Evaluation

MOMENTUM Private Healthcare Delivery

Midterm Performance Evaluation

September 2024

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Midterm Performance Evaluation

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Abstract

Data for Impact (D4I) conducted a midterm evaluation of the Moving Integrated, Quality Maternal, Newborn, and Childe Health and Family Planning and Reproductive Health Services to Scale (MOMENTUM) Private Healthcare Delivery (MPHD) Activity, a 6-year global program, funded by USAID. MPHD works globally to support private sector engagement in Maternal and child health and nutrition (MCHN), family planning/reproductive health (FP/RH) and other health areas to address acute needs in resource-constrained countries, especially to prevent maternal and child morbidity and mortality. The MPHD consortium is led by Population Services International (PSI), in collaboration with JHPIEGO, FHI360, Avenir Health, and ThinkWell, working in 15 countries to date.

A mixed methods approach was used combining document desk review, an online survey of USAID mission staff, in-person interviews with USAID staff from Washington, key informant interviews with MPHD staff and missions with MPHD activities, and other implementing partners. Additionally, group interviews and observational visits were conducted during field visits to Benin and Ghana. Document reviews and data collection occurred between July 2023 and April 2024.

MPHD has made progress towards its objectives across four key result areas and in three main technical approaches, but gaps and challenges exist. There are opportunities to strengthen programming during the remainder of the project period. These opportunities are:

1) Improve uptake of health products and services by linking more effectively to social and behavior change demand generation activities

2) Expand public-private sector collaboration strategies

3) Move the field forward with thought leadership products and learnings

4) Identify sustainability strategies

5) Strengthen country-level leadership and stewardship of private sector investments and programs

6) Expand meaningful cross-sector collaboration

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Cover

Group of women at health facility in Zogbodome, Benin. Photo: Gael O'Sullivan, Data for Impact.

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Abbreviations

ABMS	Association Beninoise pour le Marketing Social
ASRH	adolescent and sexual reproductive health
C4C	Counseling for Choice
CRS	Nepal CRS Company
CYP	couple-years of protection
D4I	Data for Impact
DHO	District Health Office
DHS	Demographic and Health Survey
EmONC	emergency obstetric and newborn care
FP	family planning
GP	general practitioner
HCD	human centered design
HCPN	healthcare provider network
HIS	health information system
HMIS	health management information systems
HMIS/DHIS2	Health Management Information System/District Health Information System 2
ICCM	Integrated Community Case Management
ICFP	International Conference on Family Planning
IMAP	Integrated Midwives Association of the Philippines
IUD	intra-uterine device
KII	key informant interview
LARC	Long-acting reversible contraceptives
LGU	local government unit
MCGL	MOMENTUM Country and Global Leadership
MCHN	Maternal and Child Health and Nutrition
MKA	MOMENTUM Knowledge Accelerator

MNH	maternal and newborn health
MoH	Ministry of Health
MOMENTUM	Moving integrated, quality maternal, newborn, and child health and family planning and reproductive health services to scale
MPHD	MOMENTUM private healthcare delivery
PCC	person-centered care
PSE	private sector engagement
PSI	Population Services International
PWD	provincial welfare department
QI	quality improvement
RH	reproductive health
SBC	social and behavior change
SDP	service delivery point
SFH	Society for Family Health
SMM	Social Male Mobilizers
TA	technical assistance
TFHO	Total Family Health Organization
TMA	Total Market Approach
USAID	United States Agency for International Development

Executive Summary

Evaluation Purpose and Questions

The purpose of the MOMENTUM Private Healthcare Delivery (MPHD) midterm performance evaluation was to assess the project's interventions, their implementation status, quality to date, and overall achievements and obstacles to achieving key results. This midterm evaluation evaluated what is working well, identified areas that need rethinking, and determined any major changes required at both the global and country levels. The evaluation addressed the following questions:

EQ1. To what extent has the MPHD project achieved its objectives to date, as identified in the conceptual framework, in the areas of family planning/reproductive health (FP/RH) and maternal and child health and nutrition (MCHN)?

EQ2. To what extent has MPHD been able to incorporate the three[1] main technical approaches – private sector engagement, person-centered care, localization – into its activities?

EQ3. How have project management, coordination, and collaboration affected the achievement of project objectives?

EQ4. How well has the project integrated cross-sectoral issues into project activities (with a specific focus on youth, gender, and the environment)?

EQ5. What are some areas for improvement in the remaining years of the project to ensure achievement of the MPHD key result areas and objectives?

Background

This midterm performance evaluation focused on the MPHD project, Award Number 7200AA20CA00007. The original award period was from June 22, 2020 to June 21, 2025. However, the end date for the project was extended to June 30, 2026, increasing the total funding for this period from $75 million to $132 million. MPHD works globally to support private sector engagement in MCHN, FP/RH and other health areas to address acute needs in resource-constrained countries, especially to prevent maternal and child morbidity and mortality. MPHD's overall goal in targeted countries is to expand private sector healthcare coverage and improve health outcomes for FP/RH and MCHN. The MPHD consortium is led by Population Services International (PSI), in collaboration with JHPIEGO, FHI360, Avenir Health, and ThinkWell. To date, 15 countries (Benin, Burundi, Ghana, India, Indonesia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Pakistan, Philippines, and Uganda) have received core support or contributed field support funding under MPHD.

Methods and Limitations

Data collection included a document desk review, an online survey of USAID mission staff, in-person meetings with USAID staff from Washington, key informant interviews (KIIs) with MPHD staff and missions with MPHD activities, and other implementing partners. Additionally, group interviews and observational visits were conducted during field visits to Benin and Ghana. Findings from the field visits were summarized in case studies in Appendices 5 and 6. Document reviews and data collection occurred between July 2023 and April 2024. In Ghana, evaluators conducted KIIs with 15 individuals and met with an

[1] Initially comprised of four main technical approaches, two were combined during the program, and details are provided below.

additional 17 individuals through site visits and group interviews. In Benin, evaluators held KIIs with 15 individuals and met with an additional 65 individuals in site visits and group interviews. A total of 55 KIIs were held with USAID mission staff (7), USAID Washington staff (6), MPHD global consortium partners (10), and MPHD in-country staff and partners (32). The evaluation was determined to be exempt by the ICF institutional review board in November 2023.

Limitations: The online survey had a poor response rate (eight out of 40) limiting the ability to generalize from the quantitative primary data collected. Consequently, most primary data collected for the evaluation is qualitative in nature. In Uganda, the stakeholders from the Kampala Capital City Authority and Uganda Healthcare Federation informed the team that they were not involved in MPHD, so no KIIs were conducted for Uganda. Therefore, the team has limited information about the Uganda program.

Results

MPHD has implemented a comprehensive mix of interventions, with significant focus on improving availability of quality health products and services through the private sector and strengthening private healthcare providers' capacity to deliver these products and services. Core funding is being used to test, refine, and share learnings about new products such as the person-centered care (PCC) training methodology. Global thought leadership efforts have shown promise, yet there is room for improvement to have MPHD, as a global project, move the field forward.

To highlight potential action items emanating from the MPHD midterm evaluation, a summary of findings for Evaluation Question 5 is listed first, followed by the remaining Evaluation Questions.

EQ5. What are some areas for improvement in the remaining years of the project to ensure achievement of the MPHD key result areas and objectives?

At the global level, while important progress has occurred using core funds to advance technical priorities such as PCC, integrated FP/child health curricula, and quality service delivery, there are opportunities for improvement across strategic priorities such as increased use of products and services, attention to adolescents/youth, expanded host country technical leadership, and global thought leadership. While MPHD field support work plans have a standard section covering transition and sustainability, the plans could be more robust and provide additional detail. In contexts with budget reductions or budget delays, such as in Indonesia and the Philippines, there was a streamlined focus on technical approaches and an emphasis on handover to local partners.

EQ1. To what extent has the MOMENTUM Private Healthcare Delivery project achieved its objectives to date, as identified in the conceptual framework, in the areas of FP/RH and MCHN?

MPHD has enabled local partners to extend and deepen activities with the private sector; however, there is wide variation in the capacity and interest in working with the private sector across countries and integration of the private sector within financing and service delivery arrangements has remained a challenge in some contexts. In some instances, MPHD has built on preexisting projects with public sector partners (e.g., Indonesia and the Philippines) or supported and expanded the scope of local partner organizations (e.g., Nepal and Pakistan). While progress has occurred in some country programs to increase uptake of priority quality health services, efforts to improve access to products and services for targeted

subpopulations, such as adolescents, have had limited reach and impact. Core funded projects have allowed for more time for implementation (4-5 years of funding) and include a focus on transition and sustainability. Country buy-ins have had significantly shorter timelines, and some have experienced significant funding cuts, impacting the achievement of objectives. Delayed workplan approvals and budget allocations have also posed implementation challenges for some activities.

EQ2. To what extent has MPHD been able to incorporate the three[2] main technical approaches – private sector engagement, person-centered care, localization – into its activities?

Technical approaches are interwoven and 'nested' in line with the MPHD theory of change. Technical approaches have been implemented at policy level through service delivery, but not always using a 'whole system' approach, which may perpetuate fragmentation. Respondents indicated that project duration, even with core funding, was short relative to the 'ambition' of technical approaches.

While private sector engagement is a core PSI capability, under MPHD they have not expanded their business model to adapt to current global priorities such as expanding insurance schemes, designing innovative public-private partnerships, and improving host country stewardship. There are missed opportunities to share and leverage some of the learnings from MPHD private sector activities within MPHD country programs, across related USAID programs, and across technical areas such as FP/SRH and MNCH. The technical approach and logic, that improved capacity leads to equitable, profitable, and sustainable services within the private sector, does not hold in all contexts nor is the pathway to service uptake, particularly for adolescents.

The PCC approach is gaining traction globally. Stakeholders appreciate the focus on the needs of the client and the mixed mode of training that includes mentorship follow-up.

In terms of localization, there are good examples of PSI supporting Total Family Health Organization (TFHO) in Ghana and transitioning to TFHO being a prime implementing partner. In Burundi, MPHD is building local capacity of two partner organizations with the goal of getting them to the point of eligibility for direct USAID funding. A central premise of localization has been sustainability, which may place significant pressure on the local partner if they are viewed as the lynchpin to this strategy. Additionally, there is a tension between a focus on results and sustainability. As part of the standard MOMENTUM template, all MPHD Field Support workplans contain a section called "Sustainability and Transition Strategy," which outlines at a high level how project activities or project impact expect to carry on after project closure. This section of the workplan is updated annually. However, given the pressure to deliver on results, in some instances this priority overshadows the longer term need to plan for and achieve sustainability on a practical level without continuing donor support.

EQ3. How have project management, coordination, and collaboration affected the achievement of project objectives?

Project management by PSI was viewed as a facilitator and not a barrier to the achievement of project objectives by consortium partners. Jhpiego has a Technical Director who participates in calls with USAID

[2] Initially comprised of four main technical approaches, two were combined during the program, and details are provided below.

and provides important 'value add' to MPHD. Avenir and ThinkWell have narrow technical roles, and their contributions have been important. FHI360 was supposed to lead on the child health work, but their expertise is focused on child nutrition. The Integrated Community Case Management (ICCM) curriculum review took a year to complete and was transferred to Jhpiego.

There were some management issues highlighted between global and country level, but these have been resolved or have been superseded by other events. In countries where there is a designated local partner, some tension was reported related to recognition of existing capacity and expertise vis-à-vis the core or global partner. As part of project implementation, project resources have leveraged existing consortium or partner structures and organizational policies, strengthening these structures and policies as needed. Short timelines and funding cuts have had implications for the delivery of technical approaches and may reduce provider motivation to participate or innovate in future activities.

Thought leadership efforts have been mixed. While certain activities have been cutting edge (e.g., the Hackathon at ICPD and early conversations about localization and PCC before they became mainstream priorities), written products such as blogs and peer-reviewed journal articles have been limited and the rigor of these products should be strengthened. The majority of what MPHD has done and shared about localization has been captured and shared through MOMENTUM-wide channels, stewarded by MOMENTUM Knowledge Accelerator (MKA). From 'Share Fair' presentations to several bespoke webinars, MPHD has contributed to localization theory and practice as it relates to private sector service delivery. It produced a paper about this currently under review with GHSP and featured in MKA In-Depth Stories and conference presentations. As a global project, MPHD is expected to address evidence gaps and push the field forward. Within the project cycle, it is natural that at midpoint there is a need to allocate more resources to thought leadership and learning products and dissemination.

MPHD's Learning Agenda is characterized by a range of learning topics and questions that were designed to address the learning efforts across the MOMENTUM suite of awards, as well as to generate evidence and learning for various audiences and stakeholders across MPHD's three approach areas. Learning and evidence from the project is regularly shared with MKA and other MOMENTUM awards. The project has contributed to all seven MPHD learning topics and this progress has been reported in the "Progress in Learning and Research" appendix of all MPHD semiannual and annual reports. MPHD has also contributed learning, insights, and data to several 'learning syntheses' lead by MKA's learning team. These have included efforts to capture learning on organizational capacity strengthening, small and sick newborn care, and digital health. There is room for improvement on the learning agenda related to FP/RH.

EQ4. How well has the project integrated cross-sectoral issues into project activities (with a specific focus on youth, gender, and the environment)?

Cross-sectoral issues, youth, gender, and the environment, have not been consistently recognized or mainstreamed in project activities. Some activities have a specific focus on youth or gender, while other projects have leveraged organizational policies and training materials. Youth tend to prefer the private sector for FP/RH products and services and, as a result, youth are a priority audience in several countries. None of the respondents interviewed had a clear understanding of the environment as a cross-sectoral issue, and MPHD had no dedicated funding for this issue.

Conclusions

MPHD has made progress towards its objectives across four key result areas and three main technical approaches, but gaps and challenges exist.

There are opportunities to strengthen programming during the remainder of the project period to:

1) Improve uptake of health products and services by linking more effectively to social and behavior change (SBC) demand generation activities

2) Expand public-private sector collaboration strategies

3) Move the field forward with thought leadership products and learnings

4) Identify sustainability strategies

5) Strengthen country-level leadership and stewardship of private sector investments and programs

6) Expand meaningful cross-sector collaboration

With renewed attention to these priorities, MPHD will be well positioned to meet its overall goal of expanded access to and use of quality, evidence-based information, products, and services through private providers.

Recommendations

- Use the midterm evaluation as an opportunity to revisit the technical approaches and logic model to clarify terminology, strategies, and assumptions as well as pathways to service uptake, drawing on country implementation experience and findings from the evaluation.
- Recalibrate the 'supply and demand' dynamic to ensure that improved technical capacity to provide high quality FP/RH and MNCH services through the private sector is complemented by state of the art, targeted SBC strategies that result in increased uptake of services.
- As part of a review of technical approaches, consider conceptualizing private sector engagement through the lens of public-private collaboration, emphasizing the readiness of the public sector to engage the private sector, particularly within service delivery arrangements. This would remove pressure on local partners and refocus attention on wider service delivery systems and governance structures.
- Sustainability should be considered more holistically, and transition plans should be developed at the beginning of the project, not in the final phases of implementation. This would align expectations among core and local implementers, as well as other stakeholders.
- Clarify how promising practices within countries can be used to inform technical approaches and the assumptions underpinning the logic model; expand learning and dissemination efforts, especially to support project partners at country level.
- Cross-sectoral issues have not been mainstreamed (so are not definitionally speaking 'cross cutting'). Consider how MPHD can strategically and consistently imbue evidence-based best practices for youth and gender programming during the remainder of the project.
- Focus more on global thought leadership efforts to move the field forward, in collaboration with other projects and in consultation with USAID. Improve communication processes to operate more proactively in updating USAID on technical issues.

Evaluation Purpose and Questions

The purpose of the MOMENTUM Private Healthcare Delivery (MPHD) midterm performance evaluation is to assess the project's interventions, their implementation status, quality to date, and overall achievements and obstacles to achieving key results. The evaluation team analyzed 1) the potential for the project to reach the desired result for each global model, tool, or technical approach developed, and 2) country-level expected results. The evaluation also identified what is working, what needs rethinking, and what changes may be required at the global and country levels. Findings will inform the design of future investments in private sector engagement for FP/RH and MCHN. Specific evaluation questions (EQs) are:

EQ1. To what extent has the MPHD project achieved its objectives to date, as identified in the conceptual framework, in the areas of FP/RH and MCHN?

EQ1.1. What are some of the key challenges in achieving project objectives?

EQ1.2. What are the recommendations to address the challenges?

EQ2. To what extent has MPHD been able to incorporate the three[3] main technical approaches – private sector engagement, person-centered care, localization – into its activities?

EQ2.1. What has been learned about the implementation of the technical approaches thus far in terms of project performance, including outcomes by key disaggregates?

EQ2.2. What disaggregated data exists (by age, gender, FP/RH, MCHN, etc.) and how does this data demonstrate progress across the four main technical approaches?

EQ3. How have project management, coordination, and collaboration affected achievement of project objectives?

EQ3.1. Is the team using project partner resources and skills in an efficient and effective manner? If so, how?

EQ3.2. Is the team collaborating with other USAID projects and/or projects funded by other donors? If so, how?

EQ4. How well has the project integrated cross-sectoral issues into project activities (with a specific focus on youth, gender, and the environment)?

EQ4.1. Which illustrative examples demonstrate integration?

EQ4.2. What is working? What is not working? What untapped opportunities exist for integration across cross-sectoral issues?

EQ5. What are some areas for improvement in the remaining years of the project to ensure achievement of the MPHD key result areas and objectives?

EQ5.1. What technical approaches need improvement? Provide recommendations for improvement.

EQ5.2 What Promising practices are being shared through learning and dissemination efforts to support private sector approaches to FP/RH and MCHN? If improvements are needed, recommendations.

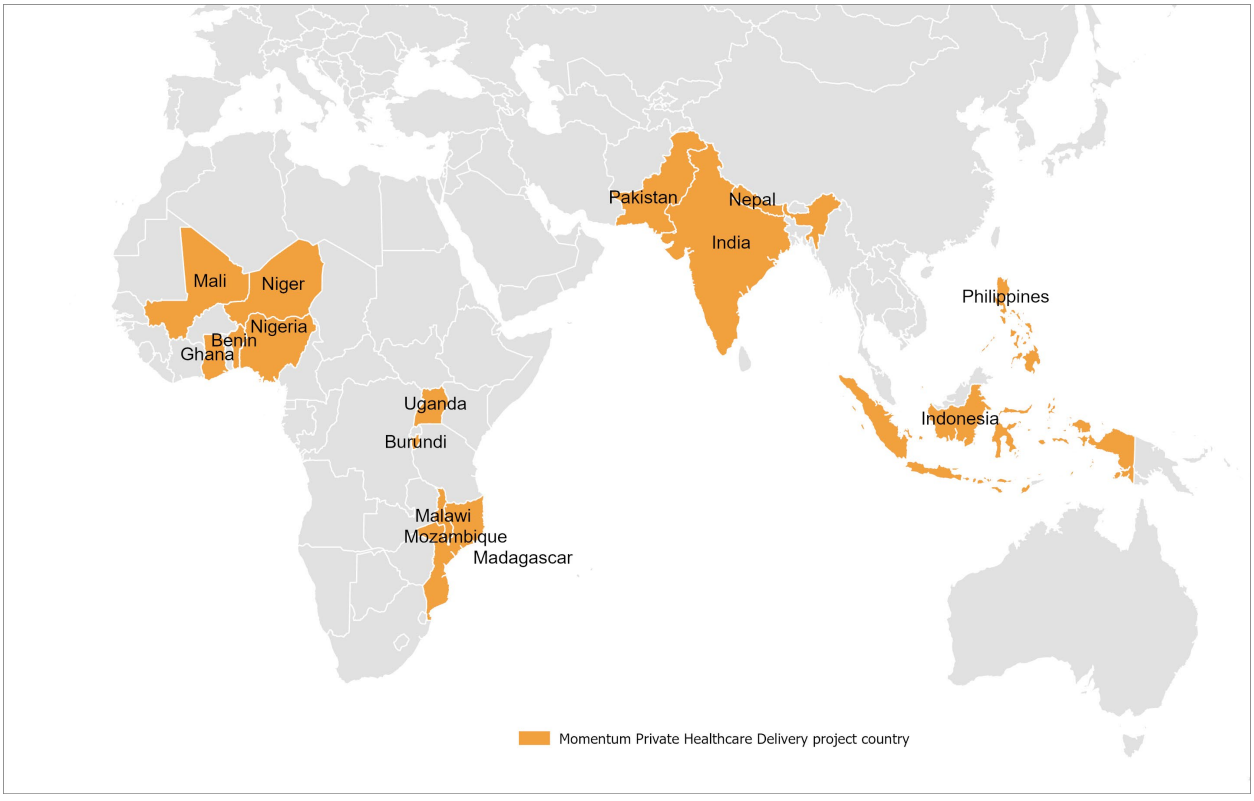
[3] Initially comprised of four main technical approaches, two were combined during the program, and details are provided below.

Background

As part of a comprehensive strategic approach since the 1960s, USAID has devoted resources to build private sector FP/RH and MCHN options within country programs. These investments, along with other sources of technical and financial support, have developed private sector organizations to be important players in advancing FP/RH and MCHN programs worldwide. Currently, there are several projects in USAID's private sector engagement portfolio.

USAID also supports a suite of awards called 'Moving Integrated, Quality Maternal, Newborn, and Child Health and Family Planning and Reproductive Health Services to Scale' (MOMENTUM). This suite consists of six flagship cooperative agreements awarded between December 2019 and September 2020. Through MOMENTUM, USAID seeks to accelerate reductions in maternal, newborn, and child mortality and morbidity in high-burden USAID partner countries. Each MOMENTUM award offers a deep understanding of different settings and approaches and is intended to work in a coordinated way across the suite to provide specialized technical and regional expertise.

Figure 1. Countries where MPHD works



This midterm performance evaluation focuses on the MOMENTUM Private Healthcare Delivery (MPHD) project, Award Number 7200AA20CA00007. *The original award date was June 22, 2020, and the end date was June 21, 2025. The new end date for the MPHD project is June 30, 2026. Total funding for this project is $132 million, up from the original $75 million.* MPHD works globally to support private sector engagement in

MCHN, FP/RH, and other health areas to address acute needs in resource-constrained countries, especially to prevent maternal and child morbidity and mortality. MPHD's overall goal in targeted countries is to expand private sector healthcare coverage and improve health outcomes, in particular for FP/RH and MCHN. The MPHD consortium is led by Population Services International (PSI), in collaboration with JHPIEGO, FHI360, Avenir Health, and ThinkWell. To date, 15 countries (Benin, Burundi, Ghana, India, Indonesia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Pakistan, Philippines, and Uganda) have received core or field support funding under MPHD.

Recognizing the need for a comprehensive approach to improve healthcare systems, MPHD works to expand public and private partnerships in collaboration with Ministries of Health (MoH) to improve market access to lifesaving and life-enhancing health commodities and services. As part of a Total Market Approach (TMA), MPHD provides localized technical assistance and capacity strengthening to private healthcare providers, healthcare networks, faith-based organizations, distributors, pharmacists, and drug shop providers to expand the market and fill gaps in healthcare systems. MPHD harnesses the potential of the private sector to expand access to and use of high-quality, evidence-based MCHN and FP/RH products and services. The project collaborates with local entities to build local capacity and generate market-based solutions that drive scale in access and use of these products and services. MPHD also works to expand public and private partnerships in collaboration with Ministries of Health (MoH) to improve market access to lifesaving and life-enhancing health commodities and services. These approaches are designed and delivered with attention to cross-cutting themes of youth, gender and the environment, and evidence-based adaptive management.

The MPHD Theory of Change (see diagram included in Appendix 1) posits that when private sector, market-based solutions are advanced to support countries' sustainable improvement in the functioning of their markets, there will be increased availability and demand for private providers delivering MCHN, FP, and RH products and services. When there is a TMA, with functioning private and public partnerships, these products and services will reach different levels within the ecosystem, thus improving health coverage and contributing to improved health outcomes.

As MPHD has evolved over time, the term TMA has been absorbed into the term Private Sector Engagement (PSE), which is a broader framing in line with USAID's PSE policy. The following context was shared with the evaluation team by PSI:

> *Whilst the RFA for MPHD in 2019 included TMA as a key objective, as did the technical proposal produced by MPHD, since that time, USAID staff at Washington and Mission levels use the TMA concept less frequently. This is illustrated e.g., by the shift from PRH convening a TMA WG to this becoming a 'Healthy Markets' Community of Practice in 2022.*

> *Meanwhile, the MPHD AOR team in 2021 highlighted that PSE is one element of TMA/Healthy Markets, and that with the Agency's recent PSE strategy, PSE was a priority for MPHD. USAID Mission Field Support program descriptions provided to MPHD also provided limited scope to analyze the total market and act across the total market (e.g., see Niger, Benin, Mozambique). Informed by this evolution away from the concepts and language of TMA, MPHD adapted and merged its two 'foundational technical approaches' of PSE and TMA into one technical priority from Y2 onwards. Rather than having dramatic implications*

overnight, this fusion of the two approaches and elevation of PSE was an adaptation by MPHD to the changing landscape and a step taken to minimize confusion for all concerned who were partnering with MPHD.

In addition, after discussions with both USAID and PSI, the following list of key term definitions was agreed upon for the context of the MPHD midterm evaluation:

1. Private sector engagement (PSE):

- A strategic approach to planning and programming through which USAID consults, strategizes, collaborates, and implements with the private sector for greater scale, sustainability, and/or effectiveness of outcomes.
- Engaging with, and strengthening the capacity of, the private for-profit and private non-profit (e.g., faith-based) sectors to improve their contribution to a well-functioning health system (these two definitions are from MPHD documents and are consistent with USAID's policy: https://www.usaid.gov/sites/default/files/2022-05/usaid_psepolicy_final.pdf).

2. Cross-sector partnerships:

- MPHD's overall approach to Result 4 – Collaboration among organizations from different sectors – is to identify, understand, apply, and share the knowledge, experiences, and networks of non-MNCH/FP/RH organizations and non-traditional partners in innovative exchanges that support improved MNCH/FP/RH outcomes in priority countries (from MPHD Core Work Plan, Year 1).

3. Coordination and collaboration (defined across MOMENTUM suite):

- **Coordination:** The intentional sharing of information across awards with the purpose of contributing to a cross-MOMENTUM deliverable(s) (usually, but not solely, led by MKA). Information may include but is not limited to data, programmatic learning, new evidence, and technical expertise. Coordination necessitates some level of effort (LOE) from various staff across all of the awards. Given that the individual staff involved in the coordination efforts will be dependent on the topic, it may be difficult to identify specific percentages of coordination LOE that should be assigned for each staff member. As such, contributing to coordination efforts should be considered a core function within each staff's position description. Specific examples of coordination LOE include gathering and sharing relevant documents; participating in a set of coordinating meetings; reviewing the deliverable outlines, drafts, and final products; and participating in key informant interviews to expand learning from existing documentation (from MOMENTUM mid-term process evaluation).
- **Collaboration:** A joint implementation of an activity that is explicitly included in more than one project work plan. Collaboration may occur to reduce duplication of efforts or in order to leverage technical expertise across projects to enable greater impact. Activities to collaborate on may be identified by awards themselves or by USAID (from MOMENTUM mid-term process evaluation).

4. Person-centered care:

- Care that is empathetic; free from bias, coercion, or discrimination; and care that responds to a client's unique needs and preferences (from MPHD's Definitions of Technical Approaches).

5. Total Market Approach (TMA):

- TMA is a model to design and deliver health interventions and nurture best practices in market stewardship, such as the need to analyze legal frameworks, decision making, and institutional arrangements required for effective stewardship, as well as to reflect on the role of global and regional bodies and financing for sustainability (from MPHD Core Work Plan, Year 1).
- As noted above, TMA was merged with PSE into one technical priority from Y2 onwards.

6. Localization:

- The set of internal reforms, actions, and behavior changes that we are undertaking to ensure our work puts local actors in the lead, strengthens local systems, and is responsive to local communities (MPHD's Definitions of Technical Approaches and consistent with USAID's policy: https://www.usaid.gov/sites/default/files/2022-12/USAIDs_Localization_Vision-508.pdf).

7. Adaptive learning:

- The Momentum Suite defines adaptive learning as "the intentional adoption of strategies and actions to facilitate critical reflection and analysis of data, information, and knowledge—on a continuous basis and from a wide range of sources—to inform decisions that optimize program implementation and effectiveness in expected, unexpected, and changing circumstances".[4]

Methods and Limitations

Data collection included a document desk review, an online survey of USAID mission staff, in-person meetings with USAID staff from Washington, key informant interviews (KIIs) with MPHD staff, and missions with MPHD activities, and other implementing partners. Additionally, group interviews and observational visits were conducted during field visits to Benin and Ghana. Document review and data collection occurred between July 2023 and April 2024. Given the focus of many MCHN, FP, and RH programs on the needs of women and girls, there is a strong emphasis in the data collected on gender-related issues. The MPHD Midterm Evaluation used a mixed methods approach, as described below, and all data sources were triangulated to formulate the findings and recommendations in this report.

Document and Data Review: The MPHD AOR team supplied a comprehensive list of project work plans, reports, and selected technical documents for this midterm evaluation. The team also reviewed the MPHD Activity Monitoring Evaluation and Learning Plan (AMELP) and the 2022 MOMENTUM Midterm Process Evaluation which analyzed progress across the entire suite of MOMENTUM projects. See Appendix 4 for a summary of the USAID-supplied documents that were analyzed. In addition, key informants were asked to share country-level data and technical materials, and the team collected additional resources through this method. The field visits to Benin and Ghana yielded a significant number of additional data sets and documents that added richness to the analysis and in this way the team was able to ground the

[4] Ross, Joey, Ami Karlage, James Etheridge, Mayowa Alade, Jocelyn Fifield, Christian Goodwin, Katherine Semrau, and Lisa Hirschhorn. 2021. Adaptive Learning Guide: A Pathway to Stronger Collaboration, Learning, and Adapting. Washington, DC: USAID MOMENTUM.

identification of key resources in the evidence emerging from the research.

USAID was interested to know about additional data sources at the country level, especially those with disaggregated data by sex, age, etc. Most respondents interviewed stated that they did not have this type of data. See Appendix 4 for an example of additional program data collected in Benin from the Association Beninoise pour le Marketing Social (ABMS).

Field Visits to Benin and Ghana: These two countries were selected by the AOR team because of specific program characteristics that were of interest to USAID. In Ghana, for example, the TFHO is a 100% locally owned entity that is now eligible for and receiving direct funding from USAID. Prior to the new award from USAID/Ghana, TFHO was a partner on MPHD. The Benin program, managed by ABMS, has deployed innovations such as creating a chatbot for youth to provide FP and RH information. In Benin, 18 individual interviews, 3 group interviews, and 3 site visits were conducted. In Ghana, 11 key informant interviews, 1 group interview, and 2 site visits were conducted. The interview guide was tailored to each stakeholder's role with MPHD. Details of individuals interviewed are included in Table 1, and case studies summarizing the Benin and Ghana field visits are found in Appendices 5 and 6.

Key informant interviews: The evaluation team interviewed 16 global stakeholders and 33 country-level stakeholders. The list of respondents was developed by the USAID AOR team in collaboration with PSI. A core discussion guide was used to guide all interviews, and the guide was tailored to the role that each interviewee played/plays on the MPHD project. A privacy and confidentiality statement was shared with all respondents and verbal consent to record the interviews was obtained. Each interview lasted approximately one hour. In addition to US-based stakeholders like USAID and PSI staff, all four partners on the MPHD consortium were interviewed, and a mix of local implementing partners and USAID Mission staff were consulted at the country level in each country where MPHD has worked.

Nine USAID mission staff were invited to participate in interviews, from six countries[5], and eight participated. A total of 32 in-country MPHD staff and partners participated in interviews from 13 countries[6] out of 33 who were invited. All six individuals from the USAID Washington AOR staff invited to participate were interviewed in two groups. Ten individuals participated in group interviews with global partners in response to invitations sent to four individuals. Interviews were conducted by members of the evaluation team, with Gael O'Sullivan and/or Gabrielle Appleford leading the English language interviews (39 individuals across all groups) and Daoudou Idrissou leading the French language interviews (16 individuals across all groups). A guide based on the research questions was used for all interviews. Interviews were recorded and notes were taken during interviews and from the recordings. Evaluation team members analyzed interview notes, referring to recordings as needed, to summarize findings. Interviews were conducted from March 14—May 8, 2024. Table 1 includes further details about the interviews conducted.

Online survey: In the protocol, the online survey was planned to be administered to 100—150 respondents, roughly half of whom were to be U.S. and participating government stakeholders and the other half non-governmental or representatives of the private sector. Respondents were to be drawn from stakeholders in the U.S. and 15 country programs. Due to limitations on who could be asked to complete

[5] Burundi, Madagascar, Mali, Mozambique, Nepal, and Niger. The team was unable to contact the individual from Madagascar who was nominated to participate.

[6] Burundi, India, Indonesia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Pakistan, Philippines, and Uganda.

the survey per requirements of the Paperwork Reduction Act, the online survey was sent to 40 USAID personnel from 15 country programs and global USAID MOMENTUM AOR team staff, though the USAID General Counsel's Office later determined it did not apply in this case, but after data collection had started. Eight respondents completed the survey. However, it should be noted that the online survey had a substantially different scope, as all respondents belonged to specific USAID workforce categories (direct hires, third country nationals, United States personal services contractors, cooperating country nationals, and foreign service nationals) and the number of respondents decreased substantially. To compensate for the limited scope of the online survey, additional individuals were added to either group interviews or key informant interviews. In summary, all MPHD countries had a shift in approach due to various constraints.

The online survey was sent to 40 USAID mission personnel in 14 countries[7] and data were collected March 12—April 8, 2024. The online survey was administered in English as all respondents were USAID personnel. Reminder emails were sent to respondents weekly, with a final reminder sent two days before the online survey closed. Eight individuals responded from six countries[8]. Further details about respondents to the online survey can be found in Table 1. Responses to open-ended questions were included in the analysis of qualitative interviews. Responses to questions were tabulated in MS Excel.

Table 1. Data collected, by type, with gender distribution of respondents

Data Collection Type	Individuals Interviewed	Respondents Gender (No. Female/No. Male)
USAID Washington KII	6	6 F
Global Consortium Partner KII	10	8 F / 2 M
USAID Mission KII	7[9]	2 F / 5 M
MPHD in-country staff and partner KII	32	18 F / 14 M
KII Total	55	34F / 21M
Ghana Field Visit KII	15	11F / 4M
Ghana Field Site Visits and Group Interviews	17	13F / 4M
Benin Field Visit KII	15	6F / 9M
Benin Field Site Visits and Group Interviews	46	33F / 13M
Online Survey, USAID	8	4 F / 2 M[10]
Online Survey, Total	*8*	*4 F / 2 M*

Limitations: As mentioned above, the online survey approach shifted. This resulted in a narrow sample of USAID respondents only, and eight completed surveys were received. Consequently, most primary data collected for the evaluation is qualitative in nature. The lists of stakeholders to interview, survey, and speak with in person in Benin and Ghana were developed by USAID and the local project teams in Benin

[7] Benin, Burundi, Ghana, Indonesia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Pakistan, Philippines, and Uganda.

[8] Online survey responses came from Benin, Ghana, India, Indonesia, Malawi, Mozambique, and Nepal

[9] One USAID personnel nominated for interviews did not respond to multiple requests for interviews and one USAID personnel invited declined to be interviewed.

[10] Two online survey respondents declined to share information about themselves.

and Ghana. This may have introduced bias into the process. Another limitation concerns the fact that some key informants interviewed had limited knowledge of the project and could only speak to a narrow set of questions or activities. Lastly, given the size and scope of this global project, the evaluation team used snowball sampling to identify which documents or products to review in detail. It was not feasible to review every activity conducted to date. The team prioritized annual work plans and reports, as well as technical documents shared by USAID.

Results

MPHD implemented a comprehensive mix of interventions, with significant focus on improving availability of quality health products and services through the private sector and strengthening private healthcare providers' capacity to deliver these products and services. Core funding is used to test, refine, and share learnings about new products such as the PCC training methodology. Global thought leadership efforts have shown promise, yet there is room for improvement to have MPHD, as a global project, move the field forward.

USAID Mission Survey Results

"*TFHO needs to establish linkages with other private sector stakeholders such as the private health insurance organizations, in order to establish linkages with these insurance companies. TFHO also needs assistance in expanding their contraceptive method mix beyond what they have. They also need to explore markets beyond Ghana*."

"*Mentoring has been well received by private providers and private facilities. Understanding and uptake of quality improvement (QI) and QI collaboratives has taken time but is now showing promise. The primary challenge lies in sustainability. No private hospitals have registered for the mentoring program which requires payment. They are hesitant due to the absence of a clear understanding of how the program will contribute to revenue growth, alongside enhancing the quality of care.*"

The MPHD midterm evaluation results are presented below by evaluation question, and reflect findings from secondary data reviews, KIIs, group interviews, and the online survey. Evaluation Question 5 is summarized first to highlight recommendations for improvement in the remaining project period.

EQ5. What are some areas for improvement in the remaining years of the project to ensure achievement of the MPHD key result areas and objectives?

Findings

- Global perspective: while important progress has occurred using core funding to advance technical priorities such as person-centered care, integrated FP/child health curricula, and quality service delivery, there are opportunities for improvement across strategic priorities such as increased use of products and services, attention to adolescents/youth, expanded host country technical

leadership, and global thought leadership.

- In Nepal, the project had refined their technical approach and had increased scale (under phase 2); the approach was refined to meet the needs of marginalized populations in the scale-up provinces. The project scope expanded to include increasing the number of private sector facilities that report Health Management Information System/District Health Information System 2 (HMIS/DHIS2) data in all intervention provinces, and the introduction of long-acting reversible contraceptives (LARCs) in select private facilities in collaboration with the government.
- In several countries, small-scale 'one off' activities were implemented. There are missed opportunities to scale effective approaches and share learnings across geographies.
- Transition and sustainability plans could be more robust. While MPHD field support work plans have a standard section covering transition and sustainability, additional detail would be helpful. In some countries transition plans were not available, either not yet developed (e.g., Nepal) or not yet approved (e.g., the Philippines).

EQ5.1. What technical approaches need improvement? Provide recommendations for improvement.

Burundi. Private health facilities did not always have access to malaria medications, despite advocacy efforts. It will be necessary to work with the Global Fund to facilitate this process. Sustained access to contraceptive products for private facilities also remained a priority for the MPHD project. It will be necessary to ensure better access to contraceptive products beyond the project's lifespan. MPHD can rationalize expenses by reducing the number of sites and adjusting the budget accordingly. MPHD should demand concrete results from partners to continue working with them. The sustainability of capacity strengthening efforts was highlighted in this year's report. The project is committed to continuing these discussions by promoting the participation of the private sector in the quarterly coordination meetings.

Indonesia. Given the major reduction in funding, the project focused on the quality improvement (QI) collaborative, while other pieces of the approach were picked up by MOMENTUM Country and Global Leadership (MCGL).

Madagascar. The person-centered care approach is a technical area that was not sufficiently implemented. It would be important for the project team to place more emphasis on this component.

Mali. Youth involvement remained low, despite being a key audience. Apart from a few caravans, the direct contribution of the youth network remained insufficient. In addition, water, sanitation and hygiene (WASH) results were weak; more emphasis on this component is needed. Person-centered care remained one of the key MPHD technical approaches that was not embraced in Mali. MPHD should reduce the number of activities and focus on those that bring more results, such as improving collaboration with the private midwives' association and increasing the quantity of products at the social marketing level to cover even more people.

Mozambique. MPHD's work is scheduled to end in September 2024, which puts particular priority on localization planning that is specific to the local context. Additionally, public and private data systems should work together to facilitate data quality and reporting. Respondents indicated a need for a collaboration, learning, and adaptation plan.

Nepal. The MPHD Nepal advanced its priority of increasing visibility of FP private sector in the Government of Nepal's HMIS/DHIS2 system by aligning tools and indicators for all service delivery points (SDPs). For

polyclinics and hospitals, the MPHD Nepal project facilitated the MoH HMIS/DHIS2 training and supported them to obtain a government-issued organizational unit identifier so the FP data and other in- and outpatient service indicators can be reported uniquely. MPHD Nepal linked pharmacies and clinics that were not eligible for an HMIS unique identified to nearby public health facilities to allow their service data to be captured.

Data integration across sectors is a priority going forward. Transition and sustainability require design and implementation of a business plan and clarity in roles between Nepal CRS Company (CRS) and CRS Healthcare. Market shaping should also be a focus to address gaps in the market for youth and migrants. While the government was interested in private sector LARC initiatives, most implants were provided in the public sector. Other areas identified were:

1) More work needed on demand creation/linkage of supply with demand

2) More integration needed on reporting into the HMIS

3) More attention needs to be given to public private integration at the Palika level

4) Greater opportunities created for exposure at a global level (MPHD and external conferences), along with participation in internal MPHD global calls to reduce knowledge lag

USAID Mission Survey Results

"The C4C and PCC training are very appreciated and helpful to the private health workers. They allowed many private facilities to improve the quality of care and the quality of the client experience and increase the rate of clients received in the health centers."

"Before this phase of the MPHD, the project activities were focused uniquely on FP activities, but for this phase, we oriented a part of the activities on maternal and newborn health. Many trainings were realized such as the EmONC training to reinforce the capacity of the clinic network."

"MPHD has improved the clinical performance of hospitals receiving support from the project. However, to what extent that support has contributed to reducing maternal and newborn institutional mortality rates is still not clear."

Niger. There is a continuing need to supervise and guide new private sector health facilities in Niger. Collaboration and data collection in the private sector have been a real challenge, as many private health facilities and providers are not up to date in terms of capacity strengthening. This made it difficult to integrate them into capacity strengthening and data reporting systems.

Philippines. The project developed a one-year sustainability and transition plan which includes the Integrated Midwives Association of the Philippines (IMAP) and provincial roles in combination (not IMAP only); it needs continued partner support. Since the intervention scale was small (two provinces out of 82), and demand is large, with many island municipalities, new models are needed that can reach these areas. The healthcare provider network (HCPN) is constrained by the accreditation process; only two to three midwifery clinics were accredited, and as a result, trained providers work in facilities that can offer FP services using their own internal arrangements.

EQ5.2 What promising practices are being shared through learning and dissemination efforts to support private sector approaches to FP/RH and MCHN? If improvements are needed, recommendations.

Indonesia. There are plans to document the approach and learnings through a local academic partner.

Madagascar. Advocacy must continue in this direction to expand private actor engagement. Other promising practices include: 1) strengthening coordination between donors, the MoH, and the private sector to ensure continued financing, 2) supporting private drug shops to collaborate with the MOH and follow its rules to be allowed to operate in the country, and 3) maintaining adequate funding to ensure the continuity of training.

Malawi. The Family Health Services team was not aware of any efforts to share the outputs of the human centered design (HCD) process with youth that generated adolescent sexual and reproductive health (ASRH) materials for girls (comic books) and boys (peer approaches and videos). MPHD developed and globally disseminated a technical document on this activity's Meaningful Adolescent and Youth Engagement approach. This approach was also shared in a cross-MPHD youth focused webinar and shared by Knowledge Success.

Pakistan. The project has closed. PSI has incorporated promising practices into other donor funded projects.

Philippines. Knowledge management products have been developed including a deck that is under review with USAID. The transition plan documents expectations in terms of roles. There has been some interest in replicating activities in other countries. There have also been opportunities to share learnings within MPHD and at global conferences such as the International Conference on Family Planning (ICFP).

EQ1. To what extent has the MOMENTUM Private Healthcare Delivery project achieved its objectives to date, as identified in the conceptual framework, in the areas of FP/RH and MCHN?

Findings

- MPHD has enabled partners to extend and deepen activities with the private sector; in some instances, this was overlaid onto preexisting projects with the public sector (e.g., Indonesia and the Philippines) or expanded in organizational scope (e.g., Nepal and Pakistan).
- Efforts to improve access to products and services, particularly for targeted sub-populations (e.g., adolescents), have had limited reach and impact.
- Core funded projects have allowed for more time for implementation (4-5 years of funding) and include a focus on transition and sustainability.

Challenges

- Within countries, there was a wide variety of capacity and interest in working with the private sector and understanding of policy and related instruments (e.g., licensing) among public sector entities responsible for service delivery.
- Project activities remained small scale in nature, often implemented as models (e.g., Nigeria, Pakistan, and the Philippines); some scale has been reached in Indonesia and Nepal, but this needs to be understood relative to the wider health ecosystem.
- The PCC training package was well received overall; however, in Indonesia there were differences in

how quality standards are applied across different sectors.

- Integration of the private sector within financing and service delivery arrangements remained a challenge in some contexts (e.g., national health insurance, national health information systems, commodity supply).
- Efforts to improve access to products and services, particularly for targeted subpopulations (e.g., adolescents), had limited reach and impact.
- Country buy-ins had significantly shorter timelines (e.g., Pakistan) or experienced significant funding cuts (e.g., Indonesia), impacting the achievement of objectives. Delayed work plan approvals and budget allocations also posed significant implementation challenges.
- In some cases, MPHD activities did not progress due to lack of approval by local governments or USAID missions.

Responses

- Country activities have been designed to be responsive to health system/market constraints and to model approaches to overcome these challenges.
- Dialogue and co-creation approaches have been used to foster engagement between public and private sectors and address health system/market constraints.
- Capacity and culture for data sharing, data integration, and data use are core features within project activities, seeking to optimize existing systems.
- Novel approaches to encourage provider productivity and engagement have been introduced using digital applications and other interactive elements (e.g., peer meetings).

Global and Country-Level Stakeholder Perspectives

Though the ultimate goal of MPHD is for women, men, adolescents, and children to be able to use different quality health products and services, the first objective focuses on 'availability and demand', indicating that MPHD is not just focused on products, but places significant emphasis on expanding services. To that end, MPHD has had different levels of success depending on the country. In Madagascar, the project is working on a training program for drug shops on ICCM and FP/RH. The idea is to create a global good in the form of a curriculum that will improve access to and use of services by a cadre of drug shops and pharmacists. In Indonesia, on the other hand, MPHD had a sizeable buy-in from the USAID Mission through which the project was implementing innovations related to mentoring and peer-to-peer learning. However, the MPHD scope of work narrowed after a shift in the Mission's priorities.

USAID Mission Survey Results:

"The project is still struggling to institutionalize what the project has achieved. Managing partnerships, including host country government, has been very challenging for them."

In terms of the second MPHD objective to expand public and private partnerships, there has been progress at the global and country level. In Ghana, the TFHO has progressed to the point where they now receive direct funding from USAID/Ghana. In Indonesia, there has been progress working with professional associations. In Burundi, the project has been able to address challenges with local partners. ThinkWell's work in the Philippines to improve health insurance payments from PhilHealth to private providers for family planning services was well received, and USAID was interested in replicating this model in Kenya. At the global level, there is some collaboration through use of products across other MOMENTUM projects,

such as the survey on preeclampsia developed by MPHD and MCGL.

Result Areas

1. **Access to and use of evidence-based, quality MNCH/FP/RH information, services, and interventions scaled up and sustained.**

MPHD's global agenda under Result 1 is to engage private providers and the clients and communities they serve in interventions that improve awareness, availability, and use of high-quality, regulated, and affordable healthcare services in the private sector.

The majority of MPHD core funds to date have been invested in Result 1. Stakeholders noted that MPHD is strongest in Result Area 1. Most activities are focused on FP/RH, with a few activities devoted to MNCH, child health, and immunization due to available funding. Typically, these activities switched over to field support funding by Year 4, with a mix of global initiatives and country-specific interventions. Global goods created included curricula for pharmacy staff and clinicians, case studies, and technical briefs (FP for youth). Global thought leadership contributions include:

1) Collaboration with global immunization partners to synthesize evidence and develop country case studies and a resource page with the World Health Organization PSE Connector
2) Participation in global technical groups on small and sick newborn care
3) Partnering with the London School of Hygiene and Tropical Medicine to organize a cross-MOMENTUM collaboration to conduct a landscape review on factors driving high rates of cesarean sections in private sector facilities
4) Conference presentations on PCC, and work with the Contraceptive and Method Choice Community of Practice
5) Partnering with the London School of Hygiene and Tropical Medicine to organize a cross-MOMENTUM collaboration to conduct a landscape review on factors driving high rates of cesarean sections in private sector facilities
6) Conference presentations on PCC, and work with the Contraceptive and Method Choice Community of Practice

2. **Capacity of host country institutions, local organizations, and providers to deliver evidence-based, quality MNCH/FP/RH services improved, institutionalized, measured, documented, and responsive to population needs.**

MPHD's global agenda under Result 2 was to partner with private providers, local businesses, nonprofits, and government agencies to strengthen their ability to sustainably contribute to improved MNCH/FP/RH health outcomes through private sector healthcare delivery. Most of the core funding under Result 2 focused on FP/RH topics at the country level, in service of the capacity strengthening focus of this result area. Training and workshops were the main modalities used, and in addition to PCC, topics included male engagement, quality of care, and Meaningful Adolescent and Youth Engagement.

MPHD has made substantial investments in the person-centered care approach in several countries. However, there were quality issues with the PCC training materials in the original design and draft of both FP/ICCM and PCC curricula. The materials were unwieldy, technical material was beyond the scope of

targeted healthcare cadre, lacked a clear pedagogical approach, and had incorrect medical information in several technical areas.

Quality was also a concern with the draft Madagascar ICCM FP drug shop curriculum. This activity was transferred from FHI360 to JHPIEGO to lead on the child health components and then piloted by PSI in Madagascar in collaboration with the USAID/Madagascar bilateral IMPACT project. It was difficult to assess the overall impact of these training efforts on local capacity, given that these initiatives are ongoing.

In countries such as Indonesia, Philippines, Madagascar, and Uganda, there was close collaboration with host country governments. The Mali program was dynamic and comprehensive, with a focus on FP/RH, MNCH, Nutrition, WASH, and COVID-19. In Indonesia, MPHD conducted a 'deep dive' with local counterparts and the London School of Hygiene and Tropical Medicine on the use of c-sections to identify ideas to address the high rate of medically unnecessary c-sections in the private sector.

3. **Adaptive learning and use of evidence in MNCH/FP/RH programming through sustained USAID and host country technical leadership increased.**

MPHD's global agenda under Result 3 is to define and explore priority knowledge gaps in the evidence, and to share knowledge gained around what works (and what does not) in support of the private sector for better MNCH/FP/RH outcomes. This result area is challenging to achieve; while there are good examples of private-public collaboration, there is less evidence that MPHD is improving host country governments' stewardship of the entire health system, with a focus on private sector leadership. Some of the core activities funded in this result area focused on the COVID-19 pandemic; other activities addressed a range of FP/RH and MNCH topics, some of which overlapped with the challenge of adapting service delivery models in the pandemic context. Notable successes in IR3 include a 'hackathon' delivered in partnership with MCGL at the ICFP conference focused on how the private sector can be tapped to improve contraceptive access for youth.

Awareness of the listed global goods provided was weak, which was not surprising, given that a number of these products are not yet in the public domain. Survey respondents were unaware of two of the resources. The integrated MCHN/FP/RH person-centered care toolkit and the 'Design and Delivery of eLearning in Support of FP/RH' had the highest recognition, four of eight respondents. When prompted and provided an explanation of the term 'global goods', KII respondents were largely unfamiliar with the term and unable to name any products.

Table 2. MPHD global goods

Global goods produced by MPHD
Integrated community case management (ICCM)/FP integrated training for drug shop/pharmacy providers
Integrated MNCH/FP/RH person-centered care toolkit
Design and delivery of eLearning in support of FP/RH, providing instructional design processes and digital platforms
Synthesis of MPHD programmatic and partnership approaches with local organizations to sustainably support private sector FP providers - for Global Health Science and Practice Journal or Implementation case study

4. **Cross-sectoral collaboration and innovative partnerships between MNCH/FP/RH and non-MNCH/FP/RH organizations increased.**

MPHD's global agenda under Result 4 is to identify, understand, apply, and share the knowledge, experiences, and networks of non-MNCH/FP/RH organizations and non-traditional partners in innovative exchanges that support improved MNCH/FP/RH outcomes in priority countries. This is an area where the stakeholders interviewed perceived that MPHD has had limited success. None of the stakeholders interviewed knew of collaboration examples beyond the health sector. However, the project has harnessed the expertise of commercial businesses to facilitate digital innovations such as through activities in India and Pakistan. In Pakistan, the project also partnered with factory workers and universities to catalyze understanding of FP/RH. In Benin, MPHD works with local youth and women's organizations with non-health mandates (such as agriculture or women's economic empowerment) to improve FP/RH awareness.

EQ1. To what extent has the MOMENTUM Private Healthcare Delivery project achieved its objectives to date, as identified in the conceptual framework, in the areas of FP/RH and MCHN?

The insights below represent a compilation of interview findings at the global and country levels, as well as information from MPHD document review and analysis.

Burundi. Over 2 years of implementation, the project worked with various private and faith-based health facilities in the areas of MCH, FP, and malaria. Providers at these health facilities have benefited from technical capacity strengthening through training and supervision, in collaboration with the Ministry of Health. MPHD also provided equipment such as maternity kits and family planning supplies in collaboration with the districts. The project contributed to demand generation through the recruitment, training, and deployment of demand creation agents at the community level.

India. Suvita, a Bihar-based NGO working with JHPIEGO under MPHD conducted an SMS campaign to remind caregivers to immunize their children and to access FP/RH services, including PPFP. Previous experience shows that SMS messages are effective in driving the uptake of routine immunization services. The MPHD effort explored whether this model also works to increase demand for PPFP services. After a four-month pilot period, in which four different messages were disseminated (on breastfeeding, return to fertility after birth, benefits of spacing pregnancies, and referral to local healthcare workers for FP methods), preliminary results indicate the impact of SMS on the uptake of PPFP was minimal. Twenty-five percent of people surveyed remembered getting a PPFP message, and a subset of these respondents took action. Confounding factors include mobile phone ownership statistics (50% owned by fathers, 25% by mothers, 25% by other family members); also, while there were a lot of private health facilities in Bihar, it was difficult to link the SMS messages to the uptake of services at the facility level. Pilot findings will be shared with the Indian government.

Indonesia. Jhpiego was not working in any substantial way on PSE before MPHD; the project allowed Jhpiego to extend their work (and relationships) on maternal and newborn health (MNH) to the private sector. Broadly, the project was meeting its result areas (a key challenge remains high infant and neonatal mortality).

Madagascar. Due to delays in the implementation of core project activities, implementing actors were not able to properly measure how the project was contributing to the availability and provision of family planning and other services. Achievements from the two separate core activities include:

1) Finalizing the provider training curriculum and organizing the initial training

2) Identifying mutuelle health insurance companies that have signed agreements with private health facilities and will integrate family planning services into the minimum service package offered

3) Obtaining support for digitalization to accelerate reimbursement of providers and facilitate the collection of information from customers wishing to join the mutuelles

Malawi. MPHD, together with Family Health Services (formerly PSI Malawi), implemented a one-year activity (originally designed to be a two-year activity) focused on youth and ASRH. Using an HCD process, the project developed prototypes based on youth input about what they would like to see when seeking ASRH services. The design and testing process took time, so in one year there was not much opportunity to implement activities. Girls indicated that they prefer to get ASRH information from comic books, while boys prefer talking to peers and watching videos. Materials were fed into Family Health Services' *Tsogolo Langa'* project via their work with a youth club network and outreach clinics in eight districts.

Mali. The MPHD project has contributed significantly to improving the population's access to FP, maternal health and WASH services, both in and out of the ProFam network of clinics. The project revitalized the private sector alliance for health promotion and improved the dialogue between the public and the private sector. This alliance serves as an interface between the project and the Ministry of Health to support public-private partnerships. The project also provided training for private providers on the integrated management of childhood illnesses. The project contributed to strengthening the capacity of providers in maternal health in ANC, childbirth, postnatal care, and PPFP through an integrated services model. Private sector doctors, midwives, and obstetric nurses were the main beneficiaries.

Mozambique. MPHD's work was funded initially through new partnerships initiative (NPI) and focused on FP/RH plus private sector reporting via pharmacies. This initiative resulted in quality improvements since pharmacy staff provided counseling in addition to selling products. Since May 2023, the program has been funded through a field support buy-in. The current focus is on MNCH issues through an expanded number of clinics. The current work was delayed in starting up, so the focus at the moment is on provider training, and there are no results to report from service statistics. MPHD adapted the MoH training curriculum and added content on private sector regulations, PCC, LARCs, etc. There is an emphasis on e-learning for the first time, along with improving the quality of care, quality of data, and leveraging PSI tools and methods. Focal points from the public sector are involved to ensure that interventions are sustainable. Short-term FP methods are most prevalent, and the public sector dominates the small market for LARCs, which are free. This is demotivating to private sector provision of LARCs. While most health services are delivered through the public sector, MPHD is working with professional associations, the MoH, and the Training Directorate to expand private sector offerings. This collaboration has ensured that the private sector is engaged when MoH guidance and policies are updated. Professional associations are also collaborating to improve data management and reporting via maternal and newborn death audits. Public sector stakeholders perceive the private sector as a competitor that will divert resources away from the public sector. Efforts to strengthen country leadership and stewardship need additional attention.

Nepal. CRS began as a social marketing organization with the support of USAID in 1978. In 2021, CRS established a wholly owned subsidiary, CRS Health Care for the financially sustainable sales of commodities enabling CRS to focus on donor-funded projects while retaining its core social marketing work. One respondent indicated, there was "no project like this before". They felt that there was a "clear

contribution" to the private sector in terms of training on FP and management, bringing in a focus on youth and adolescents. "From sales to services" brought a new dimension to CRS's work under MPHD, expanding beyond the social marketing of short-term FP methods and other products. The project has achieved some degree of scale (as per project plans) and is working in six provinces and with approximately 800 private sector delivery points, that include hospitals, polyclinics, and pharmacies.

Niger. Until 2023, MPHD was active in 83 private and 60 public facilities. The project focuses on MNCH and FP/RH. The project made it possible to better organize the private health sector through the establishment of a private sector platform, a formal framework that can allow promoters of this sector to exchange, negotiate, and advocate in terms of institutional support from the government, as well as certain other financial and technical partners. MPHD improved the quality of services through training and capacity building for providers on MNCH and FP/RH topics. The implementation of a local coaching system also helped guarantee quality care that meets professional standards.

Nigeria. MPHD works with Society for Family Health (SFH) in Nigeria, and a core funded activity allowed SFH to fill a gap in the market between a premium hormonal intra-uterine device (IUD) product (Mirena) and the donated IUD product. SFH introduced Avibela, from Medicines 360, at a 'mid-level price point', and increased availability of the product through their Healthy Family Network and other private providers. This fractional social franchise model works with hospitals, clinics, and other facilities across six zones in Nigeria. SFH conducted detailing with providers via nurse associates but did not have a media or community mobilization strategy. Hybrid training over several weeks included digital components and in-person sessions. MPHD began work in 2021, and SFH launched Avibela in 2022. SFH procured 8,000 units, and all were sold. Now, due to foreign exchange rate fluctuations, Avibela costs are similar to Mirena's cost, so demand has dropped significantly and SFH cannot afford to continue procuring the product. Lessons learned include 1) there are opportunities to diversify the market by introducing a lower-priced IUD product in rural areas, 2) hybrid training can work well to build provider skills without requiring a large time commitment, and 3) pricing can pose a challenge in terms of cost recovery for providers and changes in foreign exchange rates. This fractional social franchise model works with hospitals, clinics, and other facilities across six zones in Nigeria.

Pakistan. PSI has a long history of working on PSE, including the establishment of a large social marketing entity (Greenstar). MPHD's work began with a core activity and then the Mission bought in with field support funds. It was intended to be a one-year project that was extended to 1.5 years (the short duration was due to the Mission's planned project with Pathfinder entitled 'Building Healthy Families and Lives'). The MPHD support expanded PSI's body of work through the addition of male engagement through the public sector, specifically the provincial welfare department (PWD) of Sindh province, working in three districts. The approach started with the public sector to engage with the private sector; this was a novel entry point for PSI's work on PSE. A key achievement was an extension of PSI's traditional audience (PWD but also private general practitioners (GPs) and enterprises, while pharmacies have always been a key audience). Another achievement was expanding the digital eco-system with a chatbot that reached ~ 100,000 men.

Philippines. ThinkWell's work under a project called SP4PHC supports provincial health departments (PHDs) with modeling for universal healthcare in the public sector in two rural provinces, Antiqua and Gumaras. PHDs expanded this model to include a private sector focus via HCPNs; this was the added value

and specific achievement of MPHD. IMAP has about 40,000 members or approximately just over half of all licensed midwives in the Philippines. A key achievement in respondents' views was the selection of the two provinces, as there were very few FP providers when the project started. IMAP ensured provider competency and adherence to license and certification requirements.

EQ1.1. What are some of the key challenges in achieving project objectives?

Burundi. Challenges persist related to access of private health facilities to medical commodities and rapid diagnostic tests. MPHD is working with the MoH to find solutions by the end of the project in 2026. Another challenge relates to staff turnover, particularly among young healthcare providers. Once these providers have been trained, they often look for new job opportunities. To deal with this turnover, emphasis was placed on sharing the knowledge acquired during training and supervision, particularly on subjects such as malaria and family planning. Service providers at faith-based health facilities often have minimal technical skills, so they may need additional capacity strengthening support.

Indonesia. Some District Health Offices (DHOs) are more open to working with the private sector, so PSE was context dependent at the sub-national level. For example, in one district there was reluctance to accept donated ambulances from the private sector for fear of perceptions of corruption. While PCC is a core approach in Indonesia, there is a heavy focus on hospital accreditation, which remains a key focus for the private sector (vis-à-vis national insurance) and the MoH. The MoH tried to adopt a more process oriented "integrated" approach to quality under the Directorate of Quality but after a change in leadership this was de-prioritized and MPHD has been advocating without much traction at the national level. There is a challenge to address infant and neonatal mortality as the number of babies, and those that are low birthweight, are increasing.

Madagascar. The main challenge at the start of MPHD was the reluctance of the MoH to embrace elements of the training initiative. As this was a new approach, the MoH expressed significant reservations about pharmacy and drug shop staff's ability to provide health services. This delay in project startup had an impact on achieving objectives. Apart from the resistance of the health authorities, some providers withdrew after the training was conducted. This meant that out of 20 staff trained, eight withdrew, and MPHD had to identify new providers to be trained.

Mali. Challenges to MPHD implementation in Mali focused on 1) security concerns- the collaboration between project stakeholders and the government was difficult due to the political situation and Restriction 7008, which limited the team's ability to work; and 2) data collection and the challenge this presents with private health facilities.

Mozambique. While coordination at the national level is progressing well, it is more difficult to engage stakeholders at the provincial level and incentivize private sector actors to participate in meetings. Fostering local ownership and stewardship is a challenge; however, there is some movement, as evidenced by a request from the provincial authorities for MPHD to support a meeting to disseminate private sector laws and guidelines. Another priority is to create and share standards and guidelines to support programs over time. The project needs a transition and sustainability plan.

Nepal. According to USAID, a key challenge is how the government registers and engages with the private sector, i.e., "in the document it is the same but not in practice." There is a lack of data sharing, integration, and use between the private sector and the government, according to both USAID and CRS. According to

CRS, after the recent Demographic and Health Survey (DHS) showed a larger proportion of private sector health service utilization, the government has become interested in accessing private sector service data and information on quality. Prioritization and support for private sector data was varied; for example, some respondents felt that private sector reporting is an additional burden to them and adds data errors (as private sector is not trained on reporting). Concerns were raised about the stability of the service network related to attrition of trained social franchises and providers. There was 5% attrition of trained ASRH providers (55/1054) and 6% attrition of trained Sangini providers (62/1066) among Phase 1 and 2 SDPs, and the cost of injectables shifts to providers if the USAID subsidy were removed. While there is not a specific migrant focus in the project, it was mentioned by both USAID and CRS. The project has prioritized adolescents: in Phase 1, 19% of clients reached were adolescents (15-19 year olds), and in Phase 2 about 15% of the clients served were adolescents. Despite an adolescent focus, the percent of adolescents served by MPHD supported sites has not dramatically increased. However, this proportion is on par with the 2022 Nepal DHS, in which 14.2% of adolescents reported seeking modern contraception methods. CRS noted that as the legal age for marriage in Nepal is 20 years, many younger or unmarried sexually active adolescents and young people prefer the more discrete option of accessing FP services through the private sector. The 2022 Nepal DHS showed an increase in use of traditional methods in this adolescent cohort (15-19 years), an increase was also observed among all age groups despite marital status. However, modern contraceptive use among married adolescents, 15-19 years, has increased from 8.6% (2016) to 14.0% (2022), while modern contraceptive use remained stagnant among all adolescents, 15-19 years, regardless of marital status. MPHD focuses on service delivery, and CARE's adolescent health project is meant to lead on demand generation. However, the two projects operate in different geographies and with different timelines, so this is a significant gap. When asked about sustainability plans, CRS indicated that they hope to receive additional donor funding.

Niger. MPHD faces challenges with data quality, specifically timeliness and completeness of private sector data. A second challenge relates to government collaboration, especially with the recent unstable political situation in the country.

Nigeria. Fluctuating foreign exchange rates pose a significant barrier to continued procurement of the Avibela IUD product. Private providers are concerned about how to achieve cost recovery, and this situation reinforces the public's perception that the IUD is an expensive product.

Pakistan. Social Male Mobilizers (SMMs) were a dormant cadre and not well motivated. Support to male GPs, and the community of practice, ended with the project as GPs fell outside of PSI's typical target audience. While the project improved their exposure to FP/SRH service, there was no connection to service uptake.

Philippines. Sub-national implementation efforts have varied. The public sector provincial FP program manager in Antique is proactive, while the one in Guimaras manages multiple public health programs and had less time to engage. Specific religious convictions in Guimaras pose challenges related to demand. Public sector facilities are not accredited with PhilHealth, so they are less motivated to provide FP. There was a limited provincial health department prior to engagement with the private sector; they were seen as competitors, with limited experience in contracting. PhilHealth conducts accreditation of individuals and services (e.g., PHC, FP, HIV, etc.). Facilities' accreditation is dependent on investment and instruments (another set of requirements according to IMAP), and many FP accredited providers do not have accredited

facilities. IMAP also mentioned PhilHealth's reimbursement delays as a preexisting and ongoing issue. Commodity supply remains a key challenge, as commodities should be provided to accredited public and private FP providers through the local government units (LGUs), a policy achievement due to MPHD's efforts. However, currently there are no implants and midwives that want to buy from IMAP, which requires coming to the central office to purchase. The LGU was also interested in purchasing from IMAP, but substantial paperwork would be required to set that up.

EQ1.2. What are the recommendations to address the challenges?

Burundi. To ensure the continued availability of contraceptives and malaria treatment products in private health facilities, MPHD has advocated for support with the MoH and the partners who buy these products for Burundi. The stability of health workers remains a challenge, especially in faith-based health centers. The project organizes regular coaching sessions and experience sharing between new and old service providers to ensure continuity of services.

Indonesia. To respond to high infant and neonatal mortality a QI collaborative has been established, which tackles the specific causes of mortality, e.g., working to address newborn asphyxia. The collaborative started around the end of 2022/early 2023 and was piloted in three provinces, which has now been extended to all hospitals. The QI approach allows for flexibility; facilities can define input and process measures. There is a sense of "learning by doing, as there is no finish line for quality". Co-creation dialogues have been taking place via an established technical work group (POKJA Technical Working Group), and this work will transfer to MCGL with the aim to implement a holistic approach to QI reflected in regulations. There are also some private sector-led initiatives on QI under the Private Hospital Association which should be expanded. For example, the Hermina group is scaling QI self-assessment through their network without MPHD support. MPHD has done well to leverage initiatives and steer the stakeholder conversations. The MPHD team conducted advocacy activities to communicate the advantages that the new pharmacy/depot strategy brings in improving access to and use of services.

Nepal. According to USAID, the response to variability in the private provider registration process at the sub-national level has been to facilitate dialogue between federal, provincial, and local governments to streamline the approach; however, challenges remain. Although FHI 360 led discussions on PSE best practices, it is not clear how specifically PSE is working. CRS works with the government at federal, provincial, and local levels. In MPHD, the main focus has been at the "grassroots" (private sector service delivery level) level. At this level the work of CRS is well understood. For a long time, the government has focused on the public sector, not the private sector, so the project is influencing a more holistic approach to the health sector. CRS anticipates a 10-20% drop out of the SDPs, e.g., a number will not graduate to maintenance phase or check-in. As part of the introduction of LARCs, CRS is focusing on hospitals and polyclinics that are owner-operated to reduce provider turnover. CRS indicated that the subsidy of injectables should continue. Another key focus on Phase 2 is to increase reporting of private health sector data into the HMIS/DHIS2 system. This is supported through government endorsed training and by forging links with federal, provincial, and local governments (*Palikas*). MPHD's scope of expanding LARC services among private polyclinics and hospitals (a new focus) reinforces the important work of expanding HMIS/DHIS2 data reporting among eligible private sites to improve accountability for stock maintenance and cost reimbursement, especially for sites that receive public commodities. No concrete solutions were mentioned to address adolescent service uptake gaps and challenges.

Niger. PCC was integrated into capacity strengthening for both private and public health providers. Providers from partner health facilities received regular supervision and support visits, particularly from midwives and supervisors, to improve the quality of services. MPHD also supported the integration of family planning activities in the private sector with pricing strategies where products are free, and the client pays for the service. To improve the quality of care, materials were provided at each training session. For example, during training on contraceptive technology participants received kits for inserting and removing implants and IUDs. Delivery and resuscitation kits, consultation tables, delivery tables, electronic and obstetric blood pressure monitors, trolleys, screens, umbilical cord clamps, and score tables were also provided to compensate for shortages in certain facilities. Localization efforts focused on strengthening partnerships with the private health sector in Niger. This facilitated establishing offices in three regions to concentrate efforts locally and to coordinate with private sector associations specializing in areas such as polyclinics, care practices, and hospital-based childbirth.

Nigeria. Provider training was challenging due to the time commitment required. SFH found the hybrid model, with synchronous and asynchronous modalities, to be an effective solution.

Pakistan. To respond to the issues of limited SMM motivation, a competitive element was added through the chatbot (Viya), which spurred the SMMs to be more active, where competition revolved around referrals. In addition, a manager was employed to provide constant engagement with the SMMs via a WhatsApp group and tracking of SMM activities. There was no solution to the continued work with GPs. A similar challenge was experienced with pharmacies, but relationships continue through PSI's other programmatic work. While there was an expressed preference for e-training by GPs, this was not introduced under the project.

Philippines. According to MPHD, the PSE approach was able to reinforce relationships at different levels of government, including with rural public facilities. This win-win model was documented in the Memoranda of Agreement between the PHDs, IMAP, and providers. This was done using a human-centered design process to address pain points. Ongoing issues with PhilHealth, particularly claims management, are addressed through the monthly HCPN meetings (which are attended by the FP program manager). According to IMAP, solutions to public commodity shortages have not been identified, except for purchasing through IMAP. IMAP continues to facilitate dialogue with PhilHealth on behalf of its members, drawing on "information from the ground" via messenger groups, and lobbying PhilHealth.

EQ2. To what extent has MPHD been able to incorporate the three main technical approaches – private sector engagement, person-centered care, localization – into its activities?

Findings

- Technical approaches are interwoven and 'nested' in line with the MPHD theory of change. Technical approaches have been implemented at policy level through to service delivery, but not always using a 'whole system' approach, which may be perpetuating fragmentation.
- Project duration (even those with core funding) is short relative to the 'ambition' of technical approaches (e.g., overlay of private sector engagement, with quality/PCC, and localization).
- While private sector engagement is a core PSI capability, under MPHD they have not expanded their ways of working to link to global issues that would strengthen their ability to push the field forward with innovations and thought leadership that link to the latest challenges in today's world. There

has been some good work on small and sick newborn care, but the funding to support this is limited. The literature review of the past 25 years of private sector efforts to expand immunization coverage was an important contribution, and contributions to youth programming such as the publication on MPHD's Malawi Meaningful Adolescent and Youth Engagement (MAYE) experience are helpful. Sometimes the youth focused work lacks the resources to drive a strategic approach to youth award-wide, but MPHD has identified best practices that can inform activities in other contexts. There are missed opportunities to advance the field in the areas of innovative partnerships, youth programming, and health system strengthening.

USAID Mission Survey Results
Seven out of eight respondents to the online survey indicated that PSE/TMA had been integrated into MPHD activities adequately or better, and all eight respondents indicated both PCC and localization had been integrated fine, well, or very well. Six of eight stated that MPHD's PSE approach needs to improve when asked which technical area needed improvement. Challenges related to capacity strengthening, management, and staff mobilization were mentioned.

- Terms such as market-shaping and systems development are used in some contexts, however it is unclear how this is reflected within the technical approaches and logic model.
- The PCC initiative is getting traction globally. Some stakeholders felt that this is a repackaging of a method that has existed for some time. The new focus on getting quickly to the heart of what the client needs was appreciated. Related to this, MPHD has also worked to strengthen Respectful Maternity Care approaches. They have been asked to expand this approach beyond mothers to ensure that the pediatric quality of care standards are addressed as well. Updates about the rollout of this initiative have been lacking, and insights about how to adapt and apply learnings to other countries are also lacking.
- There are opportunities to share and leverage some of the MPHD private sector activities. For example, through NPI the project worked on postpartum family planning in urban slums in Uganda. While this work was disseminated in Uganda through conferences, for example, this initiative was not shared with relevant global stakeholders such as FP2030. Efforts to date to share PSE tools and approaches include representation and influence via conferences such as ICFP & IMNHC, and developing or revising regional or global technical guidelines and advance global strategic conversations, most notably in the MNCH/immunization space, and also in PCC.
- A central premise of localization has been sustainability, which may place significant pressure on the local partner if they are viewed as the lynchpin to this strategy.
- There is tension between the focus on results and sustainability. The technical approach and logic - that improved capacity leads to equitable, profitable, and sustainable services within the private sector – does not hold in all contexts. The pathway to service uptake, particularly for adolescents, is not clear.

The three approaches are intended to be nested, so responses often interwove PSE, PCC, and localization. Some countries have focused on one primary local partner (e.g., Nepal) while other countries have taken a broader focus, leveraging government and private sector structures more widely (e.g., Indonesia).

Burundi. For *localization*, PSI identified two organizations, the Network of Religious Confessions for the Health and Comprehensive Well-being of the Family, and the National Association for Social Franchising, as local partners. An assessment of their organizational and programmatic performance was conducted

and strengthening plans were proposed. Traditionally, the private sector has been neglected in the health system, but MPHD is strengthening collaboration through supervision and integrating private sector data into the national health information system.

Indonesia. Documentation in reports from program year 1 and 2 described the approach while program year 3 reporting focuses more on achievements.

Private sector engagement was translated for MNH and the Indonesian context, and it continues to be adapted. This involved working with established hospital chains and networks (across districts and provinces) and developing district-based networks, particularly for referral systems and quality improvement. Other forms of PSE have been modeled or tested such as a private sector 'hub and spoke' model in Tangaran district (urban, close to Jakarta) where a large private sector hospital cost shares with MPHD and collaborates with the DHO to strengthen capacity of district public and private facilities.

For *PCC*, the foundation for PCC is to improve MNH outcomes by focusing on problem solving, particularly for infant and neonatal mortality, given that this has lagged behind other aspects of MNH.

For *localization*, a key strategy has been to leverage government structures and strengthen stewardship and technical capacity; specifically focusing on DHOs in their oversight and supervisory role in service delivery. MPHD also leveraged the roles of provinces as mentors and the national MoH on policy issues. Other private sector actors have also been enlisted such as private teaching hospitals (on QI/mentorship), academia (planned documentation/learning), and faith-based networks (on mentorship). MPHD is increasingly less hands on, providing technical assistance (TA) to government and private sector entities. An example of nontraditional partnerships is the initiative with a plantation company to strengthen midwifery capacity.

Madagascar. *For PSE*, the project worked with private pharmacies and drug shops by training them to provide family planning and ICCM services. A market study was carried out on private sector financing accompanied by a roadmap to guarantee adequate financing of this sector with the involvement of all technical and financial partners. This led to an agreement to integrate family planning provided by trained drug shops into *mutuelle* health insurance, as a way of more sustainably financing these private sector providers. To raise awareness of the insurance program, the project is working on production and marketing communications to stimulate demand for family planning at the drug shop level. Apart from private pharmacies and drug shops, MPHD worked with women's and youth associations. These associations were involved in awareness-raising activities in the two regions where the project was implemented. About sixty providers were trained on family planning and integrated care for children under 5 years old in the two regions.

Mali. For *PSE*, the MPHD project worked with Jigi, a local NGO with extensive expertise in social marketing, on the issue of social marketing of contraceptive products and on market coordination, both at the country level and in intervention areas, resulting in improved access to contraceptive products. For example, for 2023, the couple-years of protection (CYP) for Protector condoms increased significantly. PSI leveraged its *Total Market Approach* and prior experience with ShopsPlus to understand the market. Demand creation was done by community health workers. Another strategy at the community level involves training traditional therapists on the front line, who then refer patients to private health centers.

For *localization*, NPI Expand also supported Jigi with technical assistance and capacity building. MPHD

also works with three local partners under memoranda of understanding: the midwives' association of Mali, the network of young ambassadors, and the private sector alliance.

Nepal. The *PSE* approach is essentially social franchising, with three distinct categories of support - intensive, maintenance, and check-in. Phase 1 SDPs are in maintenance and phase 2 SDPs are in intensive. No SDPs are in the check-in phase.

For *PCC***,** the PSE approach involves working with private sector service providers to build their capacity in FP and management to deliver FP services to adolescents. PCC has mainly focused on adolescent access or client satisfaction and training of SDPs.

For *localization*, there is a heavy emphasis on localization and sustainability, with CRS at the center of the approach, "If CRS is sustainable, then the project is sustainable". However, there were concerns that there was no clear plan for sustainability. CRS focuses on the municipality and provider levels, while other aspects of the enabling environment were led by FHI360. There is some work with the government on stewardship, but this has mainly been the PPP orientation package. CRS is the partner implementing all activities on the ground, FHI360 is the lead and liaises closely with the donor, and PSI provides some TA and has supported the development and refinement of the intervention approach using human-centered design approaches and leads on business skills training and health facility demand generation.

Niger. It was challenging to collaborate across technical areas with the MoH due to the current political situation in Niger. The revitalization of the national private health sector platform in Niger helped to concentrate efforts locally and to organize associations of the private health sector specialized in different fields, such as polyclinics, care rooms, and delivery rooms.

Pakistan. PSI has a strong *PSE* component to its work in Pakistan. The project extended its traditional audience to include public providers, PWD master trainers, business enterprises (where young men are traditionally employed), male GPs (~200), and private sector pharmacies, a sector that PSI has traditionally targeted.

For PCC, a chatbot was introduced as a resource for the social male mobilizers (SMM) and the target audience of young men and newlywed couples. This reinforced key messages and training. SMMs had been a dormant cadre under the PWD.

For *localization*, public sector support has improved at the PWD level, but this was not as clear at district level.

Philippines. The main approach to *PSE* focused on establishing HCPNs in two rural provinces. The HCPNs included midwife-run birthing homes, nurse-run clinics, community hospitals, and OBGYNs. The HCPNs were small, with six private providers per province. In urban provinces there is less public-private collaboration potential, as private providers are already part of corporate chains or networks and operate closed models. A new feature of HCPNs is that in addition to training midwives on FP, doctors and nurses are also trained. MPHD reinforced understanding of national laws and policies at the sub-national level, e.g., via training and other interactions. MPHD included the provincial FP managers in this effort, which helps improve their skills and knowledge.

For *PCC*, this is a quality overlay to the PSE approach, which includes piloting solutions to 'pain points' identified using HCD. Clients are also involved as part of the solution design process. The HCPNs reinforced public and private collaboration, e.g., referral from the public sector to private sector FP clinics, provision of commodities, contracting, licensing, etc. The model is also recognized for reducing the burden on public health facilities.

USAID Mission Survey Results

"The [three] approaches are well-designed and thoughtful, however there are limitations considering that the MPHD implementation is recent and the engagement regarding localization from the associations is still a challenge to be addressed."

"Market dynamics related to adolescence, youth, and migrants would be great to consider for CRS' business plan. Their business plan should be focused on self-sustained markets so they will be independent from donor support. CRS and CRS Health Care both coordinate in such a way that their business plan will govern strategic purchasing and be self-sustaining. A clear Memorandum of Understanding is needed between the two entities with clearcut roles and regulations."

For *localization,* IMAP focused on competency training and cluster meetings (termed PP4FP) for private FP providers. The PHDs were supported to engage private sector providers, as public-private engagement was previously limited in the two provinces. IMAP is an accredited trainer (national) and is a recognized trainer for the provinces.

EQ2.1. What has been learned about the implementation of the technical approaches thus far in terms of project performance, including outcomes by key disaggregates?

Burundi. With the support of the project, the two sub-recipients have evolved from manual financial management to computerized systems. As for health data, the project has done a good job by ensuring that private sector data is available in the MoH's DHIS2. Private health facilities benefited from training on reporting and data collection tools. Results included better integration of private sector data into the national health information system and increased private sector participation in strategic discussions with the MoH. Significant progress has been observed in the quality of data reported by private health facilities and in local partners' involvement in supervising health facilities. Overall, the completeness rate of reports provided by the private sector increased from 90% at the start of the project to more than 97%.

Indonesia. PSE is a longer-term approach, particularly when coupled with a focus on quality improvement and localization that builds stewardship and strengthens structures. One respondent noted, "There was an under estimation of time needed for buy-in".

Nepal. There has been a shift in clients from the private to public sectors (linked to NHI), but more analysis is needed to understand if this has resulted in greater access. The project was collecting data on the number of clients who accessed ECPs through MPHD supported sites. Training has been a priority for capacity strengthening of SDPs and is seen as sustainable, but private sector staff turnover has been high unless staff are owner-operators. Adolescent client feedback mechanisms are in place, but very little feedback has been provided. MPHD Nepal demand generation has been limited to health facility-demand generation efforts only. The CARE project was meant to lead on adolescent demand generation, but it

operates in different regions and has a different timeline than MPHD. There have been issues in clarifying roles between CRS and CRS Healthcare that need to be addressed through strategic planning TA. Governance mechanisms were in place for social marketing but were less well defined for service delivery. CRS remains donor dependent, as was the situation before MPHD. There is interest in overlaying an adolescent and 'hard to reach' focus for CRS, but it has not yet been incorporated into the business model. There are few private sector providers in harder to reach areas; the model mainly works in more urbanized areas. Unless CRS and CRS Healthcare can identify cross-subsidization strategies, it will be hard to have a sustainable model that serves 'hard to reach' populations.

Niger. The availability of disaggregated data by age and gender remains a challenge in Niger, and private health facility data have been incomplete or late. This situation negatively impacts the performance of the project and has made collaboration with the MoH difficult.

Pakistan. The project has ended, but the pathway from males receiving information to service uptake was not clear (this was recognized by PSI). The innovations under the project were promising, but innovations were "not as easy as they sound" and some could not be transferred as they were essentially start-ups. Project implementation should address misaligned expectations regarding social norm change, and allow for agility, remove pressure, and provide adequate time to achieve objectives.

Philippines. An important component of PSE focuses on building the readiness of the public sector to engage the private sector. In this vein, the model reinforced the role of the public sector at national, regional, and provincial levels (e.g., PhilHealth, MoH at national level, Provincial and District Health Departments). The model was mirrored by working with IMAP through national, regional, and provincial chapters and reinforcing feedback loops.

EQ2.2. What disaggregated data exists (by age, gender, FP/RH, MCHN, etc.) and how does this data demonstrate progress across the four main technical approaches?

Indonesia. Basic and comprehensive EmONC tools were adopted by the MoH and incorporated into the Health Information System (HIS). HIS data on clinical and referral performance, and the private sector, are included. The point-of-care quality improvement tool allows for solving 'facility-unique' problems. Currently this is not in the HIS, but Jhpiego is working on this as part of the sustainability plan.

Madagascar. In terms of data, the MPHD project is in the process of digitization by establishing special registries to document users of family planning services both at the level of health *mutuelles* and in drug depots. This digitization will permit data disaggregation by sex and age, but it does not yet include the ability to track private sector data at the national level of the HIS.

Mali. The project set up a shared medical file that allows private health facilities to capture all relevant information on the patient's journey. This digital tool was well appreciated by the stakeholders and work is underway so that the information in these medical files is shared with the ministry or is directly entered into the national health information system.

Nepal. Data recording and reporting to the government HMIS by private sector service delivery points is a priority for USAID, and it is considered foundational to the PSE approach. It is a two-way issue- there is government demand for data in the HMIS/DHIS2 (mainly focused on polyclinics and hospitals) and the

private sector is willing to provide this. However, data utilization is low. Some SDPs are not willing to share data due to fears of investigation, connected to regulation and taxation. MPHD has its own DHIS2 for data collection and all private sector SDPs report into it. Of the 151 polyclinics and hospitals supported by MPHD, 66 of them (44%) have been assigned an organization unit by the government and 47 of the sites with an organization unit (68%) are regularly reporting into the system. SDPs that are pharmacies and clinics are not allowed an organization unit but are supposed to report services to the nearest public health facility.

Pakistan. There is no data provided to PWD via HIS; data is only available via the project. There is not a government system in place to include data from the private sector. Private sector inclusion in the government HIS is being proposed for future project funding by PSI. PSI has leveraged the approach and incorporated this into their FCDO project (3 provinces including Sindh).

USAID Mission Survey Results

"The routine reporting system lacks the majority of quality-related indicators, and those that are available often exhibit low quality. Furthermore, quality improvement/quality assurance indicators are not integrated into the hospital information system, rendering reporting on these indicators an additional burden for healthcare staff. Additionally, the reporting of these indicators is not tied to national health insurance reimbursement, further reducing motivation for consistent and accurate reporting."

EQ3. How have project management, coordination, and collaboration affected the achievement of project objectives?

Findings

- Project management by PSI was viewed as a facilitator and not a barrier to the achievement of project objectives by consortium partners.
- All of the core and field support programs delivered during this evaluation period were initiated and delivered during the period of the global COVID pandemic. This forced frequent adaptations and disruption to delivery of the award.
- There were some issues highlighted between global and country level, such as Indonesia (discussed below), but these were resolved or have been superseded by other events (project budget cuts).
- In countries where there is a designated local partner, there has been some tension with recognition of existing capacity or expertise vis-a-vis the core and global partner.
- In all instances, project resources have built upon existing consortium or partner structures and organizational policies and leveraged or strengthened these as part of project implementation.
- Short timelines and funding cuts have had implications for the delivery of technical approaches and results and may reduce provider motivation to participate or innovate in future activities.
- Jhpiego has a strong technical director who participates in weekly calls with USAID and offers important 'value add' to MPHD. Avenir Health and ThinkWell have narrow technical roles, and their contributions have been important. FHI360 was supposed to lead on the child health work, but their

expertise is child nutrition. The ICCM curriculum review took a year to complete and was transferred from FHI360 to JHPIEGO.

- Communication from MPHD to USAID could be improved. Updates are provided upon request, but this process could be more proactive, with regular meetings and more user-friendly reports focused on technical issues more than process updates.
- Thought leadership products such as blogs and peer-reviewed journal articles are limited, and the rigor of these products should be strengthened. As a global project, MPHD is expected to address evidence gaps and push the field forward. The learning agendas identified previously under predecessor projects have not significantly moved forward.

EQ3.1. Is the team using project partner resources and skills in an efficient and effective manner? If so, how?

Burundi. The project team worked in collaboration with the MoH during the selection of health facilities and during field supervision, where work is done in close collaboration with health district officials to monitor healthcare providers and the application of national protocols. PSI staff also contributed to the development of strategic documents for the MoH, which was not the case before the MPHD project. In addition, the project implementing partners are integrated into the thematic groups of the MoH.

Indonesia. Within MPHD, it took time to work out support mechanisms. In general PSI has been respectful of Jhpiego and its relationships with partners. Contact with PSI has decreased recently due to changes in scope. There have been challenges with aligning information systems between Jhpiego and PSI under MPHD, despite both using DHIS2. This has resulted in duplication of work in terms of data review and validation. At the request of USAID, there has been a shift in focus to PHC and a change in the SOW for MPHD with large budget reductions. Some activities, such as work at the national level on policy, are now under MCGL.

Madagascar. The collaboration with the Ministry of Health was very difficult at first, but once the approach was accepted, a workshop was organized to finalize and adapt the curriculum to the country context. Then, teams from the MoH participated in training and post-training monitoring in the North. MoH support is essential for achieving the results of the project, which is why it has been involved at all levels at the expense of delays to implementation.

Nepal. In Nepal, PSI Nepal has mainly a TA role and FHI 360 is responsible for providing the overall management. Given that PSI is the prime for MPHD, this complexity has generated some operational inefficiencies, including delays in signing memoranda of understanding and developing annual implementation plans. Implementers are aware and are making improvements to address these issues, but CRS does not participate in global calls, creating a lag in feedback. There were concerns that CRS' work is not presented as theirs; this also extends to social media where project work was presented as FHI360's (and not under MPHD).

Niger. The lack of MoH collaboration in Niger has been more marked at the central level rather than at the decentralized level.

Pakistan. The project was short in duration, funded by a buy-in from the Mission until the Pathfinder project started. It was very demotivating for the team to work on innovations and not see them scaled, but PSI is channeling this work through other donors, FCDO and BMGF. These circumstances also reduced provider motivation to innovate. The country program received a lot of "hands-on" support from MPHD

global, including regular check-ins. Respondents felt that it was one of the best managed global-country engagements with PSI.

Philippines: Management from MPHD/PSI was seen as facilitative, fair, and reasonable, keeping USAID updated. IMAP was used efficiently; for example, IMAP facilitates continuous professional development activities for its members. This role was leveraged by the project for the FP training. IMAP was already an accredited FP trainer with the national Department of Health and supported by USAID under a previous investment.

EQ3.2. Is the team collaborating with other USAID projects and/or projects funded by other donors? If so, how?

Burundi. The MPHD project collaborated with another USAID bilateral project that supports the public sector. The Dutch Embassy collaborated in some sites through demand creation.

Indonesia. MPHD collaborates with the USAID Madani Civil Society Support Initiative on a third-party patient satisfaction survey, which the MoH requested, and which is being conducted through a CSO and university partner. Externally, it has been challenging to work with other IPs in-country, as timing and geography are not always aligned.

Madagascar. Beyond the MoH, MPHD collaborates with *mutuelle* health insurance companies to integrate family planning into their offers.

Mali. MPHD collaborates with two other MOMENTUM projects, namely MOMENTUM Integrated Health and Resilience, and Safe Surgery in Family Planning and Obstetrics. Periodic meetings between the three projects identify avenues for synergies and collaboration.

Mozambique. MPHD collaborates with the professional associations ThinkWell and DKT on issues such as policy dialogue and supply chain. There has been recent interest from UNFPA, FCDO, and other agencies to explore how PSI can increase access to FP/RH in the private sector, including in rural areas.

Nepal. CARE ARH has a small private sector component that is similar to MPHD, but it does not include business training, and it is implemented in the same municipalities but with different SDPs. USAID ensures that no duplication between ARH and MPDH occurs. ARH has an adolescent-focused digital component that MPHD will benefit from. CRS is a subcontractor on ARH, implementing the same activities as MPHD on this project in 275 SDPs in different municipalities. CRS participates in quarterly USAID IP and government technical FP meetings and shares learnings.

Pakistan. There was no collaboration with other USAID projects during implementation, but MPHD did work with the Willows Foundation, which has a vasectomy project. The handover to Pathfinder went well in terms of reports, materials, and meetings. It is unclear whether they can do the digital elements of the work and how much can be transferred to Pathfinder under the new project, although they will continue the support to the PWD and the SMMs.

EQ4. How well has the project integrated cross-sectoral issues into project activities (with a specific focus on youth, gender, and the environment)?

Findings

- Cross-sectoral issues – youth, gender, and the environment – have not been consistently recognized or mainstreamed in project activities.

- Some projects have a specific focus on youth or gender, while other projects have leveraged organizational policies and training materials. Malawi, the Philippines, and Nepal have gender-focused activities. Youth tend to prefer the private sector for FP/RH products and services, so they are a priority audience in several countries. In Benin, innovations such as a chatbot for youth have added value to the program.
- There are missed opportunities to integrate youth programming in a strategic and consistent manner.
- Respondents did not have a consistent or clear understanding of the environment as a cross-sectoral issue. Given that MPHD did not have dedicated funding for population, health, and the environment work, this is not surprising.

Burundi. The Dutch Embassy effort supporting the private sector has initiated vouchers for young people to facilitate their access to sexual and reproductive health services. These vouchers contributed to demand creation in participating sites.

Indonesia. There was no specific focus on youth. Gender was mainstreamed in materials and in the focus on MNH. There was no specific focus on the environment.

Malawi. The one-year activity used HCD with young people to create youth-friendly ASRH materials disaggregated for girls (comic books) and boys (peer approaches, videos).

USAID Mission Survey Results
"The Malawi Meaningful Adolescent and Youth Engagement (MAYE) activity – the platform it created to have youth and adolescents have access to information helped them to make better decisions about life."

Mali. Young people were trained on integrated services, and also on the use of digital tools to run social networks such as WhatsApp, Facebook, and Twitter.

Mozambique. Young people continue to be a priority audience for MPHD in this second phase of MPHD work. There is a need for disaggregated data by age and gender, along with indicators to track progress.

Nepal. Youth and adolescents were the core focus of the project. Gender was integrated via FHI360 policies and systems, nicely done at an operational level. There was no specific focus on the environment. RS mentioned work on waste management with SDPs and their organizational policy on plastics.

Niger. In terms of demand creation, MPHD helped establish community dialogues to encourage exchanges between providers and potential clients with a focus on young people. The project organized awareness activities, including caravans and advocacy, to better meet the needs of local populations. For nutrition activities, MPHD worked with the public sector, but especially with community stakeholders.

Pakistan. Youth and gender were a core focus of the project. There was no specific focus on the environment.

Philippines. Youth was not a specific focus of the project. IMAP works on adolescent life skills under another project, but this approach was not incorporated into MPHD activities. Gender competency training was included in the FP training. There was no specific focus on the environment.

EQ4.1. Which illustrative examples demonstrate integration?

Indonesia. Gender is incorporated into performance monitoring tools and capacity-strengthening materials, which also include respectful care and family involvement.

Madagascar. Private providers were trained to offer both FP services and integrated care for children under 5 years old. The offering of FP services through pharmacies and drug shops was initiated to meet the needs of service integration.

Nepal. MPHD had a gender operational policy, e.g., when hiring, consider gender balance and ethnicity. Gender disaggregation in training and other activities was also recorded.

Niger. MPHD strengthens service delivery with a focus on integrated training and supervision. A single provider can offer both family planning, nutrition, and malaria services. MPHD also supported the integration of family planning activities into the private sector. The continuing challenge is to figure out how to give the products for free to these private structures and ensure that these products will remain free.

Pakistan. The chatbot was a "pleasant surprise" and it has proved popular, particularly with unmarried youth, who often don't have a source of information or access to services, given the taboo nature of sex outside of marriage (40-50% of those engaging with the chatbot). This led to other innovations to reach young people via universities, using standup comedy and game jams. These 'normalized the conversation', put mixed groups of young men and women together, and also allowed the project access to the universities (some refused to cooperate).

Philippines. Gender competency training was incorporated alongside clinical training on counseling, short-term methods, and LARCs.

EQ4.2. What is working? What is not working? What untapped opportunities exist for integration across cross-sectoral issues?

Indonesia. Gender has been integrated as part of Jhpiego's training materials.

Nepal. Adolescent service uptake is not going according to plan. The integration of gender into operational policy and activities was considered a "positive, cross sectoral, feature of the project" according to USAID.

Pakistan. Female providers and Lady Health Workers (LHWs) were not engaged as part of the project; male engagement is seen as a solution to the lack of effort made by LHWs to engage men, and a lack of focus on FP (given workloads). While the project did start to work with female health assistants to reach out to households, the project ended.

Philippines. Training is not enough to address gender; this felt like a separate project. "We could have done more."

Discussion

MPHD has made important progress in achieving objectives across the four project result areas, especially regarding increasing access to evidence-based, quality FP/RH/MCHN services and strengthening capacity of private sector providers to provide these services. Of the three technical approaches, MPHD has made significant contributions to person-centered care methods and materials. Project management is sound, yet several opportunities for improvement exist.

EQ5. What are some areas for improvement in the remaining years of the project to ensure achievement of the MPHD key result areas and objectives?

- While important progress has occurred using core funding to advance technical priorities such as person-centered care, integrated FP/child health curricula, and quality service delivery, there are opportunities for improvement across strategic priorities such as increased use of products and services, attention to adolescents/youth, expanded host country technical leadership, and global thought leadership.
- There is tension between the focus on results and the need to design for sustainability. Most country programs have no plans for sustainability other than receiving additional USAID funding.
- MPHD should improve knowledge sharing and support adaptation of best practices to other country programs (e.g., chatbots in Benin and Pakistan, insurance scheme in Philippines).
- There are systemic challenges with data quality that require attention. While progress is occurring in certain countries, barriers such as automating paper-based systems, instituting data quality assurance measures, and harmonizing public and private sector data systems continue to pose challenges in some MPHD country programs.
- Delays in approval of country work plans and budgets have impacted the ability of some MPHD country programs to achieve their goals.

EQ1. To what extent has the MPHD project achieved its objectives to date, as identified in the conceptual framework, in the areas of FP/RH and MCHN?

- For Objective 1 and Result 1, MPHD has invested a large portion of core and field support funds in activities that increase availability of MNCH/FP/RH services in the private sector. Core investments have largely focused on FP/RH, with some attention to specific investments in MNCH activities such as immunization. Project activities have not always translated into results, specifically regarding improved access to and demand for services, and particularly for priority populations (e.g., adolescents). In addition, attention is needed to address incentive misalignment. For example, in Indonesia MPHD's QI component of the mentoring program does not align with local hospital accreditation standards.
- Taken as a whole portfolio of activities, MPHD has a mosaic of 'islands of implementation', or 'fragmented implementation', causing a lack of synergy and cross-learning to maximize impact and improve health outcomes. Some of the reasons for this are systemic and beyond MPHD's control. Funding cuts, workplan approval delays, as well as short and changing timelines on the part of USAID can create implementation challenges. USAID missions use their field support funding for priority activities of interest to that particular country, which adds to the challenge of building synergy across country programs.
- MPHD has a disconnect between supply side and demand side efforts that limit its ability to increase service delivery and improve health outcomes. Objective 1 of MPHD is to 'increase availability and demand for MNCH/FP/RH through private providers', and Result 1 focuses on 'scaled

up, sustained access to and use of quality health interventions.' While the project design focuses largely on supply side factors, it is crucial to calibrate those with appropriate demand generation and SBC strategies to meet the needs of priority audience groups. In several countries, MPHD has well trained private providers with LARC commodities and supplies who see very few clients. Their newfound skills will diminish if they don't use them, and the ability of MPHD to address unmet needs and improve health outcomes will be limited. In Nepal, for example, the CARE project is expected to lead on demand generation for youth, but their project and MPHD focus on different geographic areas, have different timelines, etc. In the future, USAID should consider project designs where supply and demand strategies are more closely aligned to build synergy, expand uptake of quality products and services, and improve health outcomes.

- The majority of MPHD field support workplans (Benin, Burundi, Mali, Niger) contain demand generation activities, which are implemented through diverse channels: demand generation agents/community health workers, mobile events, digital tools, and community sensitization events. In other countries (Nepal, Mozambique), USAID Missions have delineated between MPHD largely supporting supply-side activities while other bilateral awards support demand generation activities as part of their overall portfolio strategy. In Mozambique, this arrangement (between MPHD and the IFPI project) seems to be well coordinated. Additionally, core activities that result in service delivery have also made investments in demand generation that seem to be overlooked in this document. For example, in Nigeria, there were extensive demand-side interventions deployed as part of the activity. In Madagascar (as stated earlier in the report), MPHD is actively creating demand for newly trained pharmacy and drug shop providers. In Benin, demand generation is part of the field-supported work that is leveraged by the core activity. In India, the activity focuses almost exclusively on digital generation of demand. Most of the other core activities involve analyses or global level activities, and not service delivery.
- In terms of Objective 2 - expanding public and private partnerships - there was progress at the global and country level. In Ghana, the TFHO progressed to the point where they now receive direct funding from USAID/Ghana. In Indonesia, there has been progress working with professional associations. In Burundi, the project was able to address challenges with local partners. ThinkWell's work in the Philippines to improve health insurance payments from PhilHealth to private providers for family planning services was well received.
- Work under Result 2 focused on capacity strengthening of private sector hospitals and clinics to deliver FP/RH and MNCH services through a mix of training (synchronous and asynchronous), mentorship and on the job support, and provision of commodities, equipment, and supplies (e.g., Ghana, Benin). Partners were largely satisfied with these efforts, although some questions about quality assurance were raised.
- MPHD's overall approach to Result 3 was to define and explore priority knowledge gaps in the evidence, and to share knowledge gained around what works (and what does not) in support of the private sector for better MNCH/FP/RH outcomes. While several global goods were created, when probed most respondents were not aware of the term 'global goods' (except for Ghana) and were not familiar with these products. MPHD produced several global goods and documented cumulative knowledge products and learning. Result 3 was challenging to achieve; while there were some examples of private-public collaboration, there was less evidence that MPHD is improving host country government stewardship of the entire health system, with a focus on private sector leadership. Government stakeholders were generally satisfied with MPHD's contributions to strengthening health systems at the local and national levels.

- Little progress was made in Result 4 to foster cross-sector collaboration. Although a few country programs were implementing youth-focused interventions, there was minimal attention to evidence-based gender programming, and the environment was not part of the funding or project design.

EQ2. To what extent has MPHD been able to incorporate the three main technical approaches – private sector engagement, person-centered care, localization – into its activities?

- While PSE is a core PSI capability, under MPHD, this area did not evolve to adapt to current market conditions and position PSI as a thought leader in innovative PSE approaches adapted to the complexities of the world today.
- Person-centered Care and Counseling for Choice efforts were generally well received by healthcare providers such as nurses and midwives, and by host country government counterparts. The multi-modal training and mentor support features of capacity strengthening strategies were also appreciated by providers. There is room for improvement to implement these methods more consistently and identify ways to make this area sustainable. Stronger demand generation linkages are needed to increase uptake and improve outcomes.
- There have been successes in localization efforts, such as the example of TFHO in Ghana transitioning to receiving direct USAID funding. MPHD activities in Ghana had ended at the time of the field visit so it was not possible to evaluate how MPHD had contributed to strengthening TFHO. Additionally, there are examples of close collaboration with host country governments in Indonesia, Philippines, Madagascar, Mali, and Uganda.
- Few countries have disaggregated data by age, gender, or health area. Efforts to link to DHIS2 and other HIS systems are ongoing in countries like Nepal and Ghana.

EQ3. How have project management, coordination, and collaboration affected the achievement of project objectives?

- Overall project management was sound in terms of partner communication, work plans, and deliverables. MPHD had challenges sorting out partner roles in Nepal and Indonesia, but these seem to be resolved. The system for coordinating with MKA was cumbersome, as it added layers of bureaucracy when producing new technical products. More frequent communication with the USAID/W client team is needed to provide ongoing technical updates and to advance the thought leadership agenda. Delays in approving workplans and budgets have impacted MPHD's ability to achieve project goals in some countries.
- Jhpiego's technical and thought leadership role was recognized and appreciated for adding expertise to the MNCH portfolio. ThinkWell and Avenir Health could be used more strategically to add value. FHI360's expertise was not completely aligned to address child health gaps.
- Thought leadership products such as blogs and peer-reviewed journal articles were limited, and the rigor of these products should be strengthened. As a global project, MPHD was expected to address evidence gaps and push the field forward. There was limited collaboration between MPHD and other projects funded by USAID or other donors.

EQ4. How well has the project integrated cross-sectoral issues into project activities (with a specific focus on youth, gender, and the environment)?

- Cross-sectoral issues – youth, gender, and the environment – were not consistently recognized or mainstreamed in project activities. It is worth considering how MPHD can strategically and

consistently imbue evidence-based best practices for youth and gender programming during the remainder of the project.

Notably, some of the broader MPHD midterm evaluation findings, specifically related to strategy and leveraging the global nature of the project, are consistent with insights from the USAID Global Health Evaluation and Learning Support activity MOMENTUM Midterm Process Evaluation[11]. Specifically, key informants cited few examples of leveraging relationships to improve the scale of programming at either the headquarters or country level to date and that there was limited evidence of shared learning at the country level. Related to the thought leadership and production of global goods, many key informants cited that MKA presented an additional layer of bureaucracy for approvals.

Conclusion

MPHD has a strong management team and has made progress towards its objectives across four key result areas and three main technical approaches. Gaps exist, however, and there are opportunities to strengthen programming during the remainder of the project period to:

1) Improve uptake of health products and services by linking more effectively to SBC demand generation activities

2) Expand public-private sector collaboration strategies

3) Move the field forward with thought leadership products and learnings

4) Identify sustainability strategies

5) Strengthen country-level leadership and stewardship of private sector investments and programs

6) Expand meaningful cross-sector collaboration

With renewed attention to these priorities, MPHD will be well positioned to meet its overall goal of expanded access to and use of quality, evidence-based information, products, and services through private providers.

[11] Clary, Tim, Pamela Putney, and Bambang Heryanto. 2022. **USAID/global health evaluation and learning support activity (GH EvaLS) : evaluation report : 024 momentum mid-term process evaluation, 2022.**

Recommendations

- Use the midterm evaluation as an opportunity to revisit the technical approaches and the logic model to clarify terminology, strategies, and assumptions as well as pathways to service uptake, drawing on country implementation experience and findings from the evaluation.
- Recalibrate the 'supply and demand' dynamic to ensure that improved technical capacity to provide high quality FP/RH and MNCH services through the private sector is complemented by state of the art, targeted SBC strategies that result in increased uptake of services.
- As part of a review of technical approaches, consider conceptualizing private sector engagement through the lens of public-private collaboration, emphasizing the readiness of the public sector to engage the private sector, particularly within service delivery arrangements. This would remove pressure on local partners and refocus attention on wider service delivery systems and governance structures.
- Sustainability should be considered more holistically, and transition plans should be developed at the beginning of the project, not in the final phases of implementation. This would align expectations among core and local implementers, as well as other stakeholders.
- Clarify how promising practices within countries can be used to inform technical approaches and the assumptions underpinning the logic model; expand learning and dissemination efforts, especially to support project partners at country level.
- Cross-sectoral issues have not been mainstreamed (so are not definitionally speaking 'cross cutting'). Consider how MPHD can strategically and consistently imbue evidence-based best practices for youth and gender programming during the remainder of the project.
- Focus more on global thought leadership efforts to move the field forward, in collaboration with other projects and in consultation with USAID. Improve communication processes to operate more proactively in updating USAID on technical issues.
- Technical innovations such as chatbots in Benin and Pakistan should be expanded, and new modalities such as ThinkWell's work with PhilHealth in the Philippines should be scaled and leveraged elsewhere.

Appendix 1. Evaluation Statement of Work

Evaluation Statement of Work

Mid-term Evaluation of Momentum Private Healthcare Delivery (MPHD)

Project/Program being evaluated

Project/Activity Title:	**"MOMENTUM Private Healthcare Delivery" (MPHD).**
Award/Contract Number:	**7200AA20CA00007**
Award/Contract Dates:	**June 22, 2020**
Activity/Project Funding:	**$75,000,000.00**
Implementing Partner(s):	**PSI, Jhpiego, Avenir Health, ThinkWell, FHI 360**
Activity/Project COR/AOR:	**Clancy Broxton**
Activity/Project Start Date:	**June 22, 2020.**
Activity/Project End Date:	**June 21, 2025.**

Background of activity/project

USAID supports global and country programs to advance the quality, access, equity and use of family planning/reproductive health (FP/RH) and maternal and child health and nutrition (MCHN) products and services due to on-going global needs in target countries.

As part of a comprehensive strategic approach since the 1960s, USAID has devoted resources to build private sector FP/RH and MCHN options within country programs. These investments, along with other sources of technical and financial support, have developed private sector organizations to be important players in advancing FP/RH and MCHN programs worldwide.

Currently, there are several projects in USAID's private sector engagement portfolio. This mid-term evaluation will focus on the Momentum Private Healthcare Delivery (MPHD) project. MPHD works to support private

sector engagement in MCHN and FP/RH as there continues to be acute needs in resource constrained countries, especially to prevent maternal and child morbidity and mortality.

The data tell the story of the needs. In 2021, approximately 5 million children under the age of five died, largely from preventable causes. In 24 USAID priority countries, a study of sources of care for sick children with symptoms of acute respiratory infection, diarrhea, or fever found that, on average, one-third of children had a recent experience with at least one of the three illnesses. The majority (68.2%) of caregivers sought external advice or treatment for their sick children, though the level is far higher for the wealthiest (74.3%) than poorest (63.1%) families. Among those who sought out-of-home care, across the 24 countries, 51.1% used public sources and 42.5% used private-sector sources, though this varied considerably by country.

The context for expanding access to voluntary family planning is that FP is vital to safe motherhood, healthy families and prosperous communities. Family planning protects maternal and child health by reducing high-risk pregnancies and allowing sufficient time between pregnancies. Beyond the health rationale, access to quality contraception, and the voluntary option to adopt a method, is an individual's right and central to women/girl's empowerment and development.

The role of the private sector is important. In a meta-analysis of Demographic and Health Surveys (DHS) data from 57 LMICs, Campbell and colleagues [1link] find that between 15% and 25% of FP users in the poorest quintile use the private sector across all geographic regions (Sub-Saharan Africa, Middle East/Europe, Asia, Latin America), and between 45% and 50% of those in the wealthiest quintile use the private sector.

Quoting again from the same source: Among family planning users, the main source of provision was the public sector – and almost entirely from medical providers as opposed to community-based health workers. However, the private sector's role was substantial, accounting for just under two-fifths of provision in all regions, with nearly all contraceptives obtained from private commercial, as opposed to NGO or faith-based, providers. The share of non-medical providers (i.e. retailers) among the private sector was highest in sub-Saharan Africa. By their nature, these providers are likely to offer the narrowest choice of methods, mainly condoms. We also found that women using short-acting methods were most likely to obtain them from private sector providers.

A Guttmacher Institute study estimates unmet need:

- Out of 923 million women of reproductive age in LMICs who want to avoid having a pregnancy, 218 million have an unmet need for modern contraception—that is, they want to avoid a pregnancy but are not using a modern method.
- Among women who want to avoid a pregnancy, unmet need is disproportionately high for adolescents aged 15–19 (43%), compared with that among all women aged 15-–49 (24%). Fact Sheet, Adding it up, Guttmacher Institute

To address these health issues, and as part of a total market approach, MPHD provides technical assistance and capacity strengthening to private healthcare providers, healthcare networks, faith-based organizations, distributors, pharmacists, and drug shop providers to expand the market and fill gaps in healthcare systems. MPHD harnesses the potential of the private sector to expand access to and use of high-quality, evidence based MNCH and FP/RH products and services. The project collaborates with local entities to build local capacity and generate market-based solutions that drive scale in access and use of these products and services.

MPHD's overall goal in targeted countries is to improve coverage and health outcomes for FP/RH and MCHN. Recognizing the need for a comprehensive approach to improve healthcare systems, MPHD works to expand public and private partnerships in collaboration with Ministries of Health (MoH) to improve market access to lifesaving and life enhancing health commodities and services.

Despite the private sector's growing prominence in healthcare, private organizations and individuals working in health often operate in isolation, with insufficient support and oversight. This leaves consumers vulnerable to poor quality care and high out of pocket costs. Governments are often unable to effectively steward health markets. In most LMICs, the quality, range, and affordability of services available through private providers is uneven, as regulatory bodies prioritize quality assurance/QI in the public sector and private providers frequently lack incentives and/or ability to invest in improvements. Many private providers have limited opportunities for updating their skills and knowledge, resulting in outdated information and practices; and missed opportunities for clinical service integration, business efficiencies, and growth.

Private providers also struggle to access key MCHN/FP/RH commodities through MoH central stores or supplementary channels (e.g., USAID or UNFPA), leaving them to procure smaller quantities of medicines of unknown quality through more expensive medical retail sales channels – costs that are then passed on to consumers.

These are some of the major issues that MPHD addresses through its country-level programmatic work and global leadership activities to promote high quality, technically sound programs geared to private sector needs.

MPHD partners include PSI (lead), Jhpiego, FHI360, Avenir Health and ThinkWell

Theory of change of target activity/project

MPHD posits that when private sector, market-based solutions are advanced to support countries' sustainable improvement in the functioning of their market, there will be increased availability and demand for private providers delivering MCHN/FP/RH products and services. When there is a total market approach, with functioning private and public partnerships, MCHN/FP/RH health products and services will reach different levels within the ecosystem, thus improving health coverage, leading to improved health outcomes.

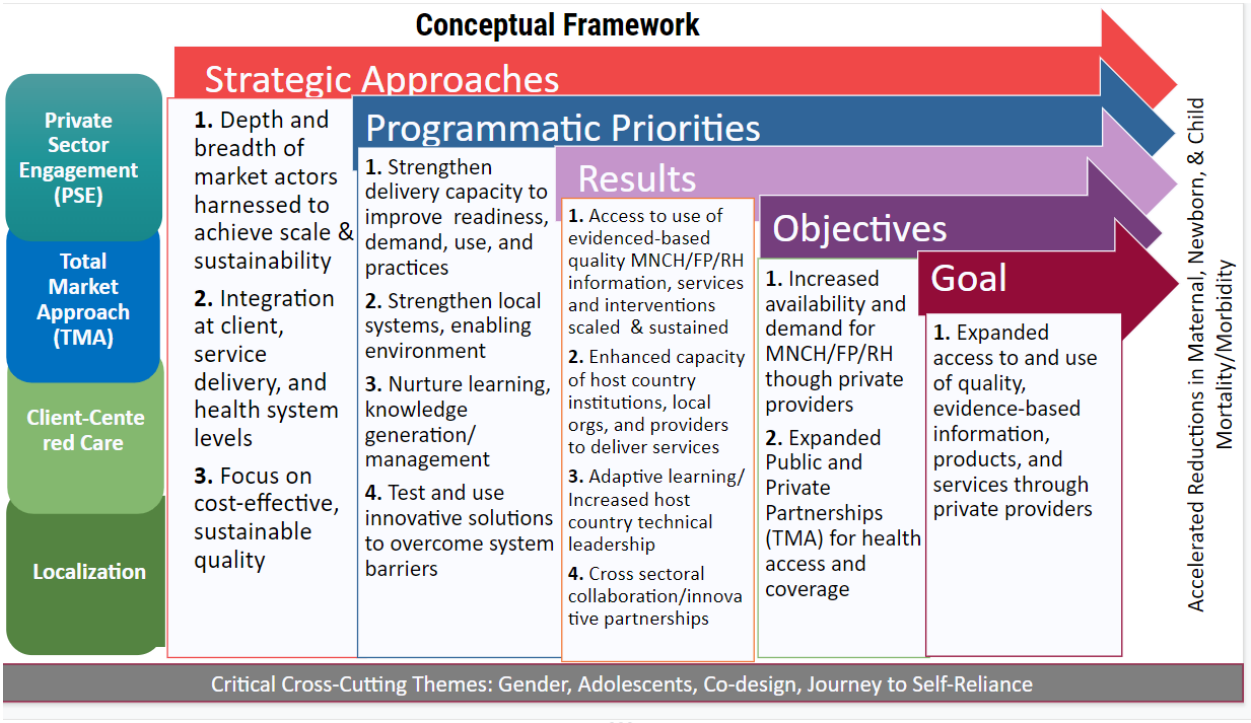
To get to the ultimate goal of "expanded access to and use of quality, evidence-based information, products and services through private providers" 3 strategic approaches are applied, along with 4 programmatic priorities (listed below). The 3 strategic approaches are: 1) depth and breadth of market actors mobilized to achieve scale and sustainability 2) integration at client, service delivery and health system levels 3) focus on cost-effective and sustainable quality.

With these strategic approaches as the foundation, and when the four programmatic priorities (listed below) become operational, programs using these approaches and priorities will increase access, quality, demand and use of MCHN/FP/RH products and services to improve women/girls/childrens' health and development.

Programmatic Priorities

1. Strengthen delivery capacity to improve readiness, demand, use and practices
2. Strengthen local systems and enabling environment
3. Nurture learning, knowledge generation and management of knowledge
4. Test and use innovative solutions to overcome system barriers.

To roll out the strategic approaches and programmatic priorities, MPHD works with 4 key elements: Private Sector Engagement, Total Market Approach, Client-centered Care and Localization.



Strategic or results framework for the activity/ project

MPHD core-funded and field support projects have the following Results:

- **Result 1:** Access to and use of evidence-based, quality MCHN/FP/RH information, services, and interventions scaled-up and sustained;
- **Result 2:** Capacity of host-country institutions, local organizations, and providers to deliver evidence-based, quality MCHN/FP/RH services improved, institutionalized, measured, documented, and responsive to population needs;
- **Result 3:** Host Country technical leadership increased via learning, knowledge generation, knowledge management and use of evidence in MCHN/FP/RH programming; and,
- **Result 4:** Cross-sectoral collaboration and innovative partnerships between MCHN/FP/RH and non-MCHN/FP/RH organizations increased.

Geographic coverage

Global "coverage" is focused on global sharing and learning activities mostly generated from the core agenda of MPHD for dissemination not only to the USAID-funded MOMENTUM Suite of projects, but to the larger FP/RH and MCHN communities and the wider international public health community. In addition, geographic coverage includes several USAID priority country programs that are funded by field support, new partner initiative (NPI) and/or core funding.

Countries receiving core and/or field support include: Benin, Burundi, Ghana, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Pakistan, and Uganda.

Purpose of the evaluation

The purpose of the MPHD midterm evaluation is to assess the project's interventions, their implementation status, quality to date as well as overall achievements and obstacles to achieving key results. Specifically, the MPHD mid-term evaluation will assess the potential for the project to reach the desired result for each global model, tool or approach's development, as well as country-level expected results.

The global MPHD project develops models, tools or approaches that are then shared with the international FP and MNCH community worldwide. These are "global goods" developed via specific activities to aid multiple countries working in similar environments with similar issues and opportunities. The mid-term evaluation is a time to identify what works, what needs rethinking or what major changes may be required at the global and country levels at the midpoint of the project.

The mid-term evaluation is also an opportunity for both USAID and MPHD to take stock of the project's future directions for the remaining years of the project. For example, a more refined dissemination-of-results plan may be a product of this exercise. Cross-learning from country examples could help in building capacity of local organizations in similar environments. This Scope of Work (SOW) is not a duplication of the recent "process evaluation" of the MOMENTUM Suite. That evaluation will inform the mid-term evaluation team as background.

Lastly, decisions about the design of future investments in private sector engagement for FP/RH and MCHN will be informed by this MPHD mid-term evaluation, along with other data sources.

Evaluation questions

	Assignment Question	Suggested Data Sources	Suggested Data Collection Methods	Suggested Data Analysis Methods
1	To what extent has the MOMENTUM Private Healthcare Delivery project achieved its project objectives (as identified in the conceptual framework, p.4) to date in FP/RH and MCHN)? What are some of the key challenges in achieving project objectives? What were/are the recommendations to address the challenges?	MPHD studies, reports, assessments and evaluations Key informant interviews with local and global implementing partner staff, as well as individual and group interviews with private sector providers, trainers and supervisors, and relevant local MOH staff. Include KIIs and/or group interviews with USAID/W PRH and MCHN staff and Mission staff (virtual interviews are OK) , as appropriate	Review MPHD studies, reports, assessments and evaluations already undertaken Key Informant interviews with a structured questionnaire in various countries group interviews with a structured questionnaire Sales and service delivery data sets	Document review with a synthesis of relevant findings In-depth interviews (IDIs) KIIs and group interviews will use qualitative analysis Quantitative analysis of sales and service delivery data for FP/RH and MCHN
2	To what extent has MPHD been able to incorporate the four main technical approaches (Private Sector Engagement (PSE), Total Market Approach (TMA); person-centered care; localization) into its activities? What has been learned about the implementation of the technical approaches thus far in terms of project performance and outcomes? (disaggregated by FP/MCHN/other). Provide illustrative examples.	Project reports - semi-annual , annual reports and other relevant documents such as programmatic and technical briefs Key informant interviews with local and global implementing partner staff, as well as interviews and focus group discussions with relevant local partners N.B., Use the AMELP document, and annual/semi-annual reports which include quasi-standards and questions by which these technical approaches can be evaluated	Project files In-depth interviews (IDIs) with structured questionnaire for a sample of the key informants	Document review and synthesis of relevant findings IDI and group interview (GI) qualitative content analysis and/or narrative analysis

	Assignment Question	Suggested Data Sources	Suggested Data Collection Methods	Suggested Data Analysis Methods
3	How has project management, coordination, and collaboration contributed to (or detracted from) achievement of project objectives? (e.g., use of project partner resources and skills, collaboration with other USAID projects or projects funded by other donors.)	Project documents MOMENTUM Suite evaluation Staff interviews PSI management, MPHD staff, partner organizations and implementing local partners and USAID staff Include KIIs with other projects with whom MPHD collaborates	Project files Staff interviews (confidentially administered) Group interviews	Document review Staff interview and group interviews using content analysis and/or narrative analysis
4	To what extent has the project integrated the cross-sectoral issues into project activities (e.g. youth, gender, environment)? Please provide examples of integration, what worked and what didn't.	Project documents especially developed by PSI and MPHD partner organizations Staff interviews with partner organizations and PSI staff. Include KIIs and/or group discussions with USAID/W PRH and MCHN staff and Mission staff, as appropriate	Project files MPHD Staff, partners and USAID interviews (confidentially administered)	Document review Staff interview questionnaires using content and narrative qualitative analysis
5	What are some areas for improvement in the remaining years of the project? Please elaborate on the technical approaches as well as global goods development, learning and dissemination of promising practices for the private sector for FP/RH and MCHN.	MPHD staff, partner organizations, USAID Mission staff, USAID/W staff and other donors and MOH staff	Key informant interviews	IDI content and narrative qualitative analysis

Methodology

Document and Data Review

The AOR team and MPHD will produce a final list of documents that will be helpful to address the evaluation questions as well as background information for the evaluation team. In general, the evaluation consultants will have access to all work plans, semi-annual and annual reports at global and country-levels, special reports such as assessments, client exit interviews, technical briefs and blogs, evaluations, sales and service delivery data and HMIS/DHIS2. ICFP posters and presentations will also be available. Information deemed proprietary by the implementing partner will be reviewed by the AO/AOR for further consideration, and would be considered as possibly not given to the evaluators, based on AO review. The MPHD M&E plan will also be used as a basis for mid-term evaluation reporting, and include results reporting by each project indicator whenever possible. The consultants may suggest adjustments to the MPHD project's M&E plan for the final years of the project.

Key Informant Interview:

- **USAID/W PRH and MCHN staff and Mission staff** for project background and insights.
- **Country-level Government Officials** to determine how MPHD is advancing their country program and a total market approach
- **Health teams in missions** contributing field support to MPHD
- **Implementing Local Partners** to measure how the MPHD technical assistance and support provided is advancing their technical skills and localization
- **Private Sector Providers, Trainers, Supervisors** to evaluate and measure how the MPHD technical assistance and support provided is advancing technical skills, competencies and improved quality
- **MPHD Staff Interviews** to provide insights into the partnership, technical skill base and programmatic implementation.
- **Other donors as appropriate**

Group Interviews

Group interviews with private sector providers, trainers and supervisors will be made up of key informants in the area of training and service delivery in specific country environments. They may be interviewed in small groups of similar respondents. These respondents will also have an option to add more confidential information (verbally or in writing) as needed. The purpose of the inquiry is to allow those recipients of MPHD technical assistance and support to address the question of the quality and usefulness of the training, supervision and/or other support in a small group format.

Additionally, the evaluators may have group interviews with USAID/W PRH and MCHN staff and Mission staff, either in person, hybrid, or virtual. Group interviews are also appropriate for MPHD staff, sub-partners and implementing partners to get input into the evaluation questions from these professionals. With private sector professionals, their time is limited so data collectors may have more luck getting a quorum with a group of providers.

Observations

Site visits to a variety of private sector outlets are possible depending on budget. The visits would be to the full range of MPHD sites that include drug shops, pharmacies, clinics and hospitals. If the program supports mobile outreach services for FP and/or MCHN, that would also be great to observe. The purpose of these types of observations is to give the evaluators real-life context for what they are reading in reports and reviewing in the data sets. Planned observations will be used to ensure that clinic sites are prepared and have personnel in place on the day of observation. If clinical observations are needed, preparation of voluntary FP clients and/or an open child health day will be important to schedule.

Illustrative timeline and deliverables

Tasks/Deliverables	Timelines & Deadlines (estimated)
Assignment Launch /In-brief with USAID	Week 1 - March 27, 2023
Desk Review	Week 1 - March 27- March 31
Team Planning Meeting/In-depth discussion with USAID	Week 2 April 4,5,6
Inception report (work plan and methodology) review briefing	Week 3-4, April 10-21, 2023
Inception Report submission (includes assignment questions, methods, timeline, data analysis plan, and data collection instruments)	Consultant submission Week 5, April 24, 2023

Tasks/Deliverables	Timelines & Deadlines (estimated)
USAID review and team makes revisions	USAID review and submit comments Week 6 due May 01 2023 Revisions done May 15, 2023
In-brief with target project/program	Week 9 May 22 2023
Fieldwork: site visits and data collection	Week 9 - May 22 to Week 13 ending June 23
Routine USAID briefings	Biweekly
Debrief with USAID with PowerPoint presentation on progress of the assignment and preliminary findings	July 14 2023
Draft report	August 14, 2023
USAID review of draft report	Aug 21, 2023
Implementing Partner and stakeholders findings review workshop with PowerPoint presentation	Aug 28, 2023
Second draft report	Sep 4, 2023
USAID and IP(s) review of the second draft report	Sep 18, 2023
Final report	September 25, 2023
Raw data (cleaned datasets in CSV or XML with code sheet)	September 29, 2023
Report posted to the DEC	September 29, 2023

Team Composition

1. **Team Lead (Key Staff 1):**

   Roles & Responsibilities: The Team Leader (TL) shall have significant experience conducting and leading health project evaluations and/or assessments, with USAID project evaluation experience preferred. Serve as a key member of the Team, providing expertise in private sector FP/RH and MCHN technical matters and program integration. Knowledge of both areas is important, with expertise in at least one of the subjects being critical. The TL is responsible for: providing team leadership; managing the team's activities; monitoring team LOE; ensuring that all deliverables are met in a timely manner; serving as a liaison between USAID and the team; producing the final report and leading briefings and presentations.

2. **Evaluation Specialists (Key Staff 2 - senior consultants)**

   Roles & Responsibilities: Two consultants also serve as members of the assignment team. These consultants may live in the field already, and are senior consultants experienced in MEL and FP/RH and MCHN. They will work together (sometimes virtually) to provide quality analyses, including development of data collection instruments, data management, and data analysis. They will be engaged in data collection, ensuring the highest level of reliability and validity of data being collected. They are the lead analysts, responsible for ensuring all quantitative and qualitative data are collected, analyzed and presented in a high quality manner. They will participate in all aspects of the assignment, from planning, data collection, data analysis and report writing.

3. **FP/RH and MCHN Subject Matter Specialist (USAID Staff)**

   Roles & Responsibilities: Serve as a key member of the Team, providing expertise in FP/RH and MCHN technical matters and program integration. General knowledge of both areas is important, with expertise in one of the subjects being critical. In many cases in our field, consultants specialize in FP/RH or MCHN. Therefore, the subject matter consultant will need to reach out to other experts in the field in which they have less expertise. Private sector programming and implementation of FP/RH or MCHN experience are required. They will participate in planning and briefing meetings, development of data collection instruments, data collection, data analysis, development of presentations, and writing of the final report.

4. **Local Staff Logistics Coordinators/Program Assistants**

   The One to Two Local Evaluation Logistics Coordinators/Program Assistants will support the Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good verbal and written command of English. They will have knowledge of key actors in the health sector and their locations including MOH, donors, and other stakeholders. To support the Team, they will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and ensure business center support, e. g. copying, internet, and printing. They will work under the guidance of the Team Lead and the Local Evaluators in each country to make preparations and arrange meetings and appointments. They will conduct programmatic administrative and support tasks as assigned and ensure the process moves forward smoothly. They may also be asked to assist in translation of data collection tools and transcripts, if needed.

Anticipated Country Travel

The Team Leader will travel to 2 MPHD countries (potentially Ghana and Uganda) to join the in-country evaluation specialists for their work in those countries. The USAID Program analyst will travel with the Team Leader (USAID funded). Also, for illustrative budget purposes, please provide a version of cost estimate with one local evaluator based in Ghana (with regional travel to Benin) and the other local evaluator in Uganda (with regional travel to Madagascar). This travel is subject to change and still under discussion with the MPHD team.

Final Report description and outline

The 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 25-30 pages (excluding executive summary, table of contents, acronym list, and annexes).

The structure of the report should follow the Evaluation Report template, including branding found here or here.

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

For additional guidance, please see the Evaluation Reports in the How-To Note on preparing Evaluation Draft Reports found here.

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 final report 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, questions, methods, and key findings or conclusions (not more than 250 words)
- **Executive Summary:** summarizes key points, including the purpose, background, questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- **Table of Contents** (1 page)
- **Table of Figures**
- **Acronyms**
- **Assignment Purpose and Questions:** state purpose of, audience for, and anticipated use(s) of the assignment (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)
- **Methods and Limitations:** data collection, sampling, data analysis, and limitations (1-3 pages)
- **Findings** (organized by Assignment questions): substantiate findings with evidence/data
- **Conclusions**
- **Recommendations**
- **Annexes**
    - Annex I: Assignment Statement of Work
    - Annex II: Methods and Limitations (if not described in full in the main body of the final report)
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviewed
        - Bibliography of Documents Reviewed
        - Databases
        - [etc.]
    - Annex V: Statement of Differences (if applicable)
    - Annex VI: Disclosure of Any Conflicts of Interest
    - Annex VII: Summary information about Team members, including qualifications, experience, and role on the team.

The assignment methodology and report will be compliant with the USAID Evaluation Policy **and** Checklist for Assessing USAID Evaluation Reports.

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

All data instruments, data sets (if appropriate), presentations, meeting notes, and reports for this evaluation/analysis will be submitted electronically 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.

Appendix 2. Evaluation Team

The MPHD midterm evaluation team was led by **Gael O'Sullivan**. A social and behavior change (SBC) expert and social marketing thought leader with more than three decades of experience, Ms. O'Sullivan's health communication and social and commercial marketing skills have shaped projects addressing pandemic threats such as avian influenza in addition to projects focused on family planning, reproductive health, HIV/AIDS, malaria, tobacco control and prevention, harmful alcohol consumption, chronic disease prevention, and child health in the U.S. and worldwide.

Currently Ms. O'Sullivan is Adjunct Professor at Georgetown University's McDonough School of Business, where she teaches 'Social Marketing for Global Good' in the MBA program. Previously, she has led SBC and social marketing efforts at Kantar Public's International Development Practice, Business for Impact at Georgetown University, and Abt Associates. Ms. O'Sullivan has steered large, multi-year USAID health, SBC and social marketing projects and research activities with decentralized teams across three continents. Much of her work has focused on public/private/non-profit partnerships to address global health challenges. Ms. O'Sullivan holds a B.S. degree in French from Georgetown University and a M.B.A. in International Marketing from George Washington University. She has worked in more than 40 countries and has lived in Switzerland and Togo. Ms. O'Sullivan is a founding board member of the International Social Marketing Association and currently serves on the board of Humanity and Inclusion-US.

Shwamill Issah served as the Evaluation Field Lead for Ghana, supporting in-country data collection efforts and leading the analysis and reporting for the case study. Dr. Issah is a Global Health and International Development professional with more than 20 years of experience in designing and implementing high impact public health programs. He holds a PhD in Health Care Management, with multiple master's degrees in public health, International Primary Health Care, and International Development Management. Dr. Issah has a track record of leading and coordinating public health preparedness and response programs, leading policy dialogue with government counterparts, country stakeholders, and development partners to bring about transformational change in the health and development sectors. He led the implementation of high value development programs funded by USAID, DFID (FCDO), DANIDA, Global Fund, World Bank and private sector organizations that sought to strengthen health systems to improve health outcomes; influence national policies; broaden primary health care services; engineer supply chain reforms; empower communities and broaden opportunities for people; accelerate sustainable development and reduce poverty and deprivation. He is experienced in the design, management, monitoring and evaluation of development projects; development of business cases; use of the logical framework approach, design of theory of change for projects and implementation of healthcare reforms. Dr. Issah is well versed in operational research, and qualitative and quantitative research approaches, including those involving children and adolescents.

Daoudou Idrissou served as the Evaluation Field Lead for Benin, supporting in-country data collection efforts and leading the analysis and reporting for the case study. Mr. Idrissou is an Africa-based reproductive, maternal, child health specialist with over 10 years of experience in West and Central Africa. Passionate about social change and international development, his work sits at the intersection of health program management, research, and people. Mr. Idrissou has worked with the ministry of health, implementing partners, and civil societies organization on ways to promote a culture of positive change through innovation, education and understanding. He has led cross-country research teams and delivered complex analytical products for a diverse array of donors and partners, including USAID, Pathfinder International, Institute for Reproductive Health (IRH) at Georgetown University.

Gabrielle Appleford served as the Senior Evaluation Specialist, working closely with Ms. O'Sullivan in the development of the protocol and data collection instruments, data collection and data analysis. Ms. Appleford has over twenty-five years of experience in humanitarian and development programs. She has specific subject experience in private sector engagement, health systems strengthening, sexual and reproductive health/family planning, and monitoring, evaluation, research and learning (MERL). She possesses strong management, leadership, creative and analytical skills and has employed these in a wide range of organizational contexts. She has a Master of Public Health degree from the London School of Tropical Medicine and a Master of Development Studies degree from the University of East Anglia, UK.

Athena Pantazis served as the D4I activity lead. Dr. Pantazis is a research and evaluation specialist with training in public health and demography. Her technical background includes experience in the evaluation of reproductive health, maternal and child health, nutrition and HIV programs. Dr. Pantazis has extensive methodological and theoretical training in quantitative research methods. She has widespread experience collecting and analyzing data primary and secondary data sources. Dr. Pantazis also has public health, and mixed-method research expertise. She is well versed in training research and data collection teams; conducting thematic analysis using different techniques and software packages; and presenting study findings and recommendations through reports, presentations, and other dissemination mechanisms.

Liyana Ido is an M&E program analyst in USAID's Office for Population and Reproductive Health (PRH), in the Policy, Communication, and Evaluation Division. In her role, she supports evaluations of PRH-funded projects like MPHD, provides technical support to project teams developing monitoring and evaluation plans and systems, and supports the FP/RH portfolios under the Data for Impact and GH PEARL projects. Her experience lies in sexual and reproductive health both in the US and globally; implementation evaluation; designing tools for, collecting, and analyzing qualitative data; designing survey tools; and quantitative analysis. Liyana holds a BS in Biochemistry and an MSPH in Sexual and Reproductive Health.

The evaluation team was supported by two research assistants:

Oluwayemisi Ishola is a research and evaluation specialist with training in public health and social work. Her professional experience spans social and behavioral change research in family planning, malaria, maternal and child health, adolescent sexual and reproductive health. With twelve years of experience in qualitative and quantitative data management, research, monitoring and evaluation of national and donor-funded health programs in Africa, 'Yemisi has technical expertise in implementing mixed-method research. She is proficient in the design and execution of research studies at the population and facility levels, developing and managing data quality improvement systems and operating databases. In addition, her expertise includes managing research and data collection teams and conducting analyses using a variety of techniques and software packages. She assisted with data analysis.

Michelle Jituboh works at ICF as a research and program specialist on projects related to strengthening capacity for malaria surveillance, monitoring and evaluation, and Information Systems. She has skills in qualitative research and analysis, project management and communication, and holds a bachelor's degree in international relations and French and a master's degree in Intercultural Communication.

Appendix 3. Data Collection and Analysis Tools

Key Informant Interview Guide- Momentum Private Healthcare Delivery (MPHD) Midterm Evaluation

Welcome, Overview and Informed Consent – NOTE: This guide will be tailored to each stakeholder. Not all questions are relevant for all respondents.

Background

Name	
Title	
Organization	
Role in the project	
Sex	
Time interview started:	
Time interview ended:	
Name of interviewer:	

Question	**Probes**
In general, do you think that the availability and accessibility of Family Planning/ Reproductive Health and Maternal, Child Health, and Nutrition (FP/RHMCHN) services and products have improved in the last three years?	*Introductory question*
MPHD's objectives are to: Increase availability and demand for MNCH/FP/RH through private providers, and Expand public and private partnerships using a Total Market Approach for health access and coverage.	
In your opinion, to what extent is MPHD achieving these two objectives	What are some of MPHD's key successes in delivering on the intended results?
Has MPHD expanded public and private partnerships to enhance the Total Market Approach and expand health access and coverage for FP/RH/MCHN?	If yes, please provide examples of partnerships and any supporting impact data. If no, why not? Do you have any suggestions for how to use partnerships to strengthen the TMA for FP/RH/MCHN?
Is MPHD meeting the needs of the audiences it is attempting to serve?	
What barriers still exist that keep people from accessing and using FP/RH and Maternal, Child Health and Nutrition (MCHN) services and products?	Do all population groups experience these barriers or only certain groups? Which ones?

What are some of the key challenges related to achieving these objectives?	Specific topics – co-design, integration, public sector collaboration, person-centered, cost-effectiveness How has the COVID-19 pandemic impacted MPHD's ability to achieve the project objectives? What recommendations do you have, if any, to address these challenges?
MPHD has four main results areas: 1. Scaled up, sustained access to/use of quality health interventions 2. Enhanced capacity of host countries, local organizations, and providers to deliver services 3. Increased host country technical leadership 4. Collaboration among organizations from different sectors In your experience, what are some of MPHD's key achievements in any of these four results areas? What are some areas for improvement in the remaining years of the project to ensure achievement of MPHD's key result areas and objectives? Please provide recommendations.	
Specific questions for each results area to be asked based on respondents' knowledge/involvement- some questions may not be applicable.	
Result 1 – Access to and use of evidence-based quality FP/RH/Maternal, Child Health and Nutrition information, services and interventions scaled and sustained – how well is this result area working?	**Why do you say this? Please provide examples with disaggregated data/data sources if possible.** **Is the program able to deliver interventions at scale? Why/why not?** **Is the program delivering interventions in a sustainable manner? Why/why not?** **What is working well?** **What areas need improvement?**
Activity 1.1 Recruit private facilities to provide LARC services.	● What progress has been made towards recruiting 100 private facilities? ○ To what extent were the selected private health facilities effectively recruited across the specified regions, and what were the key factors contributing to successful recruitment? ● Can you expand/describe the pre-set criteria and checklist used to recruit facilities? ● What were some challenges encountered during the recruitment and training process, and what strategies were most effective in overcoming these challenges?

Activity 1.2 Conduct LARC services training for health care workers from recruited facilities	● What were the outcomes of the LARC services training for healthcare workers, and how did it contribute to their ability to sustainably provide LARC services after the life of the activity? ● What feedback was received from the trained healthcare workers regarding the training, and how can this feedback be used to improve future training initiatives? ● How did the training contribute to the overall goal of expanding access to voluntary long-acting reversible contraceptive services? ● What challenges were encountered during the training process, and what strategies were most effective in overcoming these challenges?
Activity 1.3 Design, produce, and disseminate appropriate job aids for HCWs use.	● What challenges were encountered during the design, production, and dissemination of job aids? ● Have there been any challenges in using the job aids, if so- what have these been? ● What are some of the outcomes and results of using job aids?
Activity 1.4 Demand Generation	● How has the process of recruiting community agents been? Any successes? Any challenges? ● How effectively did the branding and visibility materials support the promotion of LARC services in the recruited private facilities? ● How well were the branding and visibility materials utilized by the private facilities
Activity 1.5 Sustaining Commodity Supply	● How well is the implementation of this activity progressing? ● Any challenges or areas for improvement?
Activity 1.6 Support with LARC equipment and Consumables	● How well is the implementation of this activity progressing? ● Any challenges or areas for improvement?
Activity 1.7 Routine follow up and supportive supervision of recruited private facilities in conjunction with the District Health Management Team (DHMT).	● How effective were the routine follow-up and supervision visits in improving the performance of the recruited private facilities in providing LARC services?

Activity 1.8 Monitor and Evaluate impact of the activity over 18 months.	• What were the key findings from the pre-intervention evaluation? • Have any adjustments been made to the activity to improve its effectiveness in achieving the key objectives?
Result 2 – Enhanced capacity of host country institutions, local organizations, and providers to deliver services – how well is this result area working?	**Is local stewardship improving? Why/why not with examples** **Is there a clear increase in high quality knowledge, skills and effective performance among local partners/stakeholders? Why/why not with examples** **What local capacity gaps still exist?** **How could MPHD address these gaps?** **?**
Activity 2.6: Leverage digital technologies to expand private providers' access to quality training in key FP/RH topics. (FP, RH, Health Services, Quality of Care, Digital Health)	• What is the status of the LARC course (ask to see a copy) • How was the training conducted and evaluated? • What were the findings from the user feedback? • Is the Ghana material uploaded into the Kassai online platform?
Result 3 – Adaptive learning/increased host country technical leadership – how well is this result area working?	**Is MPHD documenting learnings and iterating based on evidence? Why/why not with examples** **Are there examples of MPHD adapting to new situations and contexts, especially in fragile settings? If so, what adaptive strategies have been used?** **Are host country partners/stakeholders providing thought leadership and improved governance of the health system, including the private sector? Why/why not with examples** **Are there innovations developed through MPHD, e.g., new tools, models, interventions?** **If yes – describe and provide examples/data** **If no – why**
Result 4 – Cross sectoral collaboration/innovative partnerships – how well is this result area working? **Which promising practices are being shared through learning and dissemination efforts to support private sector approaches to FP/RH ad MNCH? If improvements are needed, please provide recommendations.**	**Is MPHD implementing partnerships to address gender equity, adolescent needs, and/or environmental challenges?** **If yes – describe and provide examples/data** **If no – why**

Activity 4.2: Collaborate with local partners in PRH priority countries to develop and deliver market-based solutions to sustainable demand for, access to, and uptake of high-quality FP information and services (FP, RH, Local Engagement, Capacity Strengthening, Partnerships)	• What is the status of this activity with TFHO? • Describe the models that were tested, implemented and supervised. • What were lessons from the coaching and mentoring of healthcare providers? • Methodist stakeholders: what was your experience with this activity? Will you continue with this activity in the future
Is there disaggregated data (by gender, age, health area, etc.) documenting MPHD's progress in any of these results areas? If so, can you share that data? As a reminder- four main results areas: 1. Scaled up, sustained access to/use of quality health interventions 2. Enhanced capacity of host countries, local organizations, and providers to deliver services 3. Increased host country technical leadership 4. Collaboration among organizations from different sectors	
Are there additional sources of disaggregated data not mentioned already that provide information about MPHD progress and impact?	Please share data and sources
Which illustrative examples exist to demonstrate progress?	
Are there additional examples of MPHD activity impact that have not already been discussed?	Please share examples with data
There are four main technical approaches included in the project – private sector engagement, total market approach, person-centered care, and localization. From your perspective, to what extent is MPHD incorporating these approaches?	
2.1.1 Private sector engagement *Definition: A strategic approach to planning and programming through which USAID consults, strategizes, collaborates, and implements with the private sector for greater scale, sustainability, and/or effectiveness of outcomes.* *Engaging with, and strengthening the capacity of, the private for-profit and private non-profit, e.g., faith-based, sectors to improve their contribution to a well-functioning health system*	*What are the successes and challenges of MPHD in terms of private sector engagement?* What has been learned about the implementation of private sector engagement thus far in terms of project performance, including outcomes by key disaggregates? What has been learned about using private sector engagement approaches to strengthen private sector healthcare providers' ability to deliver high quality FP/RH/MCHN? services? Have new actors been engaged to collaborate with MPHD stakeholders? If so – which ones, what is their role, and what is the impact? Do you have suggestions for improvement in this area?
2.1.2 Total Market Approach *Definition: TMA is a model to design and deliver health*	*What are the successes and challenges of MPHD in terms of TMA?* What has been learned about the implementation

interventions and nurture best practices in market stewardship, such as the need to analyze legal frameworks, decision making, and institutional arrangements required for effective stewardship, as well as reflect on the role of global and regional bodies and financing for sustainability.	of TMR thus far in terms of project performance, including outcomes by key disaggregates? Has the same approach been used for FP/RH/MCHN? Were other approaches considered? How have markets changed at the country level? Are there legal, policy are other governance mechanisms in place? Are there efficiencies, cost savings, etc. Attributed to MPHD? Do you have suggestions for improvement in this area?
2.1.3 Person-centered care *Definition: Care that is empathetic; free from bias, coercion, or discrimination; and care that responds to a client's unique needs and preferences*	*What are the successes and challenges of MPHD in person-centered care?* What has been learned about the implementation of person-centered care thus far in terms of project performance, including outcomes by key disaggregates? How does MPHD embed person-centered care principles into its approach and interventions? How well do you think this is working? Identify examples and data. If applicable- what has your experience been with the person-centered care toolkit ? Do you have suggestions for improvement in this area?
2.1.4 Localization *Definition: The set of internal reforms, actions, and behavior changes that MPHD is undertaking to ensure their work puts local actors in the lead, strengthens local systems, and is responsive to local communities.*	*What are the successes and challenges of MPHD in localization?* What has been learned about the implementation of localization thus far in terms of project performance, including outcomes by key disaggregates? How effective is the MPHD approach to shifting technical leadership and resources to local partners? Provide examples with data. Do you have suggestions for improvement in this area?
Questions below may be appropriate for only a subset of respondents	
EQ3. How has project management, coordination, and collaboration contributed to (or detracted from) achievement of project objectives? Can you comment on MPHD's project management, coordination, and collaboration approaches? If so:	
How have these approaches affected achievement of the project's objectives?	At core and field support levels

Is the team using project partner resources and skills in an efficient and effective manner?	Are there opportunities to make changes in the remainder of the project to enhance performance against results?
How are responsibilities divided up across the MPHD consortium? Are all partners contributing according to their expertise?	Why/why not with examples.
Is the consortium working well as a team, e.g., is MPHD communication, coordination, and collaboration effective? Why/why not please provide examples.	
Does the MPHD structure and roles support achieving the overall objectives and results	Why/why not with examples.
Is the team collaborating with other USAID projects and/or projects funded by other donors?	If so, how? With which projects does MPHD collaborate? Probe for other USAID-funded efforts and projects funded by other donors/sources. How well are these collaborations working? Provide examples and data.
How well has the project integrated the cross-sectoral issues into project activities – with a specific focus on youth, gender, and the environment?	
Can you provide examples demonstrating integration of these topics?	What is working? Please provide examples, disaggregated data, and data sources. What is not working? Please provide examples, disaggregated data, and data sources. What untapped opportunities exist for integration across cross-sectoral issues?
To what extent are MPHD activities designed to lead to changes in gender equality, female empowerment and social inclusion, particularly in facilitating equitable access to health products and services for FP/RH and Maternal, Child Health, and Nutrition (MCHN)?	
To what extent are MPHD activities integrated with programs addressing environmental challenges?	Are any of the activities that you are involved in specifically working to address issues related to the environment?
To what extent are MPHD activities designed to improve adolescent access to and use of health products and services for FP/RH and MCHN?	
What local capacity strengthening approaches are being used to foster cross-sectoral collaboration? • **Coordination definition:** The intentional sharing of information across awards with the purpose of contributing to a cross-MOMENTUM deliverable(s) (usually, but not solely, led by MKA). Information	How could cross-cutting approached be further integrated into the program? Are there any working groups, communities of practice, local conferences – etc. that you are engaged in?

may include but is not limited to data, programmatic learning, new evidence, and technical expertise. Coordination necessitates LOE from various staff across all of the awards. Given that the individual staff involved in the coordination efforts will be dependent on the topic, it may be difficult to identify specific percentages of coordination LOE that should be assigned for each staff member. As such, contributing to coordination efforts should be considered a core function within each staff's position description. Specific examples of coordination LOE include: gathering and sharing relevant documents; participating in a set of coordinating meetings; reviewing the deliverable outlines, drafts, and final products; and participating in key informant interviews to expand learning from existing documentation(from MOMENTUM mid-term process evaluation). • **Collaboration:** Joint implementation of an activity that is explicitly included in more than one project workplan. Collaboration may occur to reduce duplication of efforts or in order to leverage technical expertise across projects to enable greater impact. Activities to collaborate on may be identified by awards themselves or by USAID. (from MOMENTUM mid-term process evaluation)	
What are some areas for improvement in the remaining years of the project to ensure achievement of MPHD's key result areas and objectives?	
What technical approaches need improvement?	Why do you say that? What evidence do you know of that supports your answer? Please provide recommendations for improvement.
What global goods have been successful? What global goods need improvement?" (Definition: A global good occurs when a tested model, tool or approach is potentially beneficial beyond a country context, and is available for global (multi-country) use (per AOR team))	Why do you say that? What evidence do you know of that supports your answer? Please provide recommendations for improvement.
What promising practices are being shared through learning and dissemination efforts to support private sector approaches to FP/RH and MCHN?	Why do you say that? What evidence do you know of that supports your answer? Are there evidence gaps that MPHD should be addressing through implementation research? Please provide recommendations for improvement.
What additional information is important for us to know about MPHD?	

Online Survey

https://docs.google.com/forms/d/1x9q9-ha_GzN29YnjwVGO_o1qMAqAFDsT5kbthQLYOnI/edit

Appendix 4. Document Review Sources

Technical Documents

- Chakraborty, N. M., & Sprockett, A. (2018). Use of family planning and child health services in the private sector: an equity analysis of 12 DHS surveys. International journal for equity in health, 17(1), 50. https://doi.org/10.1186/s12939-018-0763-7
- MOMENTUM (2022). *Meeting the Contraceptive Needs of Youth through Digital Tools: Reaching Beninese Youth Where They Are*. Policy Brief. Meeting the Contraceptive Needs of Youth Through Digital Tools: Reaching Beninese Youth Where They Are - USAID MOMENTUM
- MOMENTUM (2022). Centering Adolescent And Youth Voices In Family Planning Service Delivery: Findings from a Human-Centered Design Approach in Nepal. Technical Brief.
- MOMENTUM (2020). *Cross-MOMENTUM Monitoring, Evaluation, and Learning Framework*. Technical Guide.
- Mallick, Lindsay, Meghan Reidy, Michelle Weinberger, and Rebecca Husband. (2021). Quality of Care for Family Planning: A Comparison of Private and Public Facilities in 7 Countries using Periodic Health Facility Surveys. Washington, DC: USAID MOMENTUM.
- Giri, S. (2022). Expanding access to Family Planning services for adolescents and young adults through the private sector in Nepal. International Conference on Family Planning.
- MOMENTUM Private Healthcare Delivery (2022). Activity Monitoring, Evaluation, and Learning Plan (AMELP).
- Michelle Weinberger, Georges Minga, Michel Tchuenche, Eric Obikeze, Nadia Carvalho, George Mugambage Ruhago, Steven Forsythe (2022). An exploration of cost drivers of publicly and privately provided family planning and maternal health services in DRC, Nigeria, and Tanzania. International Conference on Family Planning.
- Srishti Shah, Marya Plotkin, Basant Thapa, Seema Giri, Dr. Mona Sharma, Bhagawan Shrestha, Christine Bixiones, Donna McCarraher. 2022. Improving family planning services through a client feedback mechanism using MII (Plus) in the private sector in Nepal. International Conference on Family Planning.
- Lindsay Mallick, Meghan Reidy, Michelle Weinberger, and Rebecca Husband. 2022. Quality of Care for Family Planning: A Comparison of Private and Public Facilities in 7 Countries using Periodic Health Facility Surveys. International Conference on Family Planning.
- Sarah Straubinger, Matt Boxshall. 2022. Rapid landscape review of challenges to successful engagement of private family planning providers in public purchasing schemes MOMENTUM Private Healthcare Delivery. International Conference on Family Planning.
- Nina Shalita , Erin F. Dumas , Aminata Traore , Katie Morris, Baba Coulibaly, Mariela A. RodrÍguez. 2022. Navigating the Realities of the Private Sector in Mali: Opportunities and Challenges in SRH/FP Service Delivery. International Conference on Family Planning.

Project Documents Reviewed

Core Workplans

- Momentum Private Healthcare Delivery Year 1 Core Workplan October 1, 2020 – October 31, 2021
- Momentum Private Healthcare Delivery Year 2 Core Workplan October 1, 2021 – September 30, 2022
- Momentum Private Healthcare Delivery Year 3 Core Workplan October 1, 2022 – September 30, 2023

Annual Reports

- MOMENTUM Private Healthcare Delivery Year 1 Semi Annual Report - June 22, 2020 – March 31, 2021
- MOMENTUM Private Healthcare Delivery Year 1 Annual Report - NOVEMBER 15, 2021
- MOMENTUM Private Healthcare Deliver: Year 2 Semi-Annual October 2021-March 2022
- MOMENTUM Private Healthcare Deliver: Year 2 Annual October 2021-September 2022
- MOMENTUM Private Healthcare Deliver: Year 3 Semi-Annual October 2022-March 2023
- MOMENTUM Private Healthcare Deliver: Year 3 Annual October 2022-September 2023

Country workplans and project documents

Benin

- Private Healthcare Delivery (MPHD) Benin Country Workplan New Partnership Initiative (March 1, 2021 - May 31, 2022)
- Momentum Private Healthcare Delivery (MPHD) Benin Country Workplan Years 2-3: June 1, 2022 - September 30, 2023

Burundi

- Private Healthcare Delivery (MPHD) Burundi Country Workplan February 1, 2021 – November 30, 2022 (Years 1-2)
- Private Healthcare Delivery (MPHD) Burundi Country Workplan Year 3: October 1, 2022 - September 30, 2023
- Private Healthcare Delivery (MPHD) Burundi Country Workplan Year 4: October 1, 2023 - September 30, 2024

Ghana

- Momentum Private Healthcare Delivery (MPHD) Ghana Workplan New Partnerships Initiative (October 1, 2021 - March 31, 2023)

Indonesia

- Year 1 Private Healthcare Delivery (MPHD) Indonesia Country Workplan April 14, 2021 – February 28, 2022
- Year 2 Private Healthcare Delivery (MPHD) Indonesia Country Workplan March 1, 2022- January 31, 2023
- Year 3 Private Healthcare Delivery (MPHD) Indonesia Country Workplan January 1 – December 31, 2023

Mali

- Momentum Private Healthcare Delivery (MPHD) Mali Country Workplan June 15, 2021- October 31, 2022 (Years 1-2)
- Momentum Private Healthcare Delivery (MPHD) Mali Country Workplan Year 3: October 1, 2022 - September 30, 2023

Mozambique

- Private Healthcare Delivery (MPHD) Mozambique Country Workplan New Partnerships Initiative (September 1, 2021 – January 31 February 28, 2023)

Nepal

- Private Healthcare Delivery (MPHD) Nepal Country Workplan (Years 1-2) May 17, 2021 – November 30, 2022

- Momentum Private Healthcare Delivery (MPHD) Nepal Country Workplan Year 3: October 1, 2022–September 30, 2023

Niger

- Private Healthcare Delivery (MPHD) Niger Country Workplan June 1, 2021- November 30, 2022 (Years 1-2)
- Private Healthcare Delivery (MPHD) Niger Country Workplan December 2022 (Years 3)

Pakistan

- Private Healthcare Delivery (MPHD) Pakistan Country Workplan September 17, 2021- March 15, 2023

Uganda NPI

- Momentum Private Healthcare Delivery (MPHD) Uganda Country Workplan
- New Partnerships Initiative June 15, 2021 –April 30, 2023

Secondary Data Review Documents

Benin

- Association Beninoise pour le Marketing Social (ABMS). FP service uptake data from October 2022 to September 2023

Ghana

- MPHD Ghana Training Pre and Post Test Summaries + U20 service data.

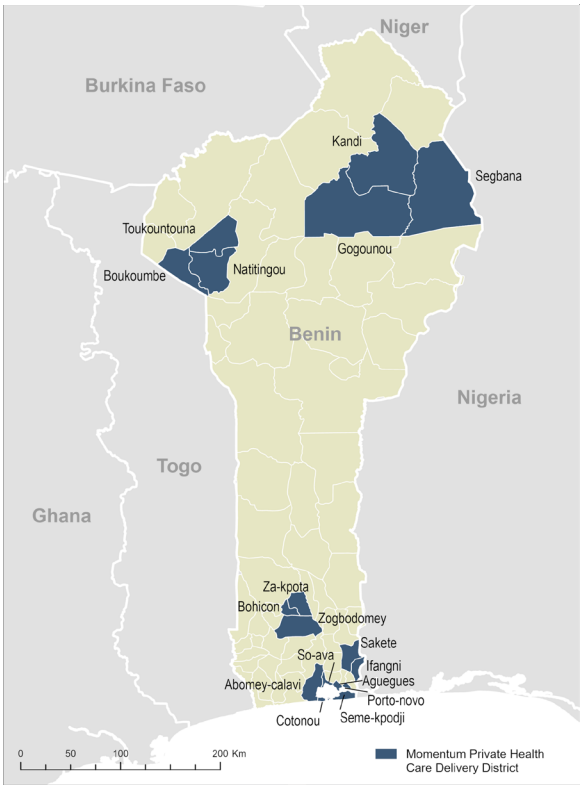
Appendix 5. MPHD Midterm Evaluation: Benin Country Case Study

Background

MOMENTUM Private Healthcare Delivery (MPHD) is an innovative initiative supported by USAID (2020-2026) and implemented by Population Services International (PSI) and its consortium partners that aims to reduce maternal, newborn, and child morbidity and mortality through greater access and use of evidence-based quality services and products provided by private sector providers. Based on PSI's substantial progress and experience working in Benin, the MPHD Activity was developed to address the needs of the local populations The main interventions proposed were as follows:

- **Strengthening service delivery**: Strengthen and increase the capacity of private sector health providers to provide quality Family Planning and Reproductive Health and Maternal, Newborn, and Child Health (FP/RH/MNCH) services and person-centered care, including for youth. This includes the provision of FP/RH and MNCH services in the current 105 private health care facilities and two mobile outreach clinics on long-acting reversible contraceptive methods (LARCs).
- **Improved demand:** Work with women's organizations within communities to build the knowledge base around MNCH/FP/RH services and demand for these services with the support of community health workers. Use digital innovations such as a chatbot to reach youth with ASRH information.
- **Creating an enabling environment:** Strengthening the institutional capacity of the ProFam private clinic network (37 clinics) to obtain and maintain the necessary certifications to operate. Continuously monitor, support, and improve the quality of services to provide optimal care that meets the needs of the population (including the needs of youth) while respecting national standards of care. Support and training in the development of business plans are also part of this dynamic. Engaging the young mayors network was also a priority to build broad support for youth services.

Figure 1 Districts served by MPHD Benin



MPHD activities in Benin were implemented by l' Association Beninoise pour le Marketing Social (ABMS), which is a member of the Population Services International (PSI) network and has been operational since 1994. ABMS interventions have historically focused on sexual and reproductive health (SRH) social marketing, the provision of SRH health services, and the development of community networks to support demand creation for SRH services. A mix of core and field support funding streams have been invested in MPHD activities in Benin. Core MPHD funding was invested to support development of initiatives such as the TataAnnie chatbot. In 2021-2022, ABMS implemented the MPHD/NPI work plan, in collaboration with 54 clinics. In the third year, ABMS (through field support funding) increased the number of facilities supported

by MPHD to a total of 105 clinics. The following table shows the 105 sites that the MPHD Activity supported in the fourth year:

Table 1 Number of Implementation clinics

Type of Implementation clinics	Number
ProFam clinics	57
Other clinics, outside the ProFam network	51
Centre amour et vie des jeunes	15
Mobile clinics	02
Total	**125**

MPHD clinics were selected based on location in the 10 MPHD-supported health zones, selected by ABMS Benin and USAID, and additional criteria including areas with poor maternal mortality indicators, current presence of ProFam clinics, and current presence of the Integrated Health Services Activity.

ICF International, through Data for Impact (D4I), is conducting a mid-term evaluation of the MPHD Project. The purpose of the MPHD midterm evaluation is to assess the Project's interventions, their implementation status, quality to date, as well as overall achievements and obstacles to achieving key results. The evaluation will also identify what works, what needs rethinking or what major changes may be required at the global and country levels at the midpoint of the project. Findings from the mid-term evaluation will inform decisions about the design of future investments in private sector engagement for FP/RH and MNCH. This report presents a case study of the Benin MPHD Activity implemented by ABMS and their partners.

Methodology

The midterm evaluation of the MPHD Activity was participatory and inclusive in nature. It used a qualitative approach through in-depth interviews and group discussions with key informants. Secondary sources such as activity reports, training documents and work plans were used to complete the analysis. The approach was carried out in four parts: preparing for the assessment, data collection and data exchange, data analysis and drafting of the interim report, and validation of the report.

Preparing for the assessment

The evaluation team in Benin met to harmonize the objectives and approach of the evaluation field work and finalize data collection plans. The team reviewed documents, including activity reports, training documents, and communication tools to finalize the protocol and data collection tools, and adapted the interview guide based on the evaluation questions while considering the conceptual framework of the MPHD project.

Data collection and data exchange

Data collection and data exchange was conducted by the Evaluation Lead and the Evaluation Field Lead in November and December 2023. Interviews were conducted in-person and virtually, based on key informants' availability and their geographical location. The research team collected primary data from stakeholders at the central level in Cotonou and in the departments of Atacora, Atlantique, Zou and health zones, to reflect the geographical diversity and include urban and rural areas. Fifteen in-depth interviews were conducted, including 5 staff from the Ministry of Health, 2 private clinics managers, 1 community health worker, 1 youth, 4 ABMS staff, and 2 USAID Benin staff. Five group discussions were also conducted for the MPHD Activity implementation team, the Bohicon women's association, youth from Bohicon, service providers from the Amour et Vie clinics, and service providers (midwives and nurses) from the ABMS/PSI ProFam clinics in Cotonou. All these interviewees were informed about the nature and objectives of the evaluation and gave informed consent. Details of study participants are shown in Table 2.

Figure 2 Group of women in Zogbodome

Table 2: Number of people interviewed

Organizations	In-person Interviews	Interviews Online	Group discussions
Ministry of Health Team	5		
ProFam clinic manager	1	1	
ProFam clinic service providers (midwives and nurses)			12
Youth		1	15
Communication Agent	1		
Women's group			10
ABMS/PSI staff	4		9
USAID Benin team	2		
Bohicon Women's Association			12
Amour et View			7

Apart from data collection, the evaluation team also visited a ProFam clinic, a contraceptive product management warehouse, and a mobile clinic.

Limitations

The main limitation of the study was limited stakeholder availability that resulted from the data collection period coinciding with the end of year activities. Where possible, this limitation was mitigated through virtual data collection.

Findings

From discussions with key informants, stakeholders had a good impression of ABMS/PSI. ABMS is among the NGOs with whom the Ministry of Health collaborates in the implementation of the country's priorities in sexual and reproductive health. The MPHD Activity, through its targets and activities, is part of the Ministry of Health's priority strategies, including the revitalization and strengthening of the private health sector in Benin. Key results identified in the implementation of the project in Benin were institutional strengthening of the private health sector, and improvement of data collection by private health facilities. Despite these achievements, certain areas such as demand creation, youth involvement, and market segmentation were identified as having room for improvement to better achieve results. Despite some demand related activities implemented by MPHD being identified by a few respondents, such as improved counseling, community engagement, posters and digital information, and capacity building in youth and women's associations related to demand creation, most respondents reported that overall MPHD implementation in Benin placed more emphasis on FP service supply strategies than on demand creation. Clinic staff indicated that very few clients come for LARC FP methods, which presents a dual challenge. First, the nurses and midwives will lose their newfound skills if they do not have an opportunity to use them, and second, the Activity is reaching very few people who need these services.

Figure 3 Visit at the ABMS pharmacy

Strengthening Service Delivery

Capacity building

To achieve the results of the project and contribute to the well-being of the Beninese population, the MPHD Activity placed particular emphasis on the training of ProFam and Amour et Vie clinic providers. Several types of training were carried out with the involvement of officials from the Ministry of Health at both the national level and at the decentralized level. Training topics included FP, emergency obstetric and newborn care (EmONC), data management, the provision of person-centered care, and Counseling for Choice (C4C) Person-centered care and C4C trainings were found to be particularly appreciated by beneficiaries. Respondents indicated that C4C not only reduces discussion time with the customer, but also helps build customer loyalty. One midwife reported:

> "*This approach saves us a lot of time, both for us and for the client. We no longer overload our clients with information. There was no longer a need to provide counseling on all the methods before the client made her choice. The client is relaxed. Finally, she makes the choice that suits her, and she comes home satisfied*."

Training on basic EmONC has made it possible to improve the management of obstetric emergencies in private health facilities, thus helping to reduce referrals to public hospitals. It allowed certain midwives to strengthen their knowledge of EmONC, as recognized by a manager of a private clinic: "*For the midwife, the*

training on EmONC allowed them to update their knowledge and what had a positive impact on his work and the clinic's performance" but also to reduce the number of referrals to public health facilities that are generally overwhelmed.

Apart from health service providers, youth and women's associations also benefited from capacity building within the framework of the MPHD Activity to carry out community activities. Through a competitive and transparent approach, several youth associations were selected to support the implementation of the Activity. These associations benefited from training to raise awareness among their peers about FP services and other maternal and neonatal health issues such as antenatal care, nutrition, and gender. More work is needed beyond awareness raising, however, for behavior change and service uptake to occur. In addition to health issues, women's and youth associations have been empowered to conduct advocacy, mobilize resources, and develop work plans.

Figure 4 Amour et Vie Clinic

Equipment

Another important point raised by the beneficiary clinics was material support. The ProFam clinics involved in the implementation of the Activity benefited from equipment to facilitate the provision of services, including bandages and autoclaves. Equipment was offered after identification of the needs of each health facility during the situation analysis and after strengthening the capacity of providers. Equipment for disinfection and family planning were distributed by ABMS. Equipment for removal and insertion of long-acting methods was also distributed. Apart from equipment for providing FP services, private clinics also benefited from suction cups and aspirators for providing EmONC.

Improved Demand

TataAnnie

In a rapidly digitalizing world, young people in Benin have benefited from the implementation of the TataAnnie chatbot to meet their information needs on sexual and reproductive health as part of the MPHD Activity. Content for TataAnnie was developed in a participatory and inclusive manner with young people

and stakeholders from the Ministry of Health. The Chatbot helped to give young people confidence and facilitates their use of reproductive health services. For one of the participants “Auntie Ani is the best confidant among young girls and is considered a big sister”. For young people, the chatbot is an easy-to-use application that provides answers to the sexual health questions they regularly face. However, young people want other information to be added such as self-esteem, gender-based violence, and positive masculinity. Given the chatbot’s importance in raising awareness and providing information about where young people can access adolescent SRH services, ABMS is in discussions with the ministry in charge of digital technology for its scaling up throughout the country.

Community mobilization

Apart from the Chatbot, the MPHD Activity also focused on local awareness by recruiting Communication Agents (CIP). These are men and women recruited from within their community and whose role is not only to raise awareness but also to refer women in need to ProFam clinics. After their recruitment, the latter receive training on how to raise awareness among families on FP, advice on baby nutrition, vaccination, and advice on ANC and the use of Long-Lasting Impregnated Mosquito Nets of Action (MILDA) to name but a few. They also benefited from communication support such as posters to facilitate their work in the community.

Figure 5 TataAnnie chatbot info flyer

In their role, CIP agents seize every opportunity to contact their peers to get their message across. Whether at the market, at the hairdresser, at the fountain, messages on the importance of FP, ANC and other issues are always addressed. The added value of these CIP Agents was well appreciated by the clinics because they contributed to the increase in attendance at these clinics through referrals as mentioned by one of the managers:

> "*The work of the CIP agents made it possible to have more clients and which contributed to a better knowledge of the clinic but also to our performance. Since their activity stopped, we have noticed a drop in attendance*.”

The results showed an insufficient synergy of action between the strategies put in place to create demand. Some CIP Agents do not know about TataAnnie and did not systematically promote it in their community outreach activities. In addition, there is no overarching, strategic social and behavior change (SBC) campaign to inform, motivate, and support potential clients in their journey to meet their reproductive needs.

Creating and Enabling Environment

Facilitative supervision

To guarantee data quality, the ABMS Monitoring and Evaluation team ensures routine monitoring in partner centers through Routine Data Quality Assessment missions, to have valid data and carry out effective actions for their improvement. This supervision also makes it possible to remind service providers of data handling standards (storage and backup, confidentiality, integrity and sharing of data). Apart from data monitoring, the beneficiary clinics are periodically supervised by project members to ensure proper implementation and continuously strengthen the skills of providers. For private clinic managers, facilitative supervision offers an opportunity to upgrade to current standards while identifying inadequacies and working to correct them.

Inter-clinical collaboration and with the Ministry of Health

One of the contributions of the MPHD Activity was the strengthening of coordination between the Ministry of Health and private clinics and the ProFam clinics themselves. ABMS/PSI supported the establishment of the Private Health Sector Platform in Benin by contributing to the development of operating documents and financing the meetings of this network.

The Ministry of Health was involved at all stages of the project. Whether for the choice of clinics, the validation of training modules, the training of providers and supervision, the Ministry of Health was one of the key players. This involvement has made it possible to improve the integration of ProFam clinics in the implementation of ministry-led activities such as Benin-Santé days, where the private health sector is widely represented.

Institutional support

Private health facilities as part of the implementation of the MPHD Activity benefited from capacity building and support in the development of business plans. For private clinics promoters, these business plans were useful for better management of clinics but also for raising funds from financial institutions.

Conclusion

Various discussions with stakeholders indicate that implementation of the MPHD Activity has had strong points which can be summarized as follows:

- Strong relationships exist between ABMS and all parties - USAID, Ministry of Health, ProFam clinics and other local partners
- Good appreciation of the person-centered care approach that integrates emotional intelligence and holistic management of the client's needs
- Relevant training activities for private providers, especially training on EmONC and FP
- Better involvement of young people in the MPHD Activity, though there remains room for improved youth engagement.

Despite these achievements, several challenges remain, including:

- Funding for Amour et Vie youth centers
- Creating demand to better reach the most vulnerable groups using proven SBC best practices.

Recommendations

To face the challenges identified in this case study the following recommendations have been suggested:

- Continue the implementation of the activity beyond the remaining 6 months.
- Strengthen the demand generation strategy and activities to create synergy with existing interventions like TataAnnie and link clients who have unmet FP/RH needs (especially for LARCs) to the clinical services offered through private health care networks in the catchment areas where MPHD operates.
- Share experiences with other MPHD countries; for example, it seems Ghana is doing a C4C/person-centered care training activity, but both countries are not aware of what each other is doing.
- Develop sustainable development strategies – there are ongoing needs for training, equipment and supplies, demand generation activities and materials, and several partners would like to expand the MPHD approach to more areas in Benin.

Appendix 6. MPHD Midterm Evaluation - Ghana Country Case Study

Background and Introduction

MOMENTUM Private Healthcare Delivery (MPHD) is an innovative initiative supported by USAID (2020-2026) and implemented by Population Services International (PSI) and its consortium partners that aims to reduce maternal, newborn, and child morbidity and mortality through greater access and use of evidence-based quality services and products provided by private sector providers. The MPHD project in Ghana focused on expanding access to long-acting reversible contraceptives (LARC) services by:

Increasing the number of private sector health facilities providing LARC services through expanding training on LARCs to include more private facilities willing to provide the service,

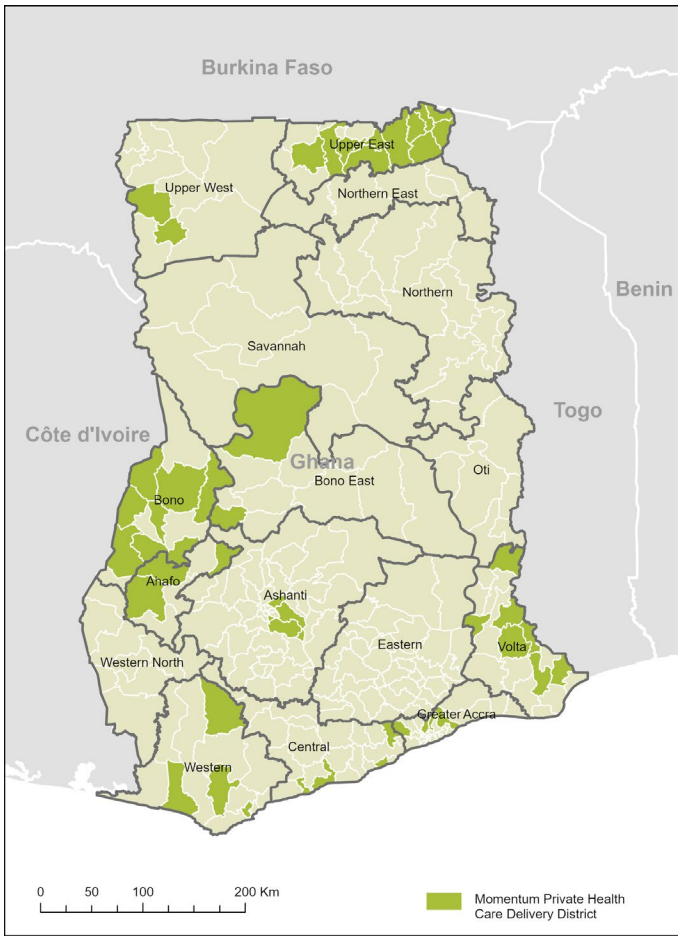
a) Ensuring sustainable LARC commodity supply, and

b) Growing demand for LARC services in private sector health facilities through strategic demand generation activities.

To achieve the objectives, the Total Family Health Organization (TFHO) in collaboration with the Ghana Health Service (GHS) and partners, recruited 100 private sector health facilities in 10 of Ghana's 16 regions for the project implementation. The regions were deemed USAID priority regions and included Ashanti, Central, Greater Accra, Northern, Northeast, Savannah, Upper East, Upper West, Volta, and Western regions.

ICF International, through Data for Impact (D4I), is conducting a mid-term evaluation of the MPHD project. The purpose of the MPHD midterm evaluation is to assess the project's interventions, their implementation status, quality to date as well as overall achievements and obstacles to achieving key results. The evaluation will also identify what works, what needs rethinking or what major changes may be required at the global and country levels at the midpoint of the project. Findings from the mid-term evaluation will inform decisions about the design of future investments in private sector engagement for FP/RH and MCHN. This report presents a case study of the Ghana MPHD project being implemented by TFHO and partners.

Figure 6 Districts served by MPHD Ghana



Methodology

Data Collection Approach

The midterm evaluation of the MPHD project was participatory and inclusive. It used multiple data collection approaches to gather information for the midterm evaluation of the MPHD project in Ghana. First, the team conducted a desk review of program documents for the global MPHD and the Ghana MPHD program. These documents included the MPHD country workplans, program implementation reports and training materials. This provided the Evaluation team with broader information, knowledge, and ideas about the operations of the MPHD project. Second, the team conducted in-depth interviews and group discussions in-person with 32 participants from 11 sites. The participants comprised donors (USAID), implementing partners (TFHO and JHPIEGO) and service providers from public and private sectors.

Sites Visited

During the field assignment, the Evaluation Team visited the following sites in two of the project beneficiary sites:

No.	NAME OF SITE	LOCATION
1	USAID Ghana	Accra, Greater Accra Region
2	Total Family Health Organization	Accra, Greater Accra Region
3	Ghana Health Service – Head Quarters	Accra, Greater Accra Region
4	Ghana Health Service – Mamprobi Hospital	Accra, Greater Accra Region
5	JHPIEGO	Accra, Greater Accra Region
6	Lapaz Community Hospital	Accra, Greater Accra Region
7	Global Star Hospital	Accra, Greater Accra Region
8	Methodist Health System – Head Quarters	Accra, Greater Accra Region
9	Bethel Methodist Hospital	Takoradi, Western Region
10	Tarkwa Mines Hospital (Euracare)	Tarkwa, Western Region
11	Nursing and Midwifery Council	Accra, Greater Accra Region

Limitations

The participants for the interviews and group discussion were selected by TFHO, so there could be some bias. The sites visited were all located in the southern sector of Ghana, so the information gathered may not be geographically representative.

Findings

Stakeholders interviewed appreciated receiving training, mentoring, and job aids, and reported finding them useful in improving counseling and clinical skills. Additionally, facilities reported having adequate FP/RH commodities and equipment, although these supplies remain donor driven. The MPHD project was reported to have a positive influence on policy. Key informants suggested more support for demand generation and data capture would improve program implementation.

Recruitment of Private Facilities to provide LARC Services

The MPHD project recognized the need to involve private health facilities to provide LARC services across the country. This is anchored on the belief that increasing the number of private sector facilities providing LARC services could improve access to and use of these services in Ghana. In this regard a total of 100 private sector facilities were recruited to offer LARC services in 10 of Ghana's 16 regions. These regions are Ashanti, Greater Accra, Northern, Northeast, Savannah, Upper East, Upper West, Volta, and Western regions. MPHD negotiated a partnership with the Methodist health network to offer LARC services in several of their facilities.

While this was a worthy achievement for the MPHD project, the selection criteria for the 100 private facilities were not clearly articulated. The regional selection as reported was aligned so that there was no duplication with the USAID/Ghana Health Marketing Activity implementation in the USAID priority regions.

Conduct LARC Services Training for Health Care Workers from Recruited Facilities

TFHO, in collaboration with the GHS and JHPIEGO, used a blended learning approach to train midwives from recruited facilities on LARC (Implanon NXT, Jadelle, and Copper intrauterine device(IUD)). The trainers were recognized national trainers/facilitators from the GHS working closely with JHPIEGO. According to participants, the blended learning approach comprised online and in-person training, as well as a six month follow up using the mentor-mentee model.

Online Training Model

The online training was conducted through the World Continuing Education Alliance platform, which made it possible for participants to log in using computers, tablets, or mobile phones from their various locations. Participants who completed the online training and scored 80 percent and above were awarded and then allowed to proceed to the in-person training.

During the stakeholder interviews, all the participants highlighted the advantages and usefulness of the online training for LARCs. For example, a midwife in one of the private facilities stated that "the online training was so convenient because it was self-paced, and I could do the courses from any location".

Similarly, a midwife in a private facility within the Greater Accra Region stated that

> "*…the online trainings were so informative, and I kept visiting the platform to undertake more courses to help me with my annual Continuous Professional Development (CPD) as required by the Nursing and Midwifery Council of Ghana*."

While the participants applauded the online training model, especially the convenience and the wide applicability for different settings, a midwife in one of the district private facilities highlighted network connectivity as one of the challenges and expressed preference for in-person trainings. This challenge seemed particular to the midwife's location as further probes in other facilities did not corroborate this challenge.

In-person Training

Enrollment into the in-person training was not automatic but contingent on the participants passing the online training. The in-person trainings served as practical sessions for the trainees to acquire counseling skills, LARC insertion and removal clinical skills, client assessment and screening skills, infection prevention and control, documentation and stock management and commodity requisition. Selected venues were identified for the in-person training and participants were brought together for a week or two weeks' training.

Most of the participants found the in-person training valuable because it provided hands-on experience for the trainees on LARC insertion and removal. In addition, participants observed that the Counseling for Choice (C4C) approach learnt during the in-person training was remarkable and will help them guide clients to make informed decisions about the desired family method. According to one service provider in the Western Region of Ghana,

> *…the C4C approach helps us - the service providers - to focus on the client's preferred method and by so doing provide adequate information on the chosen method without confusing them with methods they are not interested in. In fact, it saves a lot of time for both providers and clients.*

Figure 7 In-person training for IUD

Also, there was general appreciation of the person-centered care (PCC) approach by the LARC service providers that went through the in-person training. Like the C4C approach, the participants appreciated the PCC approach and indicated that it helped them to focus on the needs of clients, rather than using a uniform approach to all clients.

Mentor – Mentee Approach:

The mentor - mentee approach was adopted by the TFHO after the formal training sessions to ensure that service providers received trainings from experienced GHS mentors within their work settings to minimize disruption of routine clinic flow. The mentor-mentee component had practical training sessions with the LARC method suite, such as IUD insertion and removal, and implant insertion and removal. For the mentor – mentee approach to be successful, there is the need to organize sessions in facilities that have good client inflow for LARC services. In the words of a GHS Mentor on the program, "to ensure that we provide the necessary guidance and coaching we usually bring some of the mentees to a public sector facility where the client flow for LARC service is high. This has proven successful rather than limiting the mentoring in the mentee's own facility, where client flow for LARC may not be good."

According to a GHS Mentor and a Mentee at a private sector health facility in the Greater Accra Region, the mentorship period is usually not more than 3 months, and the Mentee is required to record progress in the logbook for certification. This has proven to be an effective way to promote knowledge transfer and capacity enhancement within the health care sector. Of the 159 providers trained, 118 successfully completed the Mentor Mentee phase and were certified as competent to provide LARC services. The remaining 41 providers are being integrated into TFHO's FP training plans. Under the new USAID Social Marketing and Private Sector Activity award, where TFHO is receiving direct funding from the USAID Mission in Ghana, TFHO continues to partner with private health facilities recruited under the MPHD project. Facilities with a low client pool have been trained in FP demand generation activities, which are currently ongoing. These facilities will also continue to receive supportive supervision and internal quality of care evaluations to enhance providers competence.

Design, Produce, and Disseminate Appropriate Job Aids for Health Care Workers Use

In collaboration with the GHS and other partners, TFHO developed job aids to support 100 private health facilities providing LARC services across the 10 operational regions of the MPHD project in Ghana. The job aids produced and distributed to health facilities included family planning flip charts, client counselling checklists, method comparison charts, decision kits, reference charts, family planning register and client record book.

Generally, the health care workers at the facilities visited found the job aids distributed by the TFHO very useful and indicated that they helped to improve the quality of services provided to clients. For example, in one of the facilities in the Western Region, a midwife indicated that the flip chart helped boost her confidence when counseling clients for family planning. Likewise, the decision kits were helpful to the providers and the clients. Figure 3 shows a picture of a decision kit distributed to one of the LARC service centers in the Western Region.

Figure 8 Decision Kit

Demand Generation

It was generally acknowledged by the LARC service providers that TFHO and partners undertook demand generation activities for LARC across the country and especially within the operational regions. Some providers thought the demand generation activities for LARC services could be strengthened, and they require more intentional action to help increase demand for and use of LARC services across the country. As put succinctly by one of the LARC service providers, "*The clients are not coming*." The evaluation team was told that demand generation will be addressed as a focus area under TFHO's new USAID Social Marketing and Private Sector Activity award.

Sustaining Commodity Supply

Stakeholders under the MPHD project including service providers in the private sector expressed satisfaction with the supply of implants and IUDs to public and private health facilities. Starter packs of TFHO FP commodities were distributed to both MPHD LARC Facilities and Methodist Health System Ghana facilities, with restocking as needed, including short and long-acting reversible contraceptive methods. The service providers reported that TFHO collaborated with the GHS to ensure sustained supply of LARC commodities to private health facilities. In the words of a midwife in one of the private facilities,

> *"…before the MPHD project, there used to be stockouts of LARCs in this facility, but now through TFHO we receive supply of contraceptives from the Metropolitan Health Directorate at subsidized prices. We now feel recognized by the Ghana Health Service, and we are also obliged to submit reports to the Metropolitan Health Directorate to help with the monitoring of stock utilization."*

Support with LARC Equipment

There were varying reports among private sector facilities regarding the support with LARC equipment and consumables. Most health care facilities indicated they received basic LARC equipment such as IUD insertion and removal set, implant insertion and removal set, bilateral tubal ligation (BTL) set, and vasectomy set from TFHO. In the Western Region, the Methodist facility received equipment based on a needs assessment

conducted before the intervention. This included an autoclave for sterilizing FP instruments, specialized instruments for IUD and implant insertion and removal, as well as equipment for performing vasectomy and BTL. Two providers were trained as master trainers, and the Medical Director, an Obstetrics and Gynecology specialist, received training as a master trainer specifically for BTL and vasectomy procedures. These Master trainers serve as service providers as well as Mentors for cascading FP training within the Methodist Health System.

Routine Follow-up and Supportive Supervision of Recruited Private Facilities

Due to the activity's end date and the beginning of TFHO's new USAID/Ghana award, some of the private sector LARC service providers experienced quarterly supportive supervisory visits conducted by TFHO and GHS district teams. The purpose of the supportive supervision was to improve performance of the private facilities by enhancing coaching and mentoring of the LARC service providers to fill existing and emerging gaps on LARC service provision. As narrated by a LARC service provider,

> "…*I like the supportive supervision because during the visit, the experts observe, make corrections, demonstrate correct techniques, and provide constructive feedback before leaving the facility. This helps us to improve the quality of LARC services we provide at the facility."*

Policy Influence

Stakeholders at the national level observed that the MPHD project had tremendous influence on the family planning landscape and the health system of the country. According to the GHS, the MPHD project strengthened collaboration between the public and private sectors and some of the implementation approaches for LARC service provision and counselling transcend the private sector. Notably, *The GHS approved the C4C approach to be used in Ghana, as part of a mix of approved counseling approaches that can be used throughout the county.* Similarly, the GHS found the Total Market Approach feasible for adoption at the national level but indicated that the implementation should be gradual.

Public – Private Partnership

The MPHD project was touted as one of the flagship projects that strengthened public – private partnerships within the health sector in Ghana. The project helped to bring private health care providers closer to the GHS, which they previously saw as a competitor. The GHS envisaged that the MPHD project will further strengthen the relationship between public health sector providers and private health sector providers especially for LARC. As highlighted by a LARC service provider in a private facility,

> "…*through the MPHD our facility is now able to share family planning contraceptives with other health care facilities, especially public facilities within the district. This helps reduce stockouts of vital family planning commodities in the health facilities."*

Prices of LARC Services

The GHS pointed out that cost of family planning services was now covered by the National Health Insurance of Ghana and therefore was supposed to be free at the point of service. However, it was found that public sector facilities were charging subsidized prices for IUD and implants insertions and removals whereas private sector service providers arbitrarily charged their own fees at the point of service. It was also noted that private sector facilities charged different prices for LARC services and there was no consistency or uniformity in the pricing regime for LARC services in the private sector. This is a point of concern for the GHS, but not necessarily an issue under MPHD's control.

General Access to LARC Services

There was convergence of views among all stakeholders that the MPHD project has led to improved access to LARC services in the private sector. Prior to the MPHD project most private facilities were only providing short-term family planning methods and the staff lacked the necessary skills to provide LARC services. According to a service provider in a private health facility within the Greater Accra Region,

"…*the number of family planning clients attending our facility increased because we now provide LARC services. Our main family planning method was injectables, but now clients are opting for implants and IUDs and that is good for our facility."*

In PY3, October 2022-September 2023, MPHD Ghana reported 12,463 couple-years of protection, exceeding the program target for the year by 4%.

Data Capturing and Sharing

Most of the health care facilities still use paper logs as family planning service registers and data is reported to the District Health Directorate at the end of every month for onward submission onto the DHIMS platform. The private health facilities reportedly do not have access to the DHIS2 to ensure direct reporting onto the system unlike public sector health facilities. In addition, the private sector LARC service providers did not disaggregate the data they captured at the facility level.

To ensure quality of the data generated, the LARC service providers reported that the TFHO team usually undertakes a quality audit of the data before they are uploaded onto the DHIMS. In some instances, the TFHO team will check the data during their monitoring visits to the facilities.

Value for Money

The stakeholders at all levels highlighted the comparatively lower cost of the online training vis-à-vis the normal in-person training that usually brings participants together in a hotel setting or at a certain venue. The online training and the mentor-mentee approaches under the MPHD project therefore presented value for money for the entire system.

Challenges

The following challenges were highlighted by the stakeholders:

1. Demand generation for LARC services is low. Trained providers will lose their skills if they do not have opportunities to practice what they've learned.
2. High staff attrition within the health sector including those trained to provide LARC services.
3. Cost recovery for LARC services in the private sector is currently not realistic.
4. Lack of sustainability because family planning commodity supply in Ghana is still donor driven.

Conclusion

The MPHD project has been noted to be a game changer for LARC service provision in Ghana. It created opportunities for capacity enhancement in the private health sector of the country to provide LARC services they previously could not provide. Public and private health sector partnerships have been emboldened and will strengthen the entire health system of the country. The project has won the trust of the Government of Ghana leading to the adoption of some MPHD project approaches for national implementation, such as the

inclusion of C4C into approved counseling approaches, and this is a big achievement.

Overall, TFHO and partners have successfully implemented the MPHD project in Ghana to date and sustained efforts are needed to ensure that the gains achieved are augmented or maintained.

Recommendations

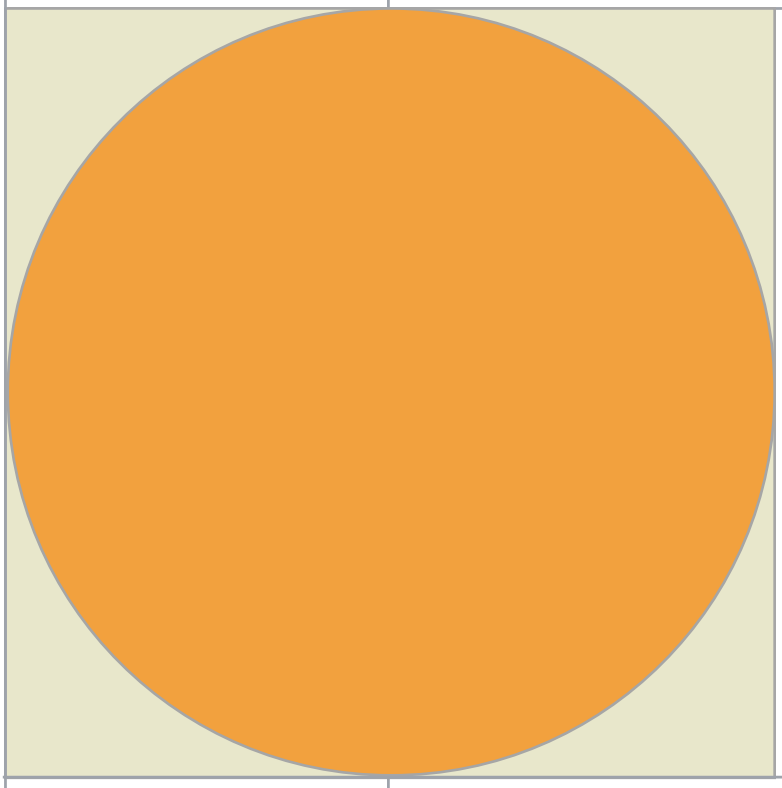
1. There is a need to intensify demand generation activities for LARCs, including support to empower providers with approaches to increase client interest in LARCs. Evidence-based SBC best practices should be deployed strategically and consistently.
2. Harmonizing pricing for LARC services, specifically in supporting the government uniform fees, should be supported as part of facility support.
3. LARC service providers should be supported to adopt digital reporting systems and gradually move away from the paper-based reporting system.

To address staff turnover, more midwives or nurses per facility should be trained on LARCs.

Appendix 7. Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Gael O'Sullivan
Title	Consultant and Adjunct Professor
Organization	Georgetown University
Evaluation Position	☒ Team Leader ☐ Team Member
Evaluation Award Number (contract or other instrument)	Data for Impact (D4I) associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Momentum Private Healthcare Delivery, Implemented by Population Services International with partners: Avenir Health, FHI 360, JHPIEGO and Thinkwell. Award number: 7200AA20CA00007
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
Signature and Date	Gael O'Sullivan May 1, 2024



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