labor market) for health services products and payment methods
e. Establishing the enabling policy and legal infrastructure required for the foregoing to function

During its first two-and-a-half years of operation, HP+ has provided TA and CD to countries around the globe in each of these areas of HF. PMP results and interviews revealed that the HF team displayed a high degree of competence in this work, responding appropriately to the different needs of countries to move away from donor dependence and toward their sustainable health sector goals. Through interactions with international partners in forums such as meetings, TWGs, conferences, and professional publications, the HF team has demonstrated a capacity to bring partners together to find consensus on ways to support such country efforts. Owing to their experience and expertise, HP+ and the HF team are well positioned to take on the challenges of the next era of development assistance in HF.

3. Need to Expand Demand for and/or Supply of FP, HIV, MCNH Services

Demand expansion needs were often mentioned in relation to engaging men to accept FP and HIV/AIDS testing and treatment services for themselves, their wives, their adolescent dependents, and support maternal health and family care roles. Overall demand for FP and HIV/AIDS services also needs to increase in specific communities (e.g., those with strong religious affiliations). Regarding supply, aside from the concerns about overall health funding levels discussed previously, concerns were expressed during interviews regarding the quality of services at the community level. There were also equity concerns regarding lack of full access to HIV services by key populations. Many respondents commented that more funding is needed for maternal and neonatal health, and that maternal and infant mortality rates are still too high. Unfortunately, many governments and donors are not prioritizing MCNH.
V. CONCLUSIONS AND RECOMMENDATIONS

Based on the evaluation team’s findings, following are the team’s conclusions and recommendations for HP+ and USAID.

CONCLUSION 1: HP+ MANAGEMENT STRUCTURE AND SYSTEMS

HP+ has created a management structure tailored to be responsive to client needs. This overarching management structure has been in place since the beginning of the HP+ CA, but it has evolved to respond to needs and priorities (e.g., reestablishment of the TLT). While overall management of HP+ resides with the PLT, appropriate layers of technical leads and managing personnel at HQ and in-country comprise a framework of focused and effective project delivery.

Feedback from multiple respondents expressed that some operational systems could be improved. For example:

- Some respondents reported that it seems there are too many different individuals involved at HP+ HQ in the review and approval of documents, resulting in delays on delivery of some work products.
- Some respondents indicated there is too much last-minute travel planning by HP+ that puts pressure on USAID missions.
- In Tanzania, the team learned there were two changes in the country activity manager in about a one-year period, resulting in some disruption in program support from HP+ HQ. Turnover in country activity managers is inevitable; however, when this occurs, another individual should be designated immediately as a new (or interim) country activity manager, so there is no lapse in continuity of HQ support.

Recommendation 1: HP+ should continue to implement a management structure that addresses all key elements of the project scope, and is responsive to changing client needs, while always looking for ways to improve its generally well-functioning management operations systems.

CONCLUSION 2: PROJECT TECHNICAL APPROACHES

Recommendation 2a: HP+ should continue using a strategic approach for deployment of embedded staff where their impact will be greatest, and be prepared for an increase in requests for embedded staff.

LTTA: Embedded or seconded staff have credibility with government officials, are getting results, and transferring skills. It is possible there may be more demand for this type of TA going forward.

STTA: The team’s findings indicate that HP+ draws on a range of staffing sources to provide STTA. According to Palladium, using field-based technical staff and local consultants is HP+’s default standard, to foster the advancement of local solutions for local issues. Data from Palladium confirm that over the past year, 60 percent of all TA was provided by field-based staff and consultants. When additional and/or specific expertise was needed, U.S.-based technical assistance was mobilized. The team supports this field-first approach to STTA, supplemented by U.S.-based TA for filling technical gaps.
• One HP+ Country Office staffer commented that HQ has a great pool of expertise, and suggested that HQ consider circulating and updating a listing of HQ staff capabilities, to help Country Offices know their options for STTA requests.

• Another HP+ Country Office HF technical staff stated that he would welcome the opportunity for technical mentoring for up to two months by an HQ HF expert, either in-country or in the United States.

Recommendation 2b: In the interest of empowering Country Office technical staff to do their jobs most effectively, HP+ should consider circulating and updating a listing of HQ staff capabilities to help Country Offices know their options for STTA requests from HQ; and consider extended TDYs by HQ experts to assist and mentor technical staff in Country Offices, if requested.

Training: As noted earlier under Findings, HP+ has trained more than 2,000 PEPFAR staff on HIV GSD, either in person or online. This is a significant accomplishment. However, feedback often expressed that HQ sends out trainers to do the on-site GSD training when local trained technical staff could do the training at a lower cost to the project. All things being equal, the team agrees that using qualified local experts would be preferable because participants appreciate receiving TA/training from local instructors who understand the local social context. Since the GSD training by implementing agencies has included ToT, there should be more capacity to rely more on these local trainers to help meet future demands for GSD training.

Recommendation 2c: Consistent with its policy to use country sources of TA as their default, HP+ should consider using qualified local trainers to conduct GSD and/or other on-site trainings in the future.

CONCLUSION 3: ACHIEVING PROGRESS ON CROSS-CUTTING PRINCIPLES
Although the areas of gender equality, health equity, CD, and sustainability receive little/no dedicated funding under HP+, they are the four cross-cutting principles that undergird the entire HP+ Project, and accordingly, each of these areas has a technical lead assigned to it. HP+’s approach of integrating these principles into the planning and implementation of activities across HP+’s portfolio is a sound one that is having good effect. The team documented numerous results that have been achieved in each of the cross-cutting theme areas.

Recommendation 3: HP+ should continue to give priority to the cross-cutting theme areas of gender equality, health equity, CD, and sustainability, using all available approaches, especially within the context of HP+ field activities.

CONCLUSION 4: COUNTRY OFFICE STAFFING
Country offices are exclusively or predominantly staffed with local experts who are already known and respected in-country, making it easier for them to gain the trust of local partners. Local staff members know the language, culture, and local political context.

Feedback from partners working with HP+ country offices was generally positive. The team repeatedly heard the key words “very responsive” and “flexible” to describe the HP+ team, indicative of a very collaborative approach to project implementation. Although country offices do not all share the same strengths, some having had problems of leadership turnover and recruiting difficulties, they are doing excellent work overall, making it possible to achieve project objectives.
However, during site visits to four HP+ countries, the team observed first-hand that Country Offices sometimes have to operate as best they can under difficult circumstances that are beyond their control. For example:

- In Guatemala, the Country Office had to reduce staff and spending for its operations due to the late delivery of USAID funds for Guatemala.
- In Kenya, USAID had to suspend its engagement with the MOH about two years ago. As a result, all but the most critical to life-saving efforts of HP+’s work with the MOH stopped, and the Country Office lost some key staff. Our team recently learned that HP+ was later granted a waiver to continue their work with the MOH, and that the suspension was lifted as of November 8, 2018.
- In Tanzania, the team heard concerns in the country office about reduced activities/funding, and worried about losing key staff who had less than two months remaining on their contracts, and no commitments yet on contract extensions or timing/amount of new USAID funding from mission FS.

**Recommendation 4a:** In instances where HP+ Country Offices are adversely affected by U.S. Government political or fiscal requirements, the AOR, relevant USAID missions, and HP+ HQ should continue to determine what positive steps, if any, can be taken to mitigate the adverse impacts of those requirements on HP+ country funding and/or operations.

During remote interviews with HP+ staff in other countries, the team heard about several needs for additional staff:

- HP+/Indonesia stated that HQ assistance for analysis and report writing is very helpful. The country office also hires local short-term consultants as needed. However, the workload for the country office continues to increase, and they may need to hire another management assistant to help handle communications with clients and partners.
- HP+/Madagascar stated that with the current staff, the HQ team is very helpful in communications, but HP+/Madagascar says it needs a person locally to work on communications, across all aspects of their portfolio.
- HP+/West Africa stated that it needs at least one additional seconded person in each of the countries in the region to work in the MOH to push activities and policies along.

**Recommendation 4b:** HP+ should consider additional staffing requests based on their merits and available funding, and take appropriate actions.

**CONCLUSION 5: THE RISE OF HF WORK**

STTA from the HF team has accomplished a great deal over the past three years, but it appears to have fallen short of expectations in building capacity of host country partners. This was a common refrain heard from different partners in government and civil society about the work of the HF team. While not invalidating their expectations, interviews also elicited from these same partners their high praise and regard for the quality and timeliness of the HF work completed. Reconciling these seemingly contradictory responses leads to the conclusion that partners want both high-quality products and services from the HF team and an in-country/in-place capacity to perform such work with local staff, and
eventually by local staff. It is clear that HP+ is delivering the former, but not yet the latter to the 
complete satisfaction of many country partners. Given the HP+’s life of project and its financial and 
personnel level of resources, it is unreasonable to expect both to have occurred. However, in the 
future, and perhaps through any follow-on project, increased emphasis can be placed on building HF 
capacity in countries through any variety of available means.

A good portion of the value of the HF work done in countries was attributed to the long-term presence 
of staff, either working in the Country Offices, seconded in government ministries, embedded in other 
organizations or contracted locally or regionally for repeated consultations. HP+ distinguishes itself from 
other projects working in HF by deploying long-term technical staff in these ways. Donors, USAID 
health teams, governments and civil society partners were uniform in their high levels of satisfaction with 
the performance and output of these long-term staff.

In interviews, USAID health team members and Country Office staff pointed out that the LTTA 
assignments that have been the most effective were those that clearly specified the objectives to be 
achieved within the timeframe of the assignment and discrete deliverables. At the same time, these 
respondents noted that flexibility is also important to build into LTTA SOWs. This is because there will 
always arise opportunities that should be taken advantage of to advance objectives that are unforeseen 
at the time contracts are being negotiated.

With regard to writing STTA SOWs, comments from country partners and USAID health teams 
suggested ways that in some cases, capacity-building could be built into the work at hand. For example, 
HF advisors could, if given sufficient time and funding, perform assigned work in tandem with a country 
counterpart (e.g., in the counterpart’s institution, a so-called “co-working arrangement”). After leaving 
the country, the HF advisor could maintain the working relationship virtually, at a minimum, through the 
completion of the assignment.

**Recommendation 5a: HP+ should increase emphasis on building health economics and 
financing capacity in government ministries, at national and subnational levels, and CSOs. 
HP+ should increase involvement of its consortium partners in its capacity-building efforts.**

In one country, the HF work was criticized for not consistently linking the findings of its analytic work to 
recommendations for implementation, or, in the words of the health team leader, “translate analyses 
into action.” In another country, a health team member was disappointed that the recommendations for 
implementation that had followed from the HF analytic work would probably not be implemented 
because the analysis itself had taken so much time to complete.

To avoid such shortfalls in the future, health teams and HP+ could make greater efforts to communicate 
regularly with USAID staff about the progress of projects and what can be accomplished within specific 
time periods and budget. It is also recommended that the HF team makes every possible effort at the 
design stage of its analytic work to link to implementation that is, at a minimum, complementary to its 
objectives. Such examples include strengthening the capacity of government analysts to use data for 
decision-making (as mentioned in Recommendation 1) and/or providing data to CSOs engaged in budget 
avocacy, together with TA or material support to use the data effectively.

A related critique of HF activities from some members of health teams is that these activities are not 
generally amenable to periodic reporting of progress made toward results, as for example, service 
delivery projects are. Most respondents appeared to understand the fundamental differences between 
HF and service delivery projects (e.g., there is no template for success for the former that can be
applied across countries). Still, some health team members expressed frustration that the pacing of reporting progress toward results was irregular at best for HF activities.

**Recommendation 5b:** HP+ should make every effort to link HF analytic work to implementation of recommendations and keep USAID informed of its progress in doing so. HP+ should also adhere as closely as possible to health teams’ expectations for periodic reporting of progress against results for HF activities.

**CONCLUSION 6: CORE ACTIVITY IMPLEMENTATION**

HP+ uses core activities for innovative work and promoting of global learning. For FP, core activities are developed collaboratively with USAID, and USAID looks to HP+ to suggest ideas for core activities. Topics tend to be strategic. HIV funds in HP+ are also core funds but their use in countries is directed largely by OGAC. An exception has been HIV funds provided to HP+ through PEPFAR’S SFI. SFI funds have been used in HP+ (and its predecessor project) to make catalytic investments in selected countries to speed up DRM for HIV. SFI produced such results in Cambodia, Kenya, and Tanzania through the mid-point of the HP+.

In the area of HF, core activities funded under the FP account have launched a range of analyses, activities, and tools used in countries and globally, to improve FP sustainability. Notable examples of each include:

- Actuarial analysis to support, including FP coverage in health insurance and other universal risk pooling schemes
- Achieving market growth and sustainability through use of a TMA
- Identifying blended financing opportunities via “crowding-in” of private sector investments for FP in middle income countries
- Support for the multi-donor financing reference group, which HP+ chairs with UNFPA
- Modifications made to and implementation of CIPs
- Development of the roadmap model to advance understanding of FP financing directed at USAID mission staff
- Maintenance of the spectrum suite of models (such as RAPID).

The main challenges in implementing core activities in the field have been finding countries where missions and country implementing partners agree to host their implementation and secure expeditious USAID mission directors’ approval of them. A related challenge for mission staff is to know about or have any reasonable control over the delivery dates of the core activities’ products. For example, three core products were substantially behind schedule in Tanzania, for reasons not fully understood by mission staff. Obviously, to be successful in finding a country to host a core activity, the mission and implementing partners first need to see the relevance and potential usefulness of the activity in that country context. But if the mission is interested in the activity, it might also be helpful for the AOR to learn what the mission’s interest is, if any, in shared management of the core activity, and what that might look like. This is already happening in several countries.

**Recommendation 6:** HP+ and USAID should continue to be open to a shared management role between the AOR and the mission regarding core activities operating in-country. The mission should have a role in core activity day-to-day decisions in-country, if it so desires, the details of which should be negotiated with the AOR.
CONCLUSION 7: GLOBAL TECHNICAL LEADERSHIP

HP+ collaborates with multiple international organizations and donors in a variety of ways at both global- and country levels. HP+ participates on the global stage in a variety of TWGs; at the country level, HP+ has taken the lead in forming HF, FP, and RH multi-donor TWGs, plays key roles in task forces on population and development, and participates in initiatives led by PEPFAR, the GF to Fight AIDS, Tuberculosis, and Malaria (GF), the WHO, and other donors and technical agencies. These contributions cut across all technical components of the project.

HP+ acts as a conduit of information between international organizations/initiatives and their developing country partners by adapting the global goals and objectives of international initiatives to the local country context and by passing on-the-ground experience and lessons learned at the country level up to international organizations to inform and ground-truth their international initiatives. In essence, HP+ is talking about an international highway of ideas and experience between health professionals and policymakers in developing countries and developed countries. This only works if everyone is publishing and sharing information freely worldwide.

However, the team heard from at least one mission health team that the respective Country Office was not disseminating and publicizing HP+ results widely enough. Though this seems to be an exception, HP+ should redouble its efforts to ensure that HP+ results and publications are made widely available and are easily accessible to all key stakeholders.

Recommendation 7: HP+ should confirm that country results and publications are always shared promptly with the local USAID mission in print and electronic form. All publications also should be accessible on the HP+ website, and on HP+ country office webpages, should be provided to the USAID DEC, and disseminated widely to the relevant host country and international partners. HP+ Country Office leadership also should take initiative to regularly offer to do presentations in person and through webinars (or other electronic means) for USAID health team staff when major new publications or work products are released.

CONCLUSION 8: MODELS AND TOOLS

HP+ and its predecessor policy projects are recognized for their development and application of computer-based policy simulation models. Their original purpose was to stimulate policy dialogue among high-level government decision-makers, at presidential, parliamentary, and ministerial levels. Over time, the models have diversified and proliferated in purpose and for intended audiences (e.g., to support advocacy at subnational levels of government by "grassroots" organizations comprising indigenous women’s groups or people living with HIV/AIDS).

In interviews with stakeholders, particularly mission health teams, two issues that need attention were raised:

1. There have been instances where HP+ has not taken the time needed to fully engage implementing partners in countries (CSOs and governments) in understanding the sources of the modeling data, how the data were gathered or how the input parameters and values of the models were selected. These omissions were mentioned in interviews and led some partners, USAID health team members and CO staff to be critical of the models' effectiveness, claiming lack of ownership.
2. Reports from models and tools need to be less technical and more accessible in language translation and choice of terminology to the variety of audiences for which models are developed, from policy-makers to grass roots CSOs, and including clearly stated policy and program implications.

Recommendation 8: HP+ should mobilize HP+ staff and consortium partners involved in modeling activities to optimize efforts to deliver all work products on time. HP+ should always fully engage CSO and government partners at each stage of model/tool development and application. HP+ also should make every effort to publish reports that are accessible to all relevant audiences, from the national to local levels, and include clear policy and program implications.

CONCLUSION 9: FUTURE TRENDS

Virtually all of the many future trends reported from KII respondents are technically within the purview of HP+. But not all are equally important. In the analysis of the common themes in this section of this report, attention was focused on some crucial HF- and health services-related issues that were raised by numerous respondents. These included efforts to strive toward sustainable UHC, opportunities for engagement with the private sector on sustainable healthcare, and the important role that HP+ can play in helping countries move forward on their journey to self-reliance.

Recommendation 9: Few of the emerging issues reported here are brand new to HP+. Still, GH should consider how these emerging issues may offer new insights or approaches, particularly on transition issues, sustainable HF, and improvement of adolescents’ access to FP and HIV test/treatment services.
ANNEX I. SCOPE OF WORK

Assignment #: 533 [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: February 1, 2018
Last update: 3/14/18

TITLE: Midterm Performance Evaluation of USAID’s Health Policy Plus Project (HP+)

I. Requester / Client
- USAID/Washington
- USAID Country or Regional Mission
  Mission/Division: ___________________________ / ___________________________

II. Performance Period
- Expected Start Date (on or about): 4/3/2018
- Anticipated End Date (on or about): 9/28/2018

III. Location(s) of Assignment: (Indicate where work will be performed)
- Washington DC Base: USAID, Palladium, HP+ Partner Organizations, Other Partners
- In-country field visits: Guatemala, Kenya, Tanzania, and Malawi Country Missions
- By phone: Indonesia, Jamaica, Mali, Madagascar, and the West African Regional Office
- Online Survey: Remaining Missions

IV. Type of Analytic Activity (Check the box to indicate the type of analytic activity)
EVALUATION:
- Performance Evaluation (Check timing of data collection)
  - Midterm
  - 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**
  - [ ] Process Evaluation
  - [ ] Impact Evaluation

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

- **Impact Evaluation** (Check timing(s) of data collection)
  - [ ] Baseline
  - [ ] Midterm
  - [ ] Endline
  - [ ] Other (specify): ______________

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

- **Economic Evaluation** (PEPFAR)

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

### V. BACKGROUND

If an evaluation, Project/Program being evaluated:

<table>
<thead>
<tr>
<th>Project/Activity Title:</th>
<th>Health Policy Plus (HP+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award/Contract Number:</td>
<td>AID-OAA-A-15-00051</td>
</tr>
<tr>
<td>Award/Contract Dates:</td>
<td>8/25/2015 - 8/27/2020</td>
</tr>
<tr>
<td>Project/Activity Funding:</td>
<td>184,984,745.00</td>
</tr>
<tr>
<td>Implementing Organization(s):</td>
<td>Prime Awardee is Palladium. Consortium partners: Avenir Health, Plan International USA, Population Reference Bureau, RTI International, the White Ribbon Alliance for Safe Motherhood, and ThinkWell</td>
</tr>
<tr>
<td>Project/Activity AOR/COR:</td>
<td>Linda Cahaelen, ScD, MPH</td>
</tr>
</tbody>
</table>
The Global Context

As countries and other global development actors come together to shape the post-2015 Development Agenda, forming the Sustainable Development Goals (SDGs), continued investment in health and population policies is essential to spurring country-level progress and achieving USAID’s goal of eliminating extreme poverty and enabling resilient, democratic societies to realize their potential. However, countries still face significant challenges in obtaining and sustaining both political and financial commitments to improving health outcomes, particularly in meeting the demand for family planning (FP), ending preventable child and maternal deaths (EPCMD), and achieving an AIDS-free generation. A supportive and strengthened environment has characteristics (economic, political, administrative, and socio-cultural) that positively impact the ability of governments and stakeholders to engage effectively and in a sustained manner. While improvements to global and in-country health systems are widely understood to benefit the health and wellbeing of individuals and communities, it is essential that the right policies be in place to ensure that essential services are developed and implemented equitably, and needed resources secured. Unprecedented global growth creates specific challenges to global and national development and offers an opportunity for programming to provide assistance in developing policies and sustainable financing initiatives to support the transition.

The Project: Health Policy Plus (HP+)

HP+ is a global cross-bureau Health Policy Plus (HP+) project launched on August 28th, 2015. As the flagship policy and financing project, HP+ works with Missions to strengthen in-country approaches in policy, sustainable financing, accountability/governance, and advocacy. The HP+ project is a five-year cooperative agreement with a $185 million ceiling, with current core funding support of $20 million and operations in over 17 countries. Expanding the efforts of prior USAID investments from the Health Policy Project (HPP), HP+ focuses on strengthening and advancing health policy priorities in FP/RH, HIV/AIDS, and maternal health (see Annex 4 for breakdown of core funds). It aims to improve the enabling environment for equitable and sustainable health services, supplies, and delivery systems through policy development and implementation, with an emphasis on voluntary, rights-based health programs, and by strengthening in-country partners’ capacity to navigate complex environments for effective policy design, implementation, and financing. By working on evidence-based and inclusive policy, sustainable financing, improved governance, and strong advocacy, HP+ offers creative strategies to strengthen the capacity of in-country partners when navigating complex political and financial environments.

This project works at the intersection of health policy and health financing by supporting key stakeholders and governments to ensure that global, national, and decentralized policies and resources prioritize and support health systems. Substantive changes in policy are required to support rapid and substantial increases in financial and human resources for successful transition. Financing and domestic resource developments are required to assure broad and critical health policy implementation; new economic approaches are needed as countries seek to improve health systems and health outcomes. As decision-making and economic power devolve to the local level, improved approaches for accountability and transparency are critical, new processes for health planning and policy development and implementation are essential, and building capacity across a range of analytic, advocacy and negotiation skills is necessary.
See Annex I for more information on HP+ background and further context, and Annex 3 for a list of HP+ tools.

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

The activities under this project continue investments in consistently building the skills and capacity of local stakeholders, whose involvement is critical in maintaining momentum and carrying the work of the project forward. The project nurtures local organizations and institutions, supports development of financing approaches, and builds approaches to active and sustainable engagement of civil society with government in both decision-making and coordinated action. These approaches and efforts, embedded in the project at global, national and decentralized levels, engender the sustainability of results and continued action toward country development goals.

HP+ addresses four Intermediate Results (IRs) that are the highest priority for achieving improvements in the global and in-country context and reaching the overarching project goals. The innovative and varied nature of these thematically connected IRs require partners with diverse areas of expertise and capabilities for creative thinking that can nimbly marry innovation and best practice with field realities and possibilities, and address the IRs in an integrated manner. Cross-cutting principles, critical to achieving the results of HP+, are gender equality, equity, capacity development, and sustainability. Work in all IRs is required to achieve the project purpose.

**Table 1: HP+ Project Results Framework**

<table>
<thead>
<tr>
<th>PURPOSE</th>
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<tbody>
<tr>
<td>Improve the enabling environment for equitable and sustainable health services, supplies and delivery systems through policy development and implementation, with an emphasis on voluntary, rights-based family planning and reproductive health, maternal and child health, and HIV and AIDS</td>
<td>Result 1</td>
<td>Result 2</td>
<td>Result 3</td>
</tr>
<tr>
<td>Health policies are developed, adopted, implemented and monitored that improve equity, access, availability, affordability, and acceptability of quality health services, supplies, and information.</td>
<td>Sustainable, predictable, and adequate financing for programs and health policy implementation is increased.</td>
<td>Policy environment for public stewardship, accountability, and transparency is improved.</td>
<td>Sustainable development goals are advanced through global leadership and advocacy.</td>
</tr>
<tr>
<td><strong>Sub IRs</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1.1: Individual and institutional capacity to develop, implement, monitor and evaluate legal and regulatory frameworks, macro-level</td>
<td>2.1: Domestic resources for health services, supplies and delivery systems are increased.</td>
<td>3.1: Policies and regulatory frameworks that support accountable and transparent stewardship for health are developed,</td>
<td>4.1: Best practices in health policy, financing, and governance are advanced.</td>
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<tr>
<td>policies and operational policies is strengthened.</td>
<td>adopted, implemented and monitored.</td>
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<tr>
<td><strong>1.2:</strong> Sustainable policies and strategies that address health equity, support non-discrimination and human rights for poor, marginalized and vulnerable populations are developed, adopted, implemented, and monitored.</td>
<td><strong>2.2:</strong> Individual and institutional capacity to efficiently and effectively prioritize, deploy, and manage resources for health services and supplies is strengthened.</td>
<td></td>
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<tr>
<td><strong>3.2:</strong> Local leaders and technical experts in public and private institutions employ effective and transparent management and monitoring of health budgets and systems.</td>
<td><strong>4.2:</strong> The evidence-base for decision making in health services, supplies, and delivery systems is strengthened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.3:</strong> Individual and institutional capacity to effectively advocate for health policies is strengthened.</td>
<td><strong>2.3:</strong> Optimal range of public and private financing markets and mechanisms is developed and utilized.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.3:</strong> Civil society is empowered and engaged in participatory processes for policy advocacy, implementation, monitoring, and reform, and fiduciary transparency.</td>
<td><strong>4.3:</strong> Global advocacy agendas for equitable and sustainable health policy implementation are advanced.</td>
<td></td>
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</tr>
<tr>
<td><strong>1.4:</strong> Multi-sectoral policies with a focus on the integral links between FP/RH, health and other development sectors, are developed, adopted, implemented and monitored.</td>
<td><strong>2.4:</strong> Public and private partnerships are forged and leveraged for domestic resource mobilization for health.</td>
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Cross-cutting Principles: Gender Equality, Equity, Capacity Development & Sustainability

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

**HP+** has a global mandate to address health policy, advocacy, financing, and governance technical assistance needs for Sub-Saharan Africa, Latin America and the Caribbean, Asia/Middle East, Asia/Near East, and the Europe and Eurasia regions. The project prioritizes the focus countries for PRH, EPCMD, and PEPFAR, though any USAID-supported country may buy into the project.

**VI. Purpose, Audience & Application**

**A. Purpose:** Why is this evaluation/assessment being conducted (purpose of analytic activity)?

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

The purpose of this midterm performance evaluation is to provide the United States Agency for International Development’s (USAID) Bureau for Global Health (GH)/Office of Population and Reproductive Health Office (PRH)/Policy, Evaluation and Communication (PEC) Division, Office of
HIV/AIDS (OHA), and Office of Maternal and Child Health and Nutrition (MCHN) an independent assessment of USAID’s Health Policy Plus (HP+) Cooperative Agreement and its progress towards achieving project goals and objectives. As outlined in the USAID Project Appraisal Document (PAD) under which this project falls, this evaluation serves to accomplish the following:

1. Assess how the following have affected or influenced overall project performance: the quality of the project’s technical approach, its current and/or altered staffing and management structure, and its progress in achieving the four IRs. Identify current and emerging trends in policy, advocacy, financing, and governance.

2. Measure satisfaction of GH offices, Missions, Regional Bureaus, Country Government Partners, as well as other stakeholders and partners in project performance and its ability to achieve key benchmarks. Provide feasible recommendations to be incorporated into the management and conduct of future projects. Assess options for implementing the highest-priority recommendations.

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

The intended audience for this analysis is the GH/PRH Front Office, GH Bureau Offices, OHA, MCHN, USAID HP+ AOR management staff, HP+ lead implementing partner (Palladium), HP+ consortium partners, Missions, and regional bureaus.

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

Findings from the midterm performance evaluation will offer knowledge on the current status of HP+ project work in meeting objectives, satisfaction of missions and other stakeholders with approach, work, and tools, future funding buy-in, and identification of emerging trends.

**VII. Evaluation/Analytic Questions & Matrix:**

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

**USAID Evaluation Policy** recommends 1 to 5 evaluation questions.

- State the method and/or data source and describe the data elements needed to answer the evaluation questions.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Method &amp; Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 HP+ Technical Approach:</strong> To what extent have the current mix of HP+ technical assistance and capacity development approaches, including long-term technical assistance, short-term technical assistance, training, organizational development, monitoring and evaluation, and communications, enabled the achievement of the project’s objectives, and met indicators as outlined in the project PMP and Field Activity PMP?</td>
<td>Document review, HP+ self-assessment, USAID AOR team interviews, USAID project management team interviews, in-country key informant interviews and group interviews, phone key informant interviews, online surveys.</td>
</tr>
</tbody>
</table>
**Stakeholder Satisfaction:** What is the current level of satisfaction of USAID Missions and other partners with the inputs and progress towards project goals to date?

_**Areas to consider:**_

a. The experience of Missions and Regional Offices in meeting in-country programming and technical needs with regards to HP+ goals and results.

b. The challenges of implementing core activities in the field, and how have they been addressed.

c. The response of stakeholders (e.g., MOHs with seconded HP+ staff, other donors, etc.) to the technical approaches and project expertise related to **health financing** as outlined in the project IR2 (this is a new area of work).

**Future Trends:** What are the emerging trends and needs in health policy, advocacy, health financing, and governance that might be addressed in the current or future project?

_**Areas to consider:**_

a. **Additional** technical areas that a project such a HP+ should address in the future.

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

**General Comments related to Methods:**

The evaluation team will follow sound accounting procedures and be prudent in using the resources of the evaluation. The evaluation team will also follow a participatory and consultative approach ensuring close involvement of governments, relevant program partners, and beneficiaries.
The primary methodologies for this midterm performance evaluation will include: (1) background document review and (2) in-depth key informant interviews by the Evaluation Team with key USAID staff, stakeholders, and partners in-person, by phone, or through online surveys. The specific methodologies for each of the evaluation areas are identified and described below; however, where feasible, methods should be combined to address multiple questions at once. Group discussions, surveys, and direct observation will be open for discussion at the Pre-Evaluation Briefing.

All data collection tools will be reviewed by USAID, prior to data collection.

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

Documents are available for review for this midterm performance evaluation. These include the HP+ proposal, annual workplans, 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. Prior to the Pre-Evaluation Briefing, the Evaluation Team will be expected to have completed the home-based preparation for document review.

The initial document review by the Evaluation Team will be used to provide background information on the project/program, and will also provide data for analysis for this midterm performance evaluation. Documents and data to be reviewed may include:

- USAID Evaluation Policy, 2016
- RFA Request for Applications
- Project Application
- Cooperative Agreement
- Financial tracking documents and financial reports
- Project Strategies
- HP+ KM Strategy
- HP+ Gender Strategy
- HP+ Evaluation Strategy
- Project workplans (core and field) as relevant
- Project Annual and Semiannual Performance Reports
- HP+ Performance Management Plan (PMP)
- Participant evaluations of trainings as relevant
- Project developed tools and products
- Community of practice meeting notes/records
- Capacity building and training curricula, as relevant
- Country case studies, health strategies and frameworks, as relevant

Additional project-related information and technical reports can be found at the USAID Health Policy Plus Project website: [http://www.healthpolicyplus.com/](http://www.healthpolicyplus.com/).

### Secondary analysis of existing data (This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>HP+ monitoring database</td>
<td>HP+ maintains a database of performance indicator results. If the Evaluation Team needs additional analyses of these data, HP+ can run the analyses for the Evaluation Team</td>
<td></td>
</tr>
</tbody>
</table>
Key Informant Interviews (list categories of key informants, and purpose of inquiry)

The Evaluation Team will develop key informant interview guides. Key-informant and group interview informants will be identified by USAID and Palladium, and approved by the USAID Management Team. They will be drawn from but are not limited to the following:

- USAID Missions
- USAID Washington GH Bureau Offices (PRH, OHA, MCHN, GH FO, CI, OHS)
- West Africa Regional Bureau
- OAA contracting officer
- USAID Washington HP+ Management staff (PRH/PEC, MCH and OHA)
- HP+ Project Management Staff: Palladium
- HP+ Consortium Partners: (Avenir, Plan International USA, Population Reference Bureau, RTI International, the White Ribbon Alliance for Safe Motherhood (WRA), and ThinkWell)
- HP+ sub-award and sub-contract holders
- Stakeholders such as external subject matter experts, local and national in-country government officials, civil society organizations, in-country partners, and other identified partners.

For Washington DC-based staff, in-person interviews of key staff is preferred. Specific individuals within these target groups will be clarified between the USAID Management Team and the Evaluation Team.

Country selections for key informant interviews are based on both the size of the field support funding buy-in and a strong balance of substantive technical area representation in activities (i.e. family planning, HIV/AIDS, and maternal and child health).

For this evaluation, in-country field visits will take place in the Guatemala, Kenya, Tanzania, and Malawi. Phone interviews will occur for Indonesia, Jamaica, Madagascar, and the West African Regional Office.

The Evaluation Team will review all available documents and ensure that appropriate data collection tools are developed to obtain the needed information to complete Evaluation Tasks 1–3. Information/data should be collected to provide sufficient detail to answer key questions and inform the design process for the follow-on agreement.

All data instruments, data sets, presentations, meeting notes, and final report for this evaluation will be submitted to USAID in electronic editable format, and are the property of USAID.

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

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

Key informants may be grouped together when they represent similar category of respondent, as long as all are feel free to provide their own opinions and answers.

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

Survey (describe content of the survey and target responders, and purpose of inquiry)
Online surveys will be considered for an expanded group of HP+ field countries. Respondents will include key USAID staff, stakeholders, and partners.

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

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

  The team will also collect relevant data/information through:
  1. meetings and discussions with relevant stakeholders, and the representatives of the program partners and stakeholders, and
  2. visiting program sites and attending events as appropriate.

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

**HP+ Self-Assessment**

The USAID Management Team will work with the Evaluation Team to develop the HP+ Palladium self-assessment questionnaire for completion by the HP+ Leadership Team (internal to Palladium) at the outset of the evaluation. The Evaluation Team will administer and analyze data from this HP+ self-assessment as part of this midterm evaluation.

If **impact evaluation** –

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

**IX. 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)
X. ANALYTIC PLAN

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

Once the data collection process is complete, results will be carefully compiled and analyzed to identify significant findings and recommendations. The information collected will be analyzed to identify correlations and determine the major issues. Data will be disaggregated, where possible, by gender to identify how program inputs are benefiting disadvantaged and advantaged groups.

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

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

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

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

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

XI. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include HP+ proposal, annual workplans, 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 the data collection begins. The TPM will:

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

**Briefing and Debriefing Meetings** – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

• **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.

• **In-brief with USAID.** This Pre-Evaluation Briefing, at the beginning of the TPM. The Evaluation Team will organize and hold a preliminary half-day pre-evaluation briefing with the HP+/USAID Management Team to review and refine the evaluation objectives and the proposed tasks comprising the scope of work. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. The meeting will be comprised of HP+/ USAID AOR Management Team, the HP+ Palladium Management Team, and the Evaluation Team. The meeting will be used to further discuss the evaluation and scope of work.

• **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 the USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email. Briefings will include:
  - Review and finalize evaluation questions,
  - Review and finalize the assignment timeline,
  - Data collection methods, instruments, tools and guidelines,
  - Review and clarify any logistical and administrative procedures for the assignment,
  - Data collection plan,
  - Draft the evaluation workplan for USAID’s approval, and
  - Assign drafting/writing responsibilities for the final report

• **Mission briefings**: The team shall use the time during the field visits to collect data/information and consolidate main impressions for a debriefing meeting with the Mission prior to departing country.

• **A debrief** between the Evaluation Team and USAID AOR Team 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. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (**Note**: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

• **Debriefings after submission of a draft report**: The Evaluation Team will be responsible for organizing and holding a series of debriefing meetings to share the findings and recommendations. This will occur following the USAID’s review of the draft report, and their approval of the content of the report. The Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations.
A smaller debrief for review and discussion of the draft report will be held with the USAID management team.
A broader debriefing meeting will be held with USAID participating offices: PRH, OHA, and MCHN representatives.

- **IP debrief/workshop** will be held with the HP+/Palladium staff, in concert with USAID, for those sections of the evaluation that are relevant to project performance. This will occur after USAID’s approval of the content of the draft report, and following the final debrief with the USAID, 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. Selection of sites to be visited will be finalized during the in-brief in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field, and will continuously coordinate data collection of phone interview countries.

**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. USAID will manage implementing partner(s)’s (IP) review of the report and compile and send their comments and edits to GH Pro. (Note: USAID will decide what draft they want the IP to review.)
5. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
6. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved, GH Pro will re-format it for 508-compliance and post it to the DEC.

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

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

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

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

<p>| Expected deliverables with associated due dates will be agreed upon at the in-brief with USAID. |
|---|---|
| Deliverable / Product | Timelines &amp; Deadlines (estimated) |</p>
<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch briefing</td>
<td>April 3, 2018</td>
</tr>
<tr>
<td>In-brief with USAID</td>
<td>April 17, 2018</td>
</tr>
<tr>
<td>Workplan and methodology review briefing</td>
<td>April 23, 2018</td>
</tr>
<tr>
<td>Workplan, including:</td>
<td>April 25, 2018</td>
</tr>
<tr>
<td>1. Evaluation questions</td>
<td></td>
</tr>
<tr>
<td>2. Data collection strategy (including data collection instruments that include interview questionnaires fulfilling Tasks 1-3 described in the scope of work),</td>
<td></td>
</tr>
<tr>
<td>3. Proposed evaluation methodology (including sample sizes for both quantitative and qualitative data collection),</td>
<td></td>
</tr>
<tr>
<td>4. Data analysis plan (detailing, but not limited to, how group interviews (if used) will be transcribed and analyzed, what procedures will be used to analyze qualitative data from key informant and other stakeholder interviews, and how the evaluation will weigh and integrate qualitative data from these sources with project performing monitoring records to reach conclusions about the effectiveness and efficiency of the HP+ project and program)</td>
<td></td>
</tr>
<tr>
<td>5. Evaluation timeline</td>
<td></td>
</tr>
<tr>
<td>In-brief with target project / program</td>
<td>April 20, 2018</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>Two Out-briefs with USAID with Power Point presentation</td>
<td></td>
</tr>
<tr>
<td>1. An initial, smaller debrief for review and discussion of the draft report will be held with the USAID management team.</td>
<td>Initial smaller USAID debrief: June 25, 2018 Broader USAID debrief: June 26, 2018</td>
</tr>
<tr>
<td>2. A broader debriefing meeting will be held with USAID participating offices: PRH, OHA, and MCHN representatives.</td>
<td></td>
</tr>
<tr>
<td>Debrief will be planned for HP+/Palladium, in concert with USAID, for those sections of the evaluation that are relevant to project performance.</td>
<td>June 26, 2018</td>
</tr>
<tr>
<td>Draft report</td>
<td></td>
</tr>
<tr>
<td>Final report</td>
<td></td>
</tr>
<tr>
<td>Raw data (cleaned datasets in CSV or XML with codesheet)</td>
<td>August 3, 2018</td>
</tr>
<tr>
<td>All presentations and the final report for this evaluation will be submitted to USAID in electronic editable format, and are the property of USAID.</td>
<td></td>
</tr>
<tr>
<td>Report Posted to the DEC</td>
<td>September 21, 2018</td>
</tr>
</tbody>
</table>
Estimated USAID review time
Average number of business days USAID will need to review the Report? _______ 15 _____ Business days

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

Evaluation/Assessment team: When planning this analytic activity, consider:
- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/assessments must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI), or describing the conflict of interest if applicable.

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

Overall Team requirements:
A three member Evaluation Team is proposed; two of the members will be external consultants, with one designated as team leader. The third team member will be from USAID staff to assist with coordination and organizational logistics of the evaluation. The Evaluation Team consultants should have substantial demonstrated knowledge in health policy, health financing, and advocacy; in international public health in the fields of family planning and HIV/AIDS; and be familiar with USAID and PEPFAR policies, procedures and procurement mechanisms, and with conducting project evaluations.

Collectively, team members will need to have the following skills and experience:
1. 10–12 years of experience in international public health, including the areas of family planning and/or HIV/AIDS and/or MCHN.
2. 7–10 years of experience in the area of international health financing, health policy, including family planning and HIV/AIDS in developing country settings.
3. Expertise is required for several of the following technical areas:
   - Health policy development and implementation
   - Advocacy and capacity building for policy champions and civil society groups
   - Data analysis and modeling and
   - Health Systems
4. Experience with conducting evaluations, assessments, and questionnaire design.

In addition, each member should have the following skills and experience:
1. An advanced degree in public health, health policy, economics, or other relevant course of study.
2. Excellent English language skills, both written and verbal.
3. Demonstrated knowledge of USAID policies, programs, and procedures.
4. Ability to effectively conduct interviews, in person or by phone.
5. Ability to interact and communicate effectively with a diverse set of professionals.
6. Spanish and/or French language proficiency is preferred.

**Team Lead:** The Lead should have significant experience conducting project evaluations/analyses. He/she will be responsible for organizing and carrying out the evaluation, communicating with the HP+/USAID management team, ensuring the quality of the questionnaire design and data collection process and writing, and editing the final the evaluation report, including a version to be shared publicly that does not include any procurement-sensitive information.

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

<table>
<thead>
<tr>
<th>Logistics support</th>
<th>will be provided by HP+ in-country offices, and supported by USAID Missions, as needed. Staff from these in-country offices will recuse themselves from interviews with other partners and Missions, and other data collection activities, per the Team Leads direction.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator</td>
<td>may be recruited as needed in each country visited by the Evaluation Team. For phone interviews where French and Portuguese is needed, the Evaluation Team will work with GH Pro and USAID to identify staff who can assist with these interviews, as needed.</td>
</tr>
</tbody>
</table>

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

- Full member of the Evaluation Team (including planning, data collection, analysis and report development) – If yes, specify who: TBD will provide logistics and administrative support to the Evaluation Team, as well as assist with data collection, as needed.
- Some Involvement anticipated – If yes, specify who:
- No

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

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

**Level of Effort in days for each Evaluation/Analytic Team member**
*(The following is an Illustrative LOE Chart. Please edit to meet the requirements of this activity.)*
<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team Lead</td>
</tr>
<tr>
<td>1 Launch Briefing</td>
<td>0.5</td>
</tr>
<tr>
<td>2 HTSOS Training</td>
<td>1</td>
</tr>
<tr>
<td>3 Desk review</td>
<td>7</td>
</tr>
<tr>
<td>4 Travel to/from DC</td>
<td>2</td>
</tr>
<tr>
<td>5 In-brief with USAID</td>
<td>0.5</td>
</tr>
<tr>
<td>6 Team Planning Meeting</td>
<td>4</td>
</tr>
<tr>
<td>7 Workplan and methodology briefing with USAID</td>
<td>0.5</td>
</tr>
<tr>
<td>8 Eval planning deliverables: 1) workplan with timeline, eval matrix, protocol (methods, sampling &amp; analytic plan); 2) data collection tools</td>
<td></td>
</tr>
<tr>
<td>9 In-brief with HP+</td>
<td>0.5</td>
</tr>
<tr>
<td>10 Data Collection DQA Workshop (protocol orientation/training for all data collectors)</td>
<td>2</td>
</tr>
<tr>
<td>11 Preparation/Logistics for Team country visits</td>
<td>1</td>
</tr>
<tr>
<td>12 Data collection including travel to 4 countries (int'l travel to Africa for 3 country visits; travel from US to Guatemala, with approx. 8 days data collection in each country)</td>
<td>40</td>
</tr>
<tr>
<td>13 Data analysis</td>
<td>7</td>
</tr>
<tr>
<td>14 Travel to/from DC for preliminary debrief</td>
<td>2</td>
</tr>
<tr>
<td>15 Preliminary debrief with USAID HP+ AOR Team with prep</td>
<td>1.5</td>
</tr>
<tr>
<td>16 Draft report(s)</td>
<td>10</td>
</tr>
<tr>
<td>17 GH Pro Report QC Review &amp; Formatting</td>
<td></td>
</tr>
<tr>
<td>18 Submission of draft report(s) to USAID</td>
<td></td>
</tr>
<tr>
<td>19 USAID Report Review</td>
<td></td>
</tr>
<tr>
<td>20 Revise report(s) per USAID feedback</td>
<td>5</td>
</tr>
<tr>
<td>21 Travel to/from DC for final debrief</td>
<td></td>
</tr>
<tr>
<td>22 2 Debriefs with USAID with prep</td>
<td>2.5</td>
</tr>
<tr>
<td>23 HP+ debrief with prep</td>
<td>1</td>
</tr>
<tr>
<td>24 Finalize and submit report to USAID</td>
<td></td>
</tr>
<tr>
<td>25 USAID approves report</td>
<td></td>
</tr>
<tr>
<td>26 Final copy editing and formatting</td>
<td></td>
</tr>
<tr>
<td>27 508 Compliance editing</td>
<td></td>
</tr>
</tbody>
</table>
### Activity / Deliverable

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Eval Report(s) to the DEC</td>
<td>Team Lead</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Total LOE</td>
<td>88</td>
</tr>
</tbody>
</table>

If overseas, is a 6-day work week permitted

- [x] Yes
- [ ] No

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

DC, Guatemala, Kenya, Tanzania, and Malawi

### XIV. LOGISTICS

**Visa Requirements**

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

- **Tourist visas for Guatemala, Kenya, Tanzania, and Malawi**

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

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

**Clearances & Other Requirements**

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

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

If **Electronic Country Clearance (eCC)** is required prior to the consultant’s travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**.

HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

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

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

☐ USAID Facility Access (FA)
   Specify who will require Facility Access: ________________________________

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

☐ GH Pro workspace
   Specify who will require workspace at GH Pro: __________________________

☐ Travel -other than posting (specify): GH Pro will arrange travel to DC and each country visited
   ________________________________

☐ Other (specify): ________________________________

XV.  GH PRO ROLES AND RESPONSIBILITIES
GH Pro will coordinate and manage the evaluation/assessment team and provide quality assurance oversight, including:
  • Review SOW and recommend revisions as needed
  • Provide technical assistance on methodology, as needed
  • Develop budget for analytic activity
  • Recruit and hire the evaluation/assessment team, with USAID POC approval
  • Arrange international travel and lodging for international consultants
  • Request for country clearance and/or facility access (if needed)
  • Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
  • Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

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

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

**Before Field Work**
- **SOW.**
  - Develop SOW.
  - Peer Review SOW
During Field Work

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

After Field Work

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

XVII. **ANALYTIC REPORT**

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

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

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

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

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).

Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people’s opinions.

Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.

If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.

If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

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

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

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

--------------------------------
All data instruments, datasets (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.
ANNEX II. EVALUATION/ANALYTIC METHODS AND LIMITATIONS

The scope of work for this midterm performance evaluation suggested the methods the evaluation team was to use. HP+ was in Year Three of its five-year agreement at the time of this evaluation. The methods employed were semi-structured interviews with key informants, an e-survey, and supplemented by document review. This performance evaluation encompassed a broad range of evaluation methods and focuses on cause/effect questions. The focus for the evaluation is how well the project is implementing its work, with a particular emphasis on health financing, as well as how the work is perceived and valued, and other questions pertinent to design, management, and operational decision-making.

The HP+ evaluation team reviewed the project’s request for application (RFA) and technical proposal, performance monitoring plan (PMP), workplans, annual reports, as well as project products, reports, presentations, and publications, a total of more than 70 project documents. The HP+ AOR and Project Leadership Teams supplied most of these documents, with additional materials suggested by key informants.

The project documents were used to understand the scope of the project, help to develop the interview guides, and to corroborate information obtained from the key informant interviews. The team was also able to triangulate data regarding evaluation questions from multiple perspectives, since they interviewed many different target groups. Field visits were used to understand the context in which the project activities are implemented. The field visits were to Guatemala, Kenya, Malawi, and Tanzania, as requested by the AOR. Interviews also took place with key informants in Washington, D.C. including donors based in Washington D.C., the AOR team, other USAID staff that work with the project, the HP+ project leadership team, and key HP+ staff. These in-person interviews helped the evaluation team fully understand key stakeholders impressions and experiences with HP+, with full range and depth of information. Some interviews led to additional key stakeholders not originally on the key information interview list. For another eight countries, the evaluation team conducted phone-based interviews with USAID Mission staff, HP+ Country Office staff, and host country partners. An online survey was sent out to the remaining stakeholders.
ANNEX III. KEY INFORMANT INTERVIEW GUIDE

Introduction and informed consent

Oral Consent Statement for interviews conducted for the
Mid-Term Evaluation of the Health Policy (HP+) Project
USAID Global Health Bureau

Good Day,

My name is ______________________________. My colleagues’ names are: _____________________________________________ 

_____________________________________.

We are here today as part of our work for USAID evaluating the HP+ project.

Thank you for making the time to talk with us today.

The Global Health Bureau of USAID has asked GH Pro to collect information through interviews such as this to evaluate the HP+ project midway through its 5-year contract with Palladium Inc. and its consortium partners. This mid-term evaluation is examining the performance of HP+ in countries and at the level of its headquarters since its inception in August, 2015. It is not examining outcomes or impact.

You were suggested as a key person to interview for this evaluation owing to your involvement with it. We greatly value and appreciate your perspective, based on your experiences and judgments concerning the Project’s successes, challenges, barriers and, especially, lessons learned.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you are willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free not to respond to any of our questions or to stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Optional: I would like to record this interview to ensure that I do not miss any important points. Please know that anything you say during the interview will be kept confidential within the GH Pro team, and that in our report we will not be attributing specific comments to any specific individual.

Before we begin, do you have any questions about this interview?

[ ] Consent provided ___________ [Interviewer/Recorder initials]
HP+ Midterm Performance Evaluation

Guidelines for Knowledgeable Informants In-Depth Interviews

**Stakeholder Key:**
- AOR = AOR Team
- SUB = Consortium Partners
- MIS = USAID Missions
- AID = Other USAID/Washington
- HCP = Host Country Partners
- PAL = HP+ Palladium (HQ)
- D = Donors/International Organizations
- CO = HP+ Country Offices

**Introduction Question to Interviewees:**

Explain your position and role in planning, managing implementation, providing assistance to HP+.

**Evaluation Question 1:** To what extent have the current mix of HP+ technical assistance and capacity development approaches, including long-term technical assistance, short-term technical assistance, training, organizational development, monitoring and evaluation, and communications, enabled the achievement of the project’s objectives, and met indicators in the project PMP and Field Activity PMP?

1.1. Assess the extent to which the health policy and implementation priorities of HP+ (i.e., policy development, advocacy, sustainable financing, and accountability/governance) help to achieve project objectives, as outlined in IRs 1-4, and enabled the achievement of the corresponding PMP indicators (both Project and Field indicators).

1.1.1. Which of the HP+ key policy and implementation priorities have been included as priorities in this country? Policy development? Advocacy? Sustainable financing? Accountability/governance? (YES/NO) [CO, HCP, MIS]

1.1.2. How are the implemented HP+ project activities helping to achieve Mission/Country priorities? [CO, HCP, MIS]

1.1.3. Describe the approach(es) being undertaken, if any, to address the cross-cutting principles of: Gender Equality, Equity, Capacity development and sustainability. [AOR, HCP, MIS, PAL, SUB]

1.1.4. How has the current HP+ staffing structure been helpful, or not, in project implementation? [AOR, CO, MIS, PAL, SUB]

1.1.5. Are there any midterm changes in management structure or staffing that might be needed to further improve project performance? [AOR, CO, MIS, PAL, SUB]

1.1.6. How has HP+ contributed to global leadership and knowledge building through collaboration with other donors and international agencies, in countries and/or at international meetings? Can you give examples? [AID, D, PAL, SUB]

1.1.7. How would you describe the role HP+ plays in working with Missions, and other country stakeholders to plan and/or implement projects? [AOR, CO, MIS, PAL]
1.1.10. What is your assessment of technical approaches and project expertise employed by HP+ related to health financing reform? [AID, AOR, CO, D, HCP, MIS, PAL, SUB]

1.1.11. What are examples where progress has met or exceeded expectations, and what are examples where progress has not met expectations? [CO, MIS, PAL]

1.1.12. How well are HQ and country offices and teams adhering to project workplans and timelines, and managing budgets and pipelines? Cite reasons for successes and shortcomings. Do you have any suggestions improving any shortcomings? [AOR, HCP, MIS, PAL]

1.1.13. How has HP+ contributed to global leadership and knowledge building through collaboration with other donors and international agencies, in countries and/or at international meetings? Can you give examples of models, tools, and other products (e.g., publications, special reports, etc.) that contribute to HP+ objectives in policy, advocacy, accountability, or sustainable financing efforts? [AOR]

1.2. Assess the extent to which HP+ tools have been used to support the project’s four IRs.

1.2.1. How have the HP+ modeling, tools and other products (e.g., publications, special reports, etc.) contributed to HP+ objectives in policy development, advocacy, accountability, and sustainable financing efforts? Has use of these models, tools, other products contributed to capacity building? Give examples. [AID, CO, D, HCP, MIS, PAL, SUB]

1.3. Assess which HP+ tools and products have been most useful in the field, and why.

1.3.1. Which HP tools, models, or other HP+ products are you using in your country? How are you using them? Which tools/models have been the most useful? [CO, HCP, MIS]

**Evaluation Question 2: What is the current level of satisfaction of USAID Missions and other partners with the inputs and progress towards project goals to date?**

2.1. Assess the experience of Missions and Regional Offices in meeting in-country programming and technical needs with regards to HP+ goals and results.

2.1.2. How are local HP+ country activity managers and Missions involved in deciding how short-term TA needs will be met? [CO, MIS, PAL]

2.1.3. What are the protocols for communicating with your USAID counterparts? Does the current communication structure adequately support and address activity needs? If not, what can be improved [CO, HCP, MIS, PAL, SUB]

2.2. Assess the challenges of implementing core activities in the field, and how they have been addressed.

2.2.1. What is the strategy for use of core activities in the HP+ project, and under what circumstances are core activities initiated? [AOR, PAL]
2.2.2. What contributions do core activities make to HP+ objectives globally, and at the field level? What are the main challenges, and how are these being addressed? [AID, AOR, CO, MIS, PAL, SUB]

2.3. Assess the response of stakeholders (e.g. MOHs with seconded HP+ staff, other donors, etc.) to the technical approaches and project expertise related to health financing, as outlined in the project’s IR2. (This is a new area of work).

2.3.1. How do HP+ Consortium Partners share roles and activities? What have been some of the strengths and weaknesses in the collaboration among Consortium partners so far? [AOR, PAL, SUB]

2.3.2. How well is HP+ meeting countries’ requests for health financing reform? What have been important successes to date? Where have there been significant shortcomings, and how were these addressed? [AOR, CO, HCP, MIS, PAL, SUB]

**Evaluation Question 3: What are the emerging trends and needs in health policy, advocacy, health financing, and governance that might be addressed in the current and/or future project?**

3.1. What do you see as some of the emerging family planning policy priorities in the coming years? [AID, AOR, CO, D, HCP, MIS, PAL, SUB]

3.2. Where do you see HP+ fitting into PEPFAR programming at present and going forward? To what extent is HP+ addressing any of these priorities? What more could HP+ do to better address some of these emerging priorities? [AID, AOR, CO, D, HCP, MIS, PAL, SUB]

3.3. What do you see as some emerging health financing policy trends/issues in the coming years? [AID, AOR, CO, D, HCP, MIS, PAL, SUB]

3.4. What do you see as emerging maternal and child health priorities in the years ahead? [AID, AOR, CO, D, HCP, MIS, PAL, SUB]
ANNEX IV. HP+ SELF-ASSESSMENT GUIDE

This self-assessment is intended to give HP+ management an opportunity to respond corporately to a number of important evaluation questions and “tell your story” in a careful and thoughtful way. Note that these questions also include embedded requests for additional information that will help our team better understand the scope of what you do, and how you do it. That said, your participation in this self-assessment is voluntary and you may opt not to respond to some/all of these questions, if you choose.

- To what extent has your launch and implementation of core and field buy-in activities met your expectations, as reflected in your annual workplans? Please describe any challenges that you have faced in activity start-up and implementation, and how these have been addressed. Please also provide a table that lists each of your core and field activities (by country), with budget levels, program description, and IRs/technical areas addressed.

- How, specifically, is HP+ addressing each of the cross-cutting principles (i.e., gender equality, equity, capacity development and sustainability), both in HQ and in countries? Specifically, to what extent are each of these issues being addressed in core and field activities? In addition, how are Palladium and its consortium partners working to advance the state of the art for addressing these cross-cutting principles in the health policy context?

- Please describe the key steps and process for start-up of new HP+ core and field activities. How long does this take on average? How and when are other stakeholders (e.g., consortium partners, AOR team, missions, host country partners) involved in the start-up process? What suggestions do you have about ways to improve or shorten the start-up process?

- How have the project’s use and development of models and toolkits furthered each of the project’s technical areas (policy, financing, accountability/governance, advocacy)? Are these models and toolkits being used to promote capacity-building? Explain how.

- What is Palladium’s rationale for the HP+ management structure and systems, and to what extent have these met your expectations re effectiveness and efficiency? Please describe the HP+ management structure and systems, and whether/how these have evolved since the beginning of the HP+ Cooperative Agreement. Include a current organogram showing all organizational units, with names of leadership and staff assigned to each unit. Also list and describe any working groups or teams that cut across organizational units.

- How are you utilizing your consortium partners in HP+ implementation? Include information on funding levels provided to date to consortium partners for technical assistance and implementation of core or field activities. Also describe whether/how consortium partner staff are working with Palladium staff in daily operations. What systems exist for coordination and communication between Palladium and its partners? What challenges, if any, are you experiencing, and how could you improve collaboration with these partners?

- How does HP+ interface and communicate with the AOR Management Team and missions? Include a description of routine meetings and reporting (e.g., workplans and progress reports), as well as receiving AOR technical guidance on project priorities, and activities development and approval. What are your suggestions for improving the effectiveness and efficiency of communications with the AOR Management Team and/or missions?
• How is HP+ collaborating with international organizations and donors, at the global level and in countries? Please describe details of how HP+ is collaborating on specific initiatives in the health sector (e.g., FP2020, SFI, GFF, etc.) with these institutions.

• For the most recent FY, what is the overall LOE (total days) for technical assistance provided by each of the following: Palladium HQ, each of the consortium partners, country office staffs, and external consultants. Please comment on the relative proportions of TA provided by each organization, and the rationale for use of U.S.-based versus local sources of TA.

• What has been missions’ level of interest in health sector financing reform TA?

• What proportion of buy-ins has been for this assistance and how does this conform to HP+ expectations? What models and tools has HP+ developed and applied to advance health sector financing reform and how are they being used (e.g., advocacy, capacity development)? What has been your experience recruiting technical experts to provide health financing reform assistance, i.e., those having appropriate country experience and language skills?

• What are some emerging or new policy health policy issues that are or should be addressed by USAID in HP+ core and/or field activities? What policy issues or trends are you seeing in FP/RH, HIV/AIDS, and health financing reform? Which of these could be addressed under the current HP+ agreement?

• What unanticipated challenges or obstacles you have encountered? Is there anything else you would like to share with the evaluation team?
The USAID Office of Population and Reproductive Health has requested that GH Pro conduct a midterm performance evaluation of the Health Policy Plus (HP+) project. The focus of the evaluation is to measure the project's achievement towards its identified results, in addition to the extent to which HP+ is meeting the needs of its key stakeholders.

You have been selected as a key person to inform this analysis and we would greatly appreciate hearing your perspective.

Any information or examples you provide and any quotes will not be attributed to a specific person or institution, and all identifying information will be removed. You are also free not to respond to any of our questions.

Your willingness to submit a completed survey will confirm your agreement to participate in this survey. The survey is brief in order to respect your time. The evaluation team would greatly appreciate receiving your completed survey no later than October 5, 2018. You will receive a reminder one week before this deadline.

If you have any questions pertaining to this survey please email Richard Cornelius at richard_cornelius@hotmail.com. Thank you for your consideration and cooperation.

1. How engaged has HP+ been in the following health elements in your country?

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<thead>
<tr>
<th></th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don't Know</th>
<th>N/A</th>
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</thead>
<tbody>
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<td>Family Planning</td>
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<td>Maternal and Child</td>
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<td>Health</td>
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<td>Tuberculosis</td>
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<td>Other</td>
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</table>
2. In family planning, how engaged has HP+ been in the following technical focus areas in your country?

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<thead>
<tr>
<th>Focus Area</th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don't Know</th>
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<td>Stewardship and Accountability</td>
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<td>Other</td>
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3. What have been the most significant HP+ achievements in family planning in these technical focus areas (policy, financing, advocacy, stewardship and accountability) in your country?


4. In HIV/AIDS how engaged has HP+ been in the following technical focus areas in your country?

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<thead>
<tr>
<th>Focus Area</th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don't Know</th>
<th>N/A</th>
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<td>Advocacy</td>
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</table>

5. What have been the most significant HP+ achievements in HIV/AIDS in these technical focus areas (policy, financing, advocacy, stewardship and accountability) in your country?


6. In **other health elements**, how engaged has HP+ been in the following **technical focus areas** in your country?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>A little</th>
<th>Some</th>
<th>A lot</th>
<th>Don't Know</th>
<th>N/A</th>
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<tbody>
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<td>Policy</td>
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<tr>
<td>Advocacy</td>
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<tr>
<td>Stewardship and Accountability</td>
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</table>

7. What have been the most significant HP+ achievements in **other health elements** (please list) in these technical focus areas (policy, financing, advocacy, stewardship and accountability) in your country?

8. HP+ is providing technical assistance in health financing to many countries. If health financing activities are being addressed by the project in your country, please rate the following:

<table>
<thead>
<tr>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don't Know</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>1. Technical assistance in health insurance</td>
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<td>2. Technical assistance in costing</td>
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<td>3. Technical assistance in GIP development</td>
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<td>4. Technical assistance in GFF investment case</td>
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<td>5. Technical assistance in sustainable financing initiative (SFI)</td>
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<td>6. Other</td>
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</table>

Please explain.

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MIDTERM PERFORMANCE EVALUATION OF USAID'S HEALTH POLICY PLUS (HP+) PROJECT / 35
9. Rate HP+ in your country on a scale of 1 to 5 for the following:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don't Know</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. Incorporating consideration of gender into project activities</td>
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<td>2. Incorporating consideration of equity into project activities</td>
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<td>3. Incorporating consideration of sustainability into project activities</td>
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<td>4. Incorporating capacity development into project activities</td>
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10. What is your assessment of the following as employed by HP+ in your country:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don't Know</th>
<th>N/A</th>
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<td>1. Training</td>
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<td>2. Monitoring and Evaluation</td>
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<td>3. Organizational Development</td>
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<td>4. Communication</td>
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11. Please list examples of where HP+ progress has **met or exceeded expectations**.

   

12. Please list and explain examples of where HP+ progress has **not met expectations**.

   


13. What is your assessment of the following as employed by HP+ in your country:

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>1. Adhering to work plans</td>
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<td>2. Adhering to timelines</td>
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<td>3. Managing budget as approved in workplan</td>
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<td>4. Communicating funding pipeline</td>
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<td>5. Managing communication with missions</td>
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14. Select up to three HP tools, models or other HP+ products being used in your country. If less than three HP tools, models or other HP+ products are being used, enter N/A to move forward.

- Spectrum: AIM (AIDS Impact Model)
- Spectrum: Goals
- Spectrum: LIST (Lives Saved Tool)
- Spectrum: DemProj
- Spectrum: OneHealth
- Spectrum: FamPlan
- Spectrum: RAPID (Resources for the Awareness of Population Impacts on Development)
- Spectrum: RNMI (Resource Needs Model)
- TIME
- DemDiv
- Other (please specify)

15. How have these tools/models/products (listed in Question 14) been helpful?

...
16. What is your assessment of the following technical assistance providers as employed by HP+ in your country:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don't Know</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. HP+/Palladium Headquarters Staff</td>
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<td>2. HP+/Palladium In-Country Staff</td>
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<td>3. HP+ Consortium Partner Staff</td>
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<td>4. HP+ Regional/Local Consultant</td>
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17. What is your assessment of communication with the HP+ AOR Team in USAID/Washington related to the following:

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<thead>
<tr>
<th>Communication</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don't Know</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. AOR Team Point of Contact ongoing communication</td>
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<td>2. AOR team response to management concerns</td>
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<td>3. AOR response and involvement</td>
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18. HP+ often implements core-funded activities in-country to further global impact or to pilot new tools and approaches. Not every country will have core funded activities. Please name up to three CORE activities implemented by HP+ in your country.

i. HP+ Core Activity 1

ii. HP+ Core Activity 2

iii. HP+ Core Activity 3
19. Have the core-funded activities (detailed in Question 18) been helpful in advancing in-country objectives? Please explain.

20. What do you see as some of the emerging **family planning policy** priorities in the next 5 to 7 years?

21. What do you see as some of the emerging **health financing** trends and issues in the next 5 to 7 years?

22. What do you see as some of the emerging **maternal and child health** priorities in the next 5 to 7 years?

23. How do you see HP+ fitting into PEPFAR programming priorities at present and going forward?

24. What could HP+ do to better address current and emerging priorities in assistance to mission objectives?

THANK YOU SO MUCH FOR YOUR PARTICIPATION!!
**ANNEX VI. E-SURVEY SUMMARY TABLES**

**HP+ Midterm Performance Evaluation Online Questionnaire**

How engaged has HP+ been in the following health elements in your country?

<table>
<thead>
<tr>
<th></th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don’t Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>3</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>5</strong></td>
<td><strong>23</strong></td>
<td><strong>37</strong></td>
<td><strong>30</strong></td>
<td><strong>25</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Answered</th>
<th>36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skipped</td>
<td>1</td>
</tr>
</tbody>
</table>

**In-country engagement of HP+ in the following health elements:**

- **Family Planning**: 3.00
- **HIV/AIDS**: 3.00
- **Maternal and Child Health**: 2.50
- **Tuberculosis**: 1.50
- **Other**: 2.00

[Graph showing weighted averages]
In family planning, how engaged has HP+ been in the following technical focus areas in your country?

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>18</td>
<td>3</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>Financing</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>Advocacy</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>17</td>
<td>4</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>Stewardship and Accountability</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>8</td>
<td>6</td>
<td>20</td>
<td>57</td>
<td>26</td>
<td></td>
<td>35</td>
</tr>
</tbody>
</table>

Answered 35
Skipped 2

In-country family planning engagement of HP+ in the following technical focus areas:

![Weighted Average Chart](image-url)

**Legend:**
- Red bar represents Weighted Average
In HIV/AIDS how engaged has HP+ been in the following technical focus areas in your country?

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>9</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>Financing</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Advocacy</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>10</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Stewardship and Accountability</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>10</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>15</td>
<td>22</td>
<td>30</td>
<td>47</td>
<td>23</td>
<td>52</td>
</tr>
</tbody>
</table>

- Answered: 35
- Skipped: 2

**In-country HIV/AIDS engagement of HP+ in the following technical focus areas:**

- **Policy**: 3.00
- **Financing**: 3.00
- **Advocacy**: 3.00
- **Stewardship and Accountability**: 2.00
- **Other**: 2.00

*Weighted Average*
In other health elements, how engaged has HP+ been in the following technical focus areas in your country?

<table>
<thead>
<tr>
<th></th>
<th>None 1</th>
<th>A little 2</th>
<th>Some 3</th>
<th>A lot 4</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>33</td>
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<tr>
<td>Financing</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>11</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>Advocacy</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>8</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Stewardship and Accountability</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>10</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>8</td>
<td>29</td>
<td>33</td>
<td>37</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

Answered: 34

Skipped: 3

In-country engagement of HP+ for other health elements in the following technical focus areas:

- **Policy**: 3.30
- **Financing**: 2.80
- **Advocacy**: 3.40
- **Stewardship and Accountability**: 2.70

*Weighted Average*
HP+ is providing technical assistance in health financing to many countries. If health financing activities are being addressed by the project in your country, please rate the following:

<table>
<thead>
<tr>
<th>1. Technical assistance in health insurance</th>
<th>Very Poor 1</th>
<th>Poor 2</th>
<th>Average 3</th>
<th>Good 4</th>
<th>Very Good 5</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Technical assistance in costing</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td>6</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>3. Technical assistance in CIP development</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>13</td>
<td>6</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>4. Technical assistance in GFF investment case</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>5. Technical assistance in sustainable financing initiative (SFI)</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td>34</td>
</tr>
<tr>
<td>6. Other</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>7</td>
<td>16</td>
<td>30</td>
<td>41</td>
<td>49</td>
<td>42</td>
<td></td>
</tr>
</tbody>
</table>

Answered 37
Skipped 0

**Rating of HP+ technical assistance through health financing in country programming:**

- **Weighted Average**
Rate HP+ in your country on a scale of 1 to 5 for the following:

<table>
<thead>
<tr>
<th></th>
<th>Very Poor 1</th>
<th>Poor 2</th>
<th>Average 3</th>
<th>Good 4</th>
<th>Very Good 5</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incorporating consideration</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>13</td>
<td>6</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>of gender into project activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Incorporating consideration</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>11</td>
<td>5</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>of equity into project activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Incorporating consideration</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>13</td>
<td>1</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>of sustainability into project activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Incorporating capacity</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>11</td>
<td>12</td>
<td>3</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>development into project activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>8</td>
<td>23</td>
<td>38</td>
<td>49</td>
<td>15</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Answered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Skipped</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Rating of in-country HP+ on a scale of 1 to 5 for the following:

- Incorporating consideration of gender into project activities
- Incorporating consideration of equity into project activities
- Incorporating consideration of sustainability into project activities
- Incorporating capacity development into project activities

**Weighted Average**
What is your assessment of the following as employed by HP+ in your country?

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Very Poor 1</th>
<th>Poor 2</th>
<th>Average 3</th>
<th>Good 4</th>
<th>Very Good 5</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Training</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>14</td>
<td>3</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>2. Monitoring and Evaluation</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>16</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>3. Organizational Development</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>14</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>4. Communication</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>13</td>
<td>2</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>8</td>
<td>19</td>
<td>51</td>
<td>40</td>
<td>12</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Answered 36

Skipped 1

Assessment of the following areas as employed by HP+ in-country:

- **Training**: Weighted Average 4.30
- **Monitoring and Evaluation**: Weighted Average 3.80
- **Organizational Development**: Weighted Average 3.70
- **Communication**: Weighted Average 4.00
What is your assessment of the following as employed by HP+ in your country?

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very Good</th>
<th>Don’t Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adhering to workplans</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>14</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>2. Adhering to timelines</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>19</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>3. Managing budget as approved in workplan</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>17</td>
<td>4</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>4. Communicating funding pipeline</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>12</td>
<td>7</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>5. Managing communication with missions</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>12</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>7</td>
<td>18</td>
<td>60</td>
<td>68</td>
<td>17</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Answered 36  
Skipped 1  

Assessment of the following as employed by HP+ in-country:

- Adhering to work plans
- Adhering to timelines
- Managing budget as approved in workplan
- Communicating funding pipeline
- Managing communication with missions

Weighted Average
Select up to three HP tools, models or other HP+ products being used in your country. If less than three HP tools, models or other HP+ products are being used, enter N/A to move forward.

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spectrum: AIM (AIDS Impact Model)</td>
<td>12.90%</td>
<td>4</td>
</tr>
<tr>
<td>Spectrum: Goals</td>
<td>16.13%</td>
<td>5</td>
</tr>
<tr>
<td>Spectrum: LiST (Lives Saved Tool)</td>
<td>9.68%</td>
<td>3</td>
</tr>
<tr>
<td>Spectrum: DemProj</td>
<td>9.68%</td>
<td>3</td>
</tr>
<tr>
<td>Spectrum: OneHealth</td>
<td>22.58%</td>
<td>7</td>
</tr>
<tr>
<td>Spectrum: FamPlan</td>
<td>16.13%</td>
<td>5</td>
</tr>
<tr>
<td>Spectrum: RAPID (Resources for the Awareness of Population Impacts on Development)</td>
<td>29.03%</td>
<td>9</td>
</tr>
<tr>
<td>Spectrum: RNM (Resource Needs Model)</td>
<td>6.45%</td>
<td>2</td>
</tr>
<tr>
<td>TIME</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>DemDiv</td>
<td>25.81%</td>
<td>8</td>
</tr>
<tr>
<td>DMPPT (Decision Makers’ Program Planning Tool) 2.1</td>
<td>6.45%</td>
<td>2</td>
</tr>
<tr>
<td>LEAP (Local Epidemic Assessment for Prevention)</td>
<td>6.45%</td>
<td>2</td>
</tr>
<tr>
<td>Family Planning Tools</td>
<td>29.03%</td>
<td>9</td>
</tr>
<tr>
<td>RAPID Women</td>
<td>3.23%</td>
<td>1</td>
</tr>
<tr>
<td>ImpactNow</td>
<td>19.35%</td>
<td>6</td>
</tr>
<tr>
<td>SDG Model</td>
<td>3.23%</td>
<td>1</td>
</tr>
<tr>
<td>TMA Model</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric HIV Transition Model</td>
<td>3.23%</td>
<td>1</td>
</tr>
<tr>
<td>DMPA-SC Impact Model</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>35.48%</td>
<td>11</td>
</tr>
</tbody>
</table>

Answered 31

Skipped 6
HP tools, models or other HP+ products being used in country:

Other (please specify)  
DMPA-SC Impact Model  
Pediatric HIV Transition Model  
TMA Model  
SDG Model  
ImpactNow  
RAPIDWomen  
Family Planning Tools  
LEAP (Local Epidemic Assessment for Prevention)  
DMPPT (Decision Makers' Program Planning Tool) 2.1  
DemDiv  
TIME  
Spectrum: RNM (Resource Needs Model)  
Spectrum: RAPID (Resources for the Awareness of…  
Spectrum: FamPlan  
Spectrum: OneHealth  
Spectrum: DemProj  
Spectrum: LIST (Lives Saved Tool)  
Spectrum: Goals  
Spectrum: AIM (AIDS Impact Model)
What is your assessment of the following technical assistance providers as employed by HP+ in your country?

<table>
<thead>
<tr>
<th>Provider</th>
<th>Very Poor 1</th>
<th>Poor 2</th>
<th>Average 3</th>
<th>Good 4</th>
<th>Very Good 5</th>
<th>Don't Know</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HP+/Palladium Headquarters Staff</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>18</td>
<td>3</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>2. HP+/Palladium In-Country Staff</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>17</td>
<td>3</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>3. HP+ Consortium Partner Staff</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>7</td>
<td>9</td>
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<td>4. HP+ Regional/Local Consultant</td>
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<td>7</td>
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<td>32</td>
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</table>

Answered 36
Skipped 1

Assessment of technical assistance providers as employed by HP+ in country:

- Weighted Average
What is your assessment of communication with the HP+ AOR Team in USAID/Washington related to the following?

<table>
<thead>
<tr>
<th></th>
<th>Very Poor 1</th>
<th>Poor 2</th>
<th>Average 3</th>
<th>Good 4</th>
<th>Good 5</th>
<th>Very Good</th>
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<tr>
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<td>12</td>
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<td>2. AOR team response to management concerns</td>
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</table>

Answered 33
Skipped 4

Assessment of communication with the HP+ AOR Team in USAID/Washington related to the following:

- AOR Team Point of Contact ongoing communication
- AOR team response to management concerns
- AOR response and involvement

**Weighted Average**
## ANNEX VII. SOURCES OF INFORMATION

<table>
<thead>
<tr>
<th>Document:</th>
<th>Provided By:</th>
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</thead>
<tbody>
<tr>
<td>1. HP+ Quarterly Reports (2015–2016)</td>
<td>USAID</td>
</tr>
<tr>
<td>2. HP+ Semi-Annual Reports (2016–2018)</td>
<td>USAID</td>
</tr>
<tr>
<td>3. Annual Workplans (Years 1–3) for:</td>
<td>USAID</td>
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<td>• Cambodia</td>
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<td>• Ghana</td>
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<td>• Jamaica</td>
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<td>• Kenya</td>
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<td>• Madagascar</td>
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<td>• Malawi</td>
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<td>• Mozambique</td>
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<td>• Tanzania</td>
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<tr>
<td>• West Africa</td>
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<tr>
<td>• West Africa Health Informatics Team (WAHIT)</td>
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<tr>
<td>• Office of HIV/AIDS Core</td>
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<tr>
<td>• Office Population and Reproductive Health Core</td>
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<tr>
<td>• Office of Maternal and Child Health Core</td>
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<tr>
<td>4. HP+ Cooperative Agreement</td>
<td>USAID</td>
</tr>
<tr>
<td>5. HP+ Budget Narrative</td>
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</tr>
<tr>
<td>6. HP+ Technical Application</td>
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</tr>
<tr>
<td>7. Core Activity Support Matrix</td>
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</tr>
<tr>
<td>8. HP+ Knowledge Management and Communications Strategy</td>
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<tr>
<td>9. HP+ Performance Monitoring Plan</td>
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<tr>
<td>10. HP+ Mission Concurrence Tracker</td>
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<tr>
<td>11. Policy, Advocacy, Financing, and Governance for Health Project Appraisal Document (PAD)</td>
<td>USAID</td>
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<tr>
<td>12. HP+ Gender Equality Strategy</td>
<td>USAID</td>
</tr>
<tr>
<td>13. HEP+ Overview</td>
<td>USAID/Guatemala</td>
</tr>
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</table>
ANNEX VIII. HP+ MIDTERM EVALUATION
LIST OF EMERGING ISSUES

3.1 Family Planning

- Concern about decreasing donor support for FP and possible effect on services.
- Expect continued declines in donor funding. How can we fill that gap? Private sector? Governments? How to plan for transition?
- How to mobilize more domestic resources for FP, starting with commodities. A related need is for better budget execution and efficiencies.
- Task shifting across health providers, encouraging private sector to play a larger role.
- High rate of population growth, and population momentum (Malawi).
- Need for better access by youth to SRH services, in and out of schools.
- Need to improve client data services statistics from the field (Guatemala).
- Not enough money for contraceptive supplies, training, materials, provisions of supplies in communities.
- Decentralization of health services is becoming more common. It is a complex issue that involves building capacity at local levels, planning for orderly transition of resources/management of health programming, and lots of changes in governance, investment, self-assessments, and capacity-building.
- Big problem of youth bulge in this region (West Africa). Need to convince leaders that more investments in FP are needed.
- Among conservative factions internationally, there is some pressure to devote less funding for FP/RH. HP+ data and models are useful in combatting that pressure.
- Promoting more participation of men in support of family planning, maybe through radio promotions or Facebook. Need more male champions for FP.
- Promotion of vasectomy, because there is a real lack of good information on that.
- Global financing for FP and the costs of consumables.
- Centralized vs. decentralized procurement of FP commodities.
- Better implementation of health policies (e.g., CIPs).
- More grassroots advocacy for FP and strengthening coordination at local level as decentralization continues. (Malawi).
- How does HP+ and AFP connect?
- In some countries 70%+ of the health budget goes for staff salaries, leaving very little for actuals services (e.g. Tanzania and Guatemala).
- Need to promote more long-term methods, more than just IUDs (Malawi)
- Need to integrate FP into UHC healthcare platform (many respondents mentioned this issue).
• E-health issues. A drive to go electronic to collect and monitor data. To the district level if there is Internet bandwidth and reliable power supply.

• It is hard to get a handle on costing for FP. Need a better understanding of true consumer costs for accessing FP services.

• Need more work on advocacy and accountability for FP services.

• Thinking about introducing new methods into health systems (e.g., Sayana Press).

• The challenge is help steer policymakers away from the “China solution” in addressing the issue of high population growth.

• Need for more understandable information on the benefits of FP to help couples make more informed decisions about childbearing.

• Need a high-level policy favoring use of contraception, which hopefully would lead to more uptake. Might religious leaders be a bridge to help make this happen? (Malawi).

• Need to continue to monitor program performance and keep stakeholders informed.

• Continue efforts to expand coverage and reach all who need to be reached with FP services.

• FP2020 countries are still dependent on donors. Ghana is moving to finance own commodities though. Nigeria too. Both financially capable but where is the will? There are also supply chain issues.

• Demand side issues: Social and Behavioral Change methods. Changing family norms.

• Re youth friendly health services, need to think about what interventions have been most cost-effective, and how best to respond re sexually transmitted diseases issues.

3.2 HIV/AIDS

• Need to empower people living with HIV/AIDS to advocate for themselves.

• Concerns about declined donor support for HIV/AIDS programs. Increased DRM, task-shifting and private sector engagement, and efficiencies are all being considered.

• Concerns that increased domestic support for HIV may take funds away from other health programs. No consistent guidance on transition from GF and PEPFAR.

• CIPs and resource mapping needed to help governments understand the full costs and resources available.

• HIV+ youth and key populations face stigma/discrimination and difficulty accessing ARV.

• AIDS policy agenda too driven by PEPFAR; needs to be driven more by countries.

• Concerns about PEPFAR plans to push more funds to local organization, relating to needs for more capacity-building at local level.

• Concerns about phaseout of SFI and impact on AID/W partners working on HIV/AIDS.

• How to better integrate HIV with other health services, and into UHC.

• Need more emphasis on HIV program governance/policy/accountability.

• Need analysis on SFI. PEPFAR is turning directly to epidemic control and costing for that work is necessary.

• How to get national governments to pay for ARVs. Transition planning needed.
• PEPFAR isn’t working. Could do a lot more with policy and implementation. Prevention, especially among mothers and children, is needed.
• Line ministries continue to be sensitive about condom distribution in schools; need a multisectoral approach to address this issue.
• LBGTs and sex workers are still stigmatized and persecuted, which makes HIV prevention programs more difficult.
• Reaching men (who are hard to reach for testing and treatment).
• One-stop testing/treatment, with costing estimation. Could see that being useful to share with other countries.
• Need more behavior change communication advocacy.
• Too much emphasis from PEPFAR on meeting targets; not enough on building systems.
• Task-sharing creates capacity-building for NGO and private partners, which will position them well for PEPFAR funding in the future.
• With growing priorities on local partners, performance targets, and services, what is future role in HIV/AIDS for HP+?
• How to attract more financial contributions to the AIDS Trust Fund? (Tanzania)
• Costing work will be needed for transition from a vertical program to integration in existing health service delivery systems. Also decentralizing supply chain for commodities.

3.3. Health Financing
• Universal Health Care was one of the most oft-mentioned current/future priorities, usually accompanied by plans to establish a national health insurance program. Both of these are massive undertakings with lots of components and questions that need to be addressed. Among those cited by respondents:
  o How to pay for it, and who should have to pay?
  o How to define insurance pools/groups?
  o What should be included in UHC essential care?
  o How to monitor, evaluate, and do needed risk analyses?
  o How to integrate FP, AIDS, or other programs that are heavily donor-funded?
  o How to ensure quality healthcare services on this scale?
  o Issues of financing and healthcare capacity.
  o How to consolidate both the formal and informal sector into coverage?
  o How to do advocacy for UHC and promote the national health insurance system?
  o How to enroll all residents into the national health insurance system?
  o Costing of these initiatives, enacting enabling laws and policies, and development of national strategies for implementation.
• Declining donor support and efforts to increase domestic mobilization of resources were often mentioned in the health financing context, as were strategies for task-shifting, more engagement of the private sector, and improved program efficiencies.
• Resource tracking is important to improve efficiencies.
Can MOH push on other government ministries and the private sector to contribute to HIV/AIDS control, since all benefit from a healthier workforce?

Decentralization and all of the accompanying issues, like laws/policies defining the roles and functions of the MOH vis. local governments; and putting in all the staffing and systems related to appropriating, managing, and absorbing local and national health funding, procurement, M&E, etc.

Decentralization also substantially increases the need capacity-building in districts and communities.

Need better income data to plan for costing of insurance programs.

More attention needed to strengthen governance at the subnational level. Pilot programs needed to promote more effective use of budget, better allocation, more focus on results, and better efficiency.

Need better health information systems in place to better monitor progress.

3.4 Maternal Child Health

Need more training and reinforcing materials on MCH at the local facilities level.

Need to decentralize reach of TA even further to the sub-county level. Also need to do more refresher training due to turnover of county leadership and staff (due to elections and attrition). Need to strengthen links between county health officials and the MOH. (Kenya)

Capacity development is still an important issue for HP+.

How to collaborate more with other health systems projects? (AID/GH)

Need to work more with Ministries of Finance as allies for allocating more funding for MCH.

More work is needed to improve health systems related to maternal health.

Also need more work on creating local ownership of their MCH programs.

More devolution of MCH programs and financing to local authorities.

Since MCH generally has so little budget, there needs to be more attention on prioritization and improving efficiencies in healthcare.

Maternal mortality and safe motherhood are important health issues (Madagascar, Malawi, Guatemala)

Malaria is implemented through MCH and ante-natal care services. But MCH is lacking in funds, especially for commodities. Affects malaria program obviously. (Kenya)

Insert into MoHP Quality of Care Guidelines: norm of six months of exclusive breastfeeding so that entire staff of hospitals understand and promote practice. (Malawi)

Re HIS system, need better technology to pass data up from the districts to the Ministry. Spotty Internet coverage is a problem. Are mobile phones an alternative? Need to look at public/private partnerships to better use technologies.

Gender-Based Violence efforts need to be better aligned with OGAC indicators for GBV.

More work needed to reduce early marriage and childbearing; Need to look at age of consent laws and look at legal/policy barriers.

More procurement of essential drugs in MCH. Strong water, sanitation, and hygiene policies?
• Financial barriers still exist for accessing MCH services. (Tanzania)
• Local civil society networks can be a powerful force in advocacy and accountability. Civil society groups are willing to work with Congress to address issues of domestic violence and child immigration issues. (Guatemala)
• In health facilities, positions for midwives ought to be reserved for trained midwives and not occupied by nurses.
• Need to look for ways to better apply health financing planning to maternal/child health.
• More support is needed for proposals re women’s rights and protection for girls. Not yet engaged on LBGT issues, but needs are evident.
• Equity needs more attention. What are the vulnerabilities that affect safe motherhood (e.g., racism, HIV status, poverty)? These issues need to be looked at through a multisectoral lens.
## ANNEX IX. HP+ RESULTS FRAMEWORK

### PURPOSE

Improve the enabling environment for equitable and sustainable health services, supplies and delivery systems through policy development and implementation, with an emphasis on voluntary, rights-based family planning and reproductive health, maternal and child health, and HIV and AIDS.

<table>
<thead>
<tr>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
<th>Result 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health policies are developed, adopted implemented and monitored that improve equity, access, availability, affordability, and acceptability of quality health services, supplies, and information.</td>
<td>Sustainable, predictable, and adequate financing for programs and health policy implementation is increased.</td>
<td>Policy environment for public stewardship, accountability, and transparency is improved.</td>
<td>Sustainable development goals are advanced through global leadership and advocacy.</td>
</tr>
</tbody>
</table>

1.1: Individual and institutional capacity to develop, implement, monitor and evaluate legal and regulatory frameworks, macro-level policies and operational policies is strengthened.

1.2: Sustainable policies and strategies that address health equity, support non-discrimination and human rights for poor, marginalized and vulnerable populations are developed, adopted, implemented, and monitored.

1.3: Individual and institutional capacity to effectively advocate for health policies is strengthened.

1.4: Multi-sectoral policies with a focus on the integral links between FP/RH, health and other development sectors, are developed, adopted, implemented and monitored.

2.1: Domestic resources for health services, supplies and delivery systems are increased.

2.2: Individual and institutional capacity to efficiently and effectively prioritize, deploy, and manage resources for health services and supplies is strengthened.

2.3: Optimal range of public and private financing markets and mechanisms is developed and utilized.

2.4: Public and private partnerships are forged and leveraged for DRM for health.

2.5: Optimal range of public and private financing markets and mechanisms is developed and utilized.

3.1: Policies and regulatory frameworks that support accountable and transparent stewardship for health are developed, adopted, implemented and monitored.

3.2: Local leaders and technical experts in public and private institutions employ effective and transparent management and monitoring of health budgets and systems.

3.3: Civil society is empowered and engaged in participatory processes for policy advocacy, implementation, monitoring, and reform, and fiduciary transparency.

3.4: Civil society is empowered and engaged in participatory processes for policy advocacy, implementation, monitoring, and reform, and fiduciary transparency.

4.1: Best practices in health policy, financing, and governance are advanced.

4.2: The evidence-base for decision making in health services, supplies, and delivery systems is strengthened.

4.3: The evidence-base for decision making in health services, supplies, and delivery systems is strengthened.

4.4: The evidence-base for decision making in health services, supplies, and delivery systems is strengthened.

### Cross-cutting Principles:

Gender Equality, Equity, Capacity Development & Sustainability
### ANNEX XI. LIST OF HP+ MODELS/TOOLS

<table>
<thead>
<tr>
<th>Tool: Name and Description</th>
<th>Key Technical Focus</th>
<th>Relation to IRs*</th>
<th>Capacity Development Approach and Result</th>
<th>Countries Where Applied</th>
<th>Policy Results from Tool/Model Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Incidence Analysis Tool</td>
<td>Using hospital expenditure data and national household survey data to understand if health insurance is successfully reaching the poor, near-poor, middle, and rich groups equally.</td>
<td>• Focused on IR 1 • Supports IR 2</td>
<td>Developed capacity of Ministry of Finance in understanding the distribution of Indonesia’s single-payer national health insurance program, Jaminan Kesehatan Nasional’s (JKN’s), hospital-level benefits across the population, by geography and socioeconomic status.</td>
<td>Indonesia</td>
<td>National stakeholders realized that JKN hospital expenditure is disproportionately distributed geographically and across socioeconomic status. Highlighted need for policy to better target national health insurance resources to vulnerable groups and address supply-side challenges.</td>
</tr>
<tr>
<td>Catastrophic Health Expenditure Analysis Tool</td>
<td>Using national household survey data to measure (1) the proportion of households that experience catastrophic health spending over time and (2) important factors that influence catastrophic health expenditure.</td>
<td>• Focused on IR 1</td>
<td>Strengthened understanding among stakeholders from MOH, Social Security Administration, Ministry of Finance, Planning Ministry, USAID of effects of reliance on out-of-pocket health expenditure, methodologies for interpreting household health expenditure, and need for regular and reliable data.</td>
<td>Guatemala</td>
<td>Highlighted need for policymakers to explore other barriers, both financial and non-financial, to health service access.</td>
</tr>
<tr>
<td>Tool: Name and Description</td>
<td>Key Technical Focus</td>
<td>Relation to IRs*</td>
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| Costed Implementation Plan (CIP) Resource Kit | CIPs help country programs bring together stakeholders to assess the current FP situation, identify programmatic priorities, set targets, generate cost estimates, implement the plan, and monitor progress. Tools include:  
• Combined Excel costing and gap analysis tool and user guide  
• CIP: 10-Step Process for Planning, Development, and Execution  
• Communicating with Multisectoral Stakeholders about CIPs  
• CIP Performance Dashboard User Guide and Tool  
• Team Roles and Responsibilities for CIP Development and Execution  
• Performance Dashboard and user guide  
• Stakeholder Engagement for Family Planning CIPs: A Four-Step Process  
• CIP Execution Checklist  
• Performance Review Process Guidelines | • IR1  
• IR3  
• IR4 | Builds capacity of MOH policy makers and implementers in strategic planning and costing. | Benin, Burkina Faso, Ethiopia, Liberia, Madagascar, Mauritania, Niger, Pakistan, Sierra Leone, and Togo  
HP+ is supporting the development of CIPs in Nigeria, Mali, and Côte d’Ivoire | HP+ West Africa countries Mauritania and Benin applied the CIP execution checklist to conduct CIP midterm reviews.  
As part of CIP 10-step process, HP+ supported Burkina Faso, Liberia, Togo, and Madagascar to conduct a gap analysis exercise, several of which applied the Costing/Gap combined tool.  
HP+ supported Pakistan to develop a CIP strategy map to support CIP execution as part of the 10-Step process.  
Sierra Leone, Liberia, Ethiopia, Niger, Madagascar, and Bauchi and Ebonyi states in Nigeria applied the 10-Step Process and Costing tool to develop new CIPs.  
HP+ Mali and HP+ Madagascar applied the performance dashboard as part of CIP execution. |
<table>
<thead>
<tr>
<th>Tool: Name and Description</th>
<th>Key Technical Focus</th>
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<th>Policy Results from Tool/Model Application</th>
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<tbody>
<tr>
<td>Costing tool to help understand resource needs to meet 90/90/90</td>
<td>This Excel-based tool provides evidence on the resource needs for the government to meet 90-90-90 by 2020, with a HIV treatment cascade lens. Results can be used to advocate for financing and to inform policy</td>
<td>• Focused on IR 2</td>
<td>Presented tool at stakeholder meetings with National AIDS Control Programme, Ghana AIDS Commission, other key stakeholders.</td>
<td>Ghana</td>
<td>Tool estimates costs of interventions that may help retain clients and reinitiate those lost to follow-up; it also quantifies possibility for cost efficiencies from differentiated care.</td>
</tr>
</tbody>
</table>
| DemDiv | Developed under the Health Policy Project, DemDiv was updated under HP+ to better address the economic inputs to the model. | • Supports IR 1  
• Supports IR 4 | DemDiv model application process includes a CD dimension. \[\text{During applications, in-country partners—like ministries of health—are trained on the underlying theory and methodology of the model, how it functions, future independent use, and results presentation.} \] | Burkina Faso, Cote d’Ivoire, Madagascar | Results for all three recent applications demonstrate that a scenario in which fertility declines rapidly through family planning use, combined with other investments, helps facilitate or unlock a demographic dividend—measured specifically as an increase in per capita gross domestic product (GDP) in the final simulation year and an increase in the growth rate of GDP per capita. |
<table>
<thead>
<tr>
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<tr>
<td><strong>The DMPA-SC Impact Model</strong></td>
<td>Using country-level data, as well as assumptions based on existing DMPA-SC research results, this model can be applied using different scale-up and service-delivery scenarios, to help understand the potential outcomes of DMPA-SC introduction, providing decision-makers with valuable information on whether to invest in it, policy and service delivery changes needed to maximize the benefits, and how scale-up might roll out.</td>
<td>• Focus on IR 1 • Supports IR 2</td>
<td>This tool helps stakeholders to understand the pivotal nature of a range of policy/regulatory options, e.g., the additive value of CHWs providing DMPA-SC, versus (or in tandem with), and allowing drug shops to sell, versus self-injection. Each policy option yields different modeling results. The model application results can also be used as data for advocacy, to show the benefits of certain policy/service delivery options.</td>
<td>Nigeria, Cameroon Desk applications in Malawi and Tanzania</td>
<td>Nigeria has included the model results in their new National DMPA-SC Accelerated Introduction and Scale up Plan (2017–2021).</td>
</tr>
<tr>
<td><strong>Equitable Impact Sensitive Tool (EQUIST)</strong></td>
<td>A web-based analysis and strategic planning tool designed to help decision-makers identify and develop equitable strategies to improve health and nutrition for the most vulnerable women and children.</td>
<td>• Supports IR 1 • Supports IR 2 • Supports IR 3 • Supports IR 4</td>
<td>Trained MOH, civil society and implementing and development partners on how to use and manipulate the model.</td>
<td>Mozambique, Madagascar</td>
<td>In Mozambique, the technical working group was able to identify priority regions and target populations for investment. In Madagascar, the reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) investment case technical working group identified target regions and populations, a selection of high-impact interventions with target coverage, and key strategies to address systemic bottlenecks.</td>
</tr>
<tr>
<td>Tool: Name and Description</td>
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<tr>
<td>Family Planning Market Demand and Financing Analysis Tool</td>
<td>Using DHS data and secondary financial cost data to estimate future demand for family planning by method, method source, financing need by source, and fiscal space to assess feasibility of different scenarios for achieving sustainable family planning financing.</td>
<td>• Focused on IR 2 • Supports IR 1</td>
<td>Strengthened awareness of stakeholders from MOH, Ethiopia Health Insurance Agency, USAID, and implementing partners of the prospects for achieving sustainable family planning financing through a range of health financing mechanisms and reforms.</td>
<td>Ethiopia</td>
<td>A brief establishing a framework for sustainable financing of family planning through increased contributions from households and insurance. This analysis demonstrated that key policy actions, such as the inclusion of family planning in public insurance schemes, is necessary to ensure the sustainable, long-term financing of family planning.</td>
</tr>
<tr>
<td>Family Planning-Sustainable Development Goals (FP-SDGs) Model</td>
<td>Model results emphasize the vital role that family planning, fertility, and population dynamics play in achieving socioeconomic development, specifically showing how family planning can accelerate countries’ progress toward the Sustainable Development Goals (SDGs), across health and non-health sectors.</td>
<td>• Focus on IR1 and IR4 • Supports IR2 and IR3</td>
<td>The development of new evidence through the FP-SDGs Model encourages sustainability by promoting integration of best practices for development into policy and planning frameworks. Model trainings and inter-ministerial forums strengthen the capacity of national stakeholders to use data to prioritize policies and plans and manage resources.</td>
<td>Malawi</td>
<td>Indicated that if Malawi exceeds its family planning goal, the number of people living below the poverty line could shrink by 25%, food insecurity could decrease by half, and the income growth rate could increase by 7%, among other beneficial outcomes, boosting the country’s prospects for achieving the SDGs. Reflecting on these results, stakeholders developed advocacy messages related to policy, programs, and funding.</td>
</tr>
<tr>
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<td>Key Technical Focus</td>
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| Fiscal Space for Health Analysis Tool                           | Using macro-economic, budget, and expenditure data to estimate the potential resources available for health at the national and municipal levels and through the Guatemalan Social Security Institute. | • Focused on IR 2  
• Supports IR 1 | Strengthened awareness among the MOH, the Instituto Guatemalteco de Seguridad Social, municipal health offices, and other stakeholders of the prospects for increasing resources for health through the achievement of different macro-fiscal and budgetary targets. | Guatemala               | A report projecting available resources for health under a range of macro-fiscal and budgetary scenarios. Within current legal and regulatory framework, modest targets for revenue generation and prioritization of health could result in significant funding for the health sector. |
| Fostering Joint Accountability within Health Systems Curriculum  | Under the global advocacy and leadership pillar, HP+ helps countries translate their commitments to global agendas into local action. This supports multisectoral groups of family planning advocates to increase joint accountability for commitments. | • Focuses on IR 3 | This is a CD process, designed for sustainability and local ownership. To meet FP2020 goals, countries must reach those with equity barriers to services, thus, increasing accountability for commitments advances equity in access. | Kenya, Malawi, Uganda (including follow-up assessment)  
Adapted and used in part in Pakistan and Nigeria | In Iganga, Uganda, district officials added family planning data review to their quarterly meetings and increased training for data focal persons. |
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<tr>
<td>Family Planning Financing Roadmap Tool</td>
<td>This online resource can help identify sustainable family planning financing options for achieving countries’ family planning goals. Stakeholders can use the website to (1) learn more about health financing concepts, terms, relevant resources and (2) explore specific family planning financing options based on a country’s context through an interactive roadmap feature.</td>
<td>• Focused on IR 2 • Supports IR 4</td>
<td>Family planning stakeholders can develop their capacity to understand health financing issues and how they relate to family planning by accessing learning materials on the website. HP+ presented tool at the Attaining Sustainable Financing for Family Planning in Sub-Saharan Africa conference in Accra, Ghana in January 2018 and had one-on-one sessions with country teams. HP+ led a webinar in July 2018 to train potential users on how to use the interactive roadmap; the webinar recording is available on the HP+ website.</td>
<td>Currently includes data for 13 low and middle-income countries; an additional 50 countries are being added</td>
<td>The tool was launched in April 2018 and has had over 800 unique users. A majority of users are from countries outside of the US. Stakeholders from Uganda, Ghana, and Mali attending the Attaining Sustainable Financing for Family Planning in Sub-Saharan Africa conference used the roadmap when initially developing action plans for their respective countries.</td>
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<td>Healthcare Utilization Trends and Determinants Tool</td>
<td>Using national household survey data to measure outpatient and inpatient utilization trends over time and by sub-population, as well as understanding the factors that influence healthcare utilization.</td>
<td>• Focused on IR 1</td>
<td>Developed capacity of a Government of Indonesia institution (TNP2K) to understand healthcare utilization trends and determinants in Indonesia and how to conduct household survey data analysis.</td>
<td>Indonesia</td>
<td>National health insurance has increased healthcare utilization among the poor and near-poor, however a gap remains between the most vulnerable and rich. Highlighted need to explore barriers beyond financial factors that influence healthcare use.</td>
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<td>HIV Case-Finding Cost-Efficiency Tool</td>
<td>Using financial, programmatic, and epidemiological data to estimate current costs and project the costs of scaling up case-finding interventions.</td>
<td>• Focused on IR 2  • Supports IR 1</td>
<td></td>
<td>Kyrgyz Republic, Tajikistan</td>
<td>Highlighted current and future case-finding costs of new peer-driven outreach model for case-finding and active case-finding interventions.</td>
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<td>HIV Integration into Health Insurance Analysis Tool</td>
<td>This Excel-based tool analyzes policy options related to a proposed set of HIV services to be covered under health insurance. HP+ forecasted incremental costs to the schemes from HIV expenditure and assessed scheme sustainability to inform policies related to national health insurance scale-up.</td>
<td>• Focused on IR 2</td>
<td>Tool was built with a lot of flexibility to show how changes to key inputs would affect the results/outcomes.</td>
<td>Tanzania, Rwanda</td>
<td>HIV integration into health insurance is a way to increase DRM for HIV and is now part of the policy dialogue as the Government of Tanzania introduces new legislation for health insurance.</td>
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<td>HIV Policy Scan and Action Plan (HIV PSAP) Tool</td>
<td>The HIV PSAP approach allows countries to:  • Identify and prioritize HIV service gaps  • Analyze relevant policies and their implementation  • Engage stakeholders to develop, monitor, and adapt policy, regulatory, and legal action plans to achieve HIV related outcomes</td>
<td>• Focused on IR 1</td>
<td>Stakeholders are guided through a methodology to identify service gaps, analyze policies, and develop action plans to resolve policy barriers and gaps. Following application, stakeholders report liking the methodology and intending to apply it to other issues in the future. A facilitator’s guide accompanies the tool to ease use.</td>
<td>Ghana, Kenya, Lesotho</td>
<td>Action plans developed in Ghana and Lesotho.</td>
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<td>Lives Saved Tool (LiST)</td>
<td>A Spectrum-based model that evaluates the impact of increasing the coverage of high impact RMNCAH-N interventions to inform how resources should be allocated to have impact.</td>
<td>• Supports IR 1 • Supports IR 2 • Supports IR 3 • Supports IR 4</td>
<td>Provided stakeholders with information on the tool as part of the EQUIST training mentioned above and OneHealth costing analysis.</td>
<td>Mozambique, Madagascar</td>
<td>Informed the Global Financing Facility RMNCAH-N investment case by supporting the identification of the highest impact approach.</td>
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<td>National Health Insurance: Financial Sustainability Analysis Tool</td>
<td>Using secondary demographic, claims, and labor market data to project enrolment, contributions, expenditures and deficit to help policymakers understand if national health insurance is sustainable and will reach universal insurance enrolment goals.</td>
<td>• Focus on IR 2 • Supports IR 3 • Supports IR 4</td>
<td>Developed capacity of Ministry of Finance in projecting scheme deficits (one-on-one meetings). Institutionalized tool and related documentation with government counterparts. Trained local academics and researchers on tool and related methods.</td>
<td>Indonesia</td>
<td>National stakeholders reconsidered increasing premium contributions to the subsidized group, as this would bias the scheme to fund high utilization by upper income groups. Created demand for robust actuarial analysis of the national insurance scheme.</td>
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<td>OneHealth Tool (OHT)</td>
<td>The OHT is a model for medium- to long- term (3 to 10 years) strategic planning in the health sector, that estimates the costs of an entire health system, and links cost assumptions with health outcome models.</td>
<td>• Supports IR 1 • Supports IR 2 • Supports IR 4</td>
<td>HP+ held a refresher training on the OHT at the onset of the OHT application in Malawi with key MOH staff. HP+ provided hands-on mentoring to MOH staff in how to use the tool throughout the application process.</td>
<td>Malawi (under HP+, more countries under the Health Sector Strategic Plan II and revisions to the country’s essential health package.</td>
<td>The OHT application in Malawi informed development of the Health Sector Strategic Plan II and revisions to the country’s essential health package.</td>
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| **Oral PrEP Modeling Framework** | This modeling framework helps country programs use evidence to strategically plan for scale-up of PrEP. It helps countries inform policy using relevant impact, cost, and cost-effectiveness data. This framework is not a single tool, but rather uses a combination of the Incidence Patterns Model, Goals Model, and a newly developed oral PrEP workbook (Excel-based). | • IR 1  
• IR 2 | While this HP+ activity does not involve an explicit CD component, it has increased capacity of country stakeholders to apply modeling data toward their policy development and program planning. | Full modeling applications: Lesotho, Mozambique  
Desk applications: Ethiopia, Haiti, Kenya, Malawi, Namibia, Nigeria, Tanzania, Zambia, Zimbabwe | Final modeling results were shared with all countries in December 2017 to inform country operational planning (COP). Because the results were shared only very recently, they haven’t yet been incorporated into strategic planning decisions. |
| **PEPFAR Gender and Sexual Diversity (GSD) Training Curriculum** | Works to build capacity of participants to integrate GSD into existing program activities and direct services. Provides a nuanced understanding of GSD to expand impact of gender-based programs. | • IR 1  
• IR 4 | Trained over 4,000 individuals across 40+ countries:  
• Cohort of over 100 individuals with the capacity to lead the training, representing multiple countries.  
• Adapted curriculums for Uganda, Kenya, Jamaica, Nigeria, Mali.  
• Adapted to online training tool. | Under HP+: Jamaica, Kenya, Burundi, Nigeria, Mali, US, and online reach of 35 countries  
Under Health Policy Project: 40 countries | GSD Training targeting PEPFAR staff and implementing partners to sensitize them to fundamental knowledge pertaining to GSD to impact quality and reach of HIV programming. |
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<td><strong>Positive Health, Dignity and Prevention Curriculum (PHDP)</strong></td>
<td>This curriculum builds on the 2011 PHDP global policy framework, with the aim to strengthen the capacity of people living with HIV to advance the PHDP framework in Jamaica’s HIV response.</td>
<td>• IR 4</td>
<td>Builds capacity of people living with HIV.</td>
<td>Jamaica</td>
<td>Curriculum plays a key role in the national response. HP+ developed a framework to support mainstreaming PHDP within the national response, and the Government of Jamaica had adopted the curriculum as part of the national HIV strategy.</td>
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<td><strong>RAPID</strong></td>
<td>RAPID is not a new model, but continues to be relevant and applied under HP+ and has garnered numerous family planning funding and policy wins when applied with technical assistance from HP+.</td>
<td></td>
<td>Like with many other Health Policy Project and HP+ models, the RAPID application process includes a CD dimension. During applications, in-country partners—like ministries of health—are trained on the underlying theory of the model, how it functions, future independent use, and results presentation.</td>
<td>Nigeria (national level and Bauchi, Ebonyi and Sokoto states), Malawi</td>
<td>Results from the national application in Nigeria show that if the country achieves the contraceptive prevalence rate aspirations of its national population policy, 23 million fewer primary students will need to be educated in 2050 and 52,000 fewer doctors will need to be trained, ₦2.8 trillion less will be required to purchase rice imports, and 19 million fewer new jobs will be required between now and 2050.</td>
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| RMNCAH-N Resource Mobilization Tool | An Excel-based resource mapping tool to determine who is funding RMNCAH-N, where it is funded, and which RMNCAH-N domains are being funded to determine how resources are allocated and used and level of resources available. | • Supports IR 2  
• Supports IR 3  
• Supports IR 4 | Reviewed the tool with stakeholders and provided feedback on completion in person and remotely. | Mozambique, Madagascar | Supported increased coordination between the government and development partners on priority activities.    
Informed the Global Financing Facility RMNCAH-N investment case by identifying what additional or redistribution of resources was needed to support identified priorities. |
| Subnational HIV Cost Model | HP+ developed a framework and model to estimate HIV service delivery costs from 2018 to 2023 at the national and provincial levels in Indonesia. The cost model estimates provincial costs based on province-specific targets and unit costs. | • Supports IR 1  
• Supports IR 2 | HP+ worked closely with the subdirectorate for HIV in the MOH to develop and apply the cost model. 
HP+ transitioned the cost model to the subdirectorate for HIV following completion of the analysis, so they can continue updating and using the model to inform planning and budgeting. | Indonesia | The cost model results are informing higher-level discussions in Indonesia on what HIV service delivery costs could be better integrated with and covered by JKN, and the responsibility of local governments in funding HIV. |
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| Total Market Approach Model| This TMA Model provides estimates of the future state in which policies that enable better segmentation of the market can lead to growth of public, subsidized (socially marketed), and commercial sector growth, quantifying the win-win scenario that all stakeholders can align behind to improve access to and sustainability of family planning programs. | • Focus on IR 1  
• Supports IR 2 and IR 3 | Uganda, Nepal | Contributed to the Uganda FP Total Market Approach Strategy, currently in development. |
ANNEX XII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

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

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

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

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

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

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

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

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

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

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

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

Page 113 of 131

MIDTERM PERFORMANCE EVALUATION OF USAID'S HEALTH POLICY PLUS (HP+) PROJECT / 120
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.

Richard M. Horne 02/15/2018
Signature Date

Richard Cornelius Consultant
Name Title
# ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

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<td>Terri Lukas (Theresa)</td>
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ANNEX XIII. SUMMARY BIOS OF EVALUATION TEAM

**Richard Cornelius** is an international health professional with 32 years’ experience in the population and health sector at USAID as a demographer, project manager, supervisor, and senior policy advisor; two years with a for-profit NGO as Director of Technical Operations; and 10 years as an independent consultant in international population and public health, focused mainly on external evaluations of population and health projects. He holds an MA in Sociology (Demography specialization) from Bowling Green State University. He is a team player with proven ability to achieve exceptional results. He has provided technical assistance to more than 25 countries in Africa, Asia, Europe/Eurasia, and Latin America. Along with his significant experience with demographic analysis, program evaluation, and performance monitoring, Mr. Cornelius has excellent oral and written communication skills.

**Terri Lukas** holds graduate degrees in Applied Economics and Public Health Planning and Economics. She has more than 30 years’ experience working in technical and managerial positions in USAID and NGOs. Her competencies include policy analysis, implementation planning and management, and monitoring and evaluation, and she has recently applied to programs in maternal and child health, infectious disease prevention and control, systems strengthening, and livelihoods. She has field experience in Sub-Saharan Africa, North Africa, the Himalayan region, South and Central Asia, and South and Central America and works in English, French, and Spanish.

**Kelly Thomas** has been a Program Analyst in the Policy, Evaluation, and Communication Division in the Office of Population and Reproductive Health (PRH) since 2014. She supports the policy team managing award administration, finances, and logistics for Health Policy Plus (HP+) and Policy, Advocacy, Communication Enhanced (PACE). She also supports the PRH response for the Global Financing Facility in support of Every Woman Every Child and supports the Bureau for Global Health Pakistan, Niger, and Burkina Faso Country Teams. Before joining USAID, she worked in the Best Practice Division at the American College for Obstetricians and Gynecologists. She completed her Master’s in Public Administration, International Development Management, at George Washington University and Bachelor of Arts in International Relations at American University in Washington, D.C.

**Kristen Rancourt** is a Program Analyst in the Research, Technology, and Utilization Division in the Office of Population and Reproductive Health (PRH) at USAID. She supports biomedical and social science research projects, as well as the World Health Organization Grant. She also supports the Democratic Republic of the Congo Global Health Country Team. Prior to joining USAID in 2015, she worked on data analysis and market research projects at the Department of Health and Human Services. She has a Bachelor of Arts degree in International Studies from American University and is pursuing a Master of Science degree in Government Analytics from Johns Hopkins University.
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