act for performance

UNAIDS

Independent Evaluation of Phase I: PEPFAR-UNAIDS Faith Initiative Strengthening Faith Community Partnerships for Fast Track

FINAL REPORT

ACT for Performance

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List of Acronyms

ACHAP	African Christian Health Association Platform
ART	Antiretroviral Therapy
BAI	Black AIDS Institute
CBS	Contextual Bible Study (WCC)
CEO	Chief Executive Officer
CHAK	Christian Health Association of Kenya
CHAP	CHAK HIV/AIDS Program
CHAs	Christian Health Associations
CHAZ	Christian Health Association of Zambia
CSE	Comprehensive Sexuality Education
DAC	Development Assistance Committee
EAA	Ecumenical Advocacy Alliance
EHAIA	Ecumenical HIV and AIDS Initiatives and Advocacy
EM	Evaluation Matrix
FBHS	Faith Based Health Systems
FBO	Faith Based Organization
HCT	HIV Counselling and Testing
IHP	Interfaith Health Program
IPs	Implementing Partners
OECD	Organisation for Economic Co-operation and Development
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PD	Political Declaration
PLHIV	People Living with HIV
PrEP	Pre Exposure Prophylaxis
SPU	St. Paul's University (Kenya)
UCT	University of Cape Town
UNEG	The United Nations Evaluation Group
WCC-EHAIA	World Council of Churches – Ecumenical HIV and AIDS Initiatives and Advocacy
WCC-EAA	World Council of Churches – Ecumenical Advocacy Alliance
World YWCA	World Young Women's Christian Association

1 EXECUTIVE SUMMARY

Introduction

Purpose: ACT-for-Performance (ACT) was commissioned by UNAIDS to undertake an external independent evaluation of Phase 1 of the PEPFAR-UNAIDS Faith Initiative Strengthening Faith Community Partnerships for Fast Track. The specific objectives of the mid-term evaluation were to:

- analyze the context and relevance of PEPFAR-UNAIDS Faith Initiative towards the achievement of 90-90-90 by 2020;
- identify key results achieved and analyse the likelihood that they will be sustainable;
- identify enabling factors, opportunities, challenges, and threats in implementing this initiative;
- identify lessons and good practices for each of the five priority programming areas;
- analyze the full integration of gender equality and human rights throughout the entire spectrum of the initiative and recommend any improvement if required;
- analyze the management of the initiative, from its governance down to the actual flow of money to partners;
- recommend concrete actions to be implemented rapidly as Phase II is unfolding.

Timing: The evaluation took place from June 2017 (with the preparation of the Inception Report), with data collection in July and August 2017, and analysis, preparation of results, and reporting writing in August and September 2017. The evaluation covered all five Implementing Partners (IPs) included in this initiative and the two initial countries from Phase I: Kenya and Zambia.

Methods: The methods employed included: desk review of documents, interviews with various stakeholders by Skype and on field visits, collection of data from IPs using a report card template, and debriefing/validation session in New York on September 12, 2017. The field missions took place between July 17 and July 28 to carry out face-to-face interviews in Kenya (July 17-24) and Zambia (July 25-28) with various stakeholders. In Kenya, 21 people took part in 11 interviews/focus groups; in Zambia, 10 people took part in 6 interviews/focus groups. In total, across the evaluation, 62 people took part in 43 interviews/focus groups.

Limitations: One limitation was that the results are largely based on interview data, including people's subjective perceptions. Limited documentation was also available. Some challenges were faced because the timing of the evaluation took place over the summer months, making it more challenging to book interviews and receive documentation from IPs as interviewees had busy schedules including summer vacations. Lack of familiarity by some interviewees about what activities and projects constituted Phase I was a challenge. A final challenge is attribution since IPs have multiple activities, and multiple spin-offs, and it is not always clear to all stakeholders which activities are funded all (or part) by this Phase I initiative. In addition, the length of Phase I was short, making it a challenge to assess outcomes and impact. Details on how these limitations were addressed can be found in the full report.

Findings

Relevance: The initiative was generally viewed as relevant at the global UNAIDS and PEPFAR levels, through addressing stigma and discrimination, strengthening capacity of FBOs, and therefore helping to address the 2016-2021 UNAIDS strategy, Getting to Zero, and 90-90-90.

However, this viewpoint was not universal. A number of respondents felt that while the concept for the initiative was on the right track, the scale of the initiative was too small to make a large impact, and fragmented into multiple activities, lacking integration.

From a country level, overall it was felt that the initiative's objectives fit with the broad country policies, but that

the initiative was not designed to work with existing institutions and mechanisms. Hence, global and in-country respondents identified that the relevance of the project to the country level strategies was a challenge, given the top-down nature of Phase I and the lack of adequate consultation and involvement at the country level. Consultations with country level partners were not done until after the project had already been designed. Hence, it was strongly identified that better engagement in-country, as well as integration with the country system and the National AIDS Control groups, was needed.

Effectiveness: While it is too early to comment on longer-term outcomes of the initiative, the numerous activities to date have contributed to the following general outcomes, including some early indication of: increased engagement of FBOs generally in the initiative, and among US black FBOs; increased awareness of global players of pediatric care challenges and best practices resulting in the development of action plans around pediatric care and the Start Free, Stay Free AIDS Free Framework by PEPFAR and UNAIDS; knowledge development and sharing through documenting what FBOs do; increased understanding and awareness of the important role that FBOs can generally play in addressing HIV; and development of some common messaging for FBOs to use (e.g. sermon messages).

In terms of what worked well: key activities were conducted (e.g. consultations, meetings, data collected for use in the next Phase); collaboration, communication, and engagement took place that had not occurred before; and alterations were made to plans to adapt to the context. Some felt that the right partners were at the table for what the initiative was trying to achieve. There was also a perception that this was the right timeframe to bring together FBOs to develop a large-scale initiative and address the lack of data in this area, and that there was determination amongst the various players to make this initiative work.

Respondents identified a number of challenges. Country ownership and integration into current systems was a challenge in Phase I in both Zambia and Kenya. In addition, respondents noted: that it was too early to identify outcomes given that work has only been underway for a short period of time, that in some cases the language used (e.g. comprehensive sexuality education) and certain key populations (MSMs) may prove to be issues when working with partners in-country, and that more sharing of knowledge between IPs and externally would have been useful. It was also felt that not all key FBO players had been involved in the initiative. This included inclusion of all local key stakeholders, as well as limited involvement of non-Christian FBOs, resulting in insufficient inclusion of other faiths beyond Christian at all levels (global and national). There were some examples where it was difficult to collect the appropriate data required to support the initiative.

In terms of concrete results related to human rights and gender, there were varying opinions about the extent of results from Phase I on gender and human rights. While some noted that human rights and gender were incorporated and addressed through some of the activities to date (particularly gender), others felt that: gender and human rights were not a focus of this initiative, or that it was “too early to say” in terms of the work of gender and human rights (Global Staff), or that measuring the results of work on gender and human rights results is a challenge, or that respondents did not feel they could comment on the results with regards to gender and human rights as they did not have sufficient information. Sex-disaggregated data was not collected as part of the project, nor was gender and human rights a focus of reporting.

Efficiency: Most interviewees thought that the roles and responsibilities between UNAIDS and PEPFAR were clear, although they had not seen these clearly outlined on paper. The role and responsibilities of the Advisory Group did not seem to be well understood by many of its members, despite UNAIDS providing draft ToRs to the July 18, 2016 Advisory Group meeting in Durban. The IP selection rationale was not explained to project stakeholders and many interviewees had the perception that it was a top-down and not a very transparent approach. However, this is consistent with the underlying objective sought by PEPFAR who wanted to bridge information gaps on FBOs’ roles and responsibilities towards HIV/AIDS and work with FBOs who have already been very active in that field. Internal communications between IPs and UNAIDS for ongoing daily management were generally very good. However, communications between HQ and some IPs and country stakeholders (government, UNAIDS, PEPFAR) were quite insufficient. Reporting was perceived as being sufficient by most stakeholders, but some suggested more frequent reporting on activities, as one report at mid-point and one final report almost a year later proved to be insufficient, and an additional progress report was thus added by UNAIDS. From the document analysis, it is clear that the reporting format provided by

UNAIDS was not followed by all IPs.

Most planned activities did occur during Phase I, with the major exceptions being delays in the start of the contract and activities for ACHAP's work, and some of the activities in Zambia that were not undertaken given challenges arising from the WCC consultation. Other changes to activities included a change made to the activities to reflect local FBOs' feedback (e.g. Emory's work on stigma and healthcare professionals) and additional activities took place such as the Nigeria multi-country consultations on pediatric care undertaken by CARITAS.

The lengthy approval process (requiring a lot of detailed budgeting and delays to send the first payments) was a major challenge. A few respondents reported that there was not enough flexibility to move money around in line with evolving requirements. Generally, budget management and financial reporting was considered to be good.

At the global level, many felt that the choice of activities was the right fit for the needs. At the country level, many respondents noted that work should have been done in closer consultation with the country government and other relevant stakeholders (including country-level PEPFAR and UNAIDS).

Sustainability: With this initiative, some results achieved at the global level are more likely to be sustained than those at the country level. In some cases, activities are grounded in the IPs' institution, and are likely to continue. However, the short-term nature of projects in Phase I (and moving to different countries in Phase II) could negatively affect sustainability. At the country level, activities undertaken in Kenya and Zambia are much less likely to be sustainable, as they were not undertaken within the country systems and institutions (and in the case of Zambia, limited activities were undertaken).

At this time, not all systems are in place to ensure the sustainability of the results of this initiative. But initial steps have taken place (e.g. gathering country-level data on health services of FBOs in Kenya). There are no existing mechanisms to ensure networking and sharing knowledge between all stakeholders at both global and country levels.

Recommendations

Relevance and Effectiveness

1. There is a difference in opinion between PEPFAR and UNAIDS on the scope of work. UNAIDS and PEPFAR should clarify the scope of this initiative – including Phase II.
2. UNAIDS and PEPFAR should ensure sufficient time to address concerns from Phase I before starting Phase II to ensure Phase I challenges are addressed. These were discussed at the September 2017 Advisory Group meeting, and PEPFAR and UNAIDS committed to continuing to address issues moving into Phase II.
3. UNAIDS and PEPFAR should ensure timelines and resources match with expectations including adequate time for Phase II activities to realize outputs and short and medium-term outcomes. It is expected that while the initiative would contribute to higher level outcomes, attribution becomes more difficult the more longer-term the outcomes, and this needs to be clear in the results matrix.
4. UNAIDS and PEPFAR, along with the IPs, should better communicate project results and lessons learned to the outside world for greater impact. This would include a communication strategy in all projects specific to the targeted audience to disseminate project results, knowledge, and lessons learned.
5. UNAIDS and PEPFAR, along with the IPs, should find additional ways to ensure interfaith is addressed in a comprehensive way (beyond Christianity).
6. UNAIDS and PEPFAR should encourage the development or alignment with MAISHA-type plans in countries for interfaith networking and engagement.
7. While some activities are incorporating gender and human rights, UNAIDS and PEPFAR, working with IPs, should continue to find more systematic ways to address gender and key populations across the initiative's activities and in monitoring and evaluation. This may include having further discussions with the Advisory Group on the challenges faced in working with key populations (as discussed in the September 2017 meeting in New York) and the development of a strategy on challenges, opportunities for framing, and ways forward.

8. UNAIDS and PEPFAR, along with the IPs, should address faith healing in relevant countries (e.g. Zambia and Kenya, and other Phase II countries where this is identified) given the potentially negative impact on ARV adherence.

Efficiency

9. PEPFAR and UNAIDS should detail their respective roles and responsibilities, including those of the country offices, for this initiative and communicate this to IPs and other stakeholders.
10. For the Advisory Group, UNAIDS should clearly spell out the roles and responsibilities of the Advisory Group with a focus on knowledge sharing and communicate it to all its members to ensure a common awareness and understanding of its role. Consideration should be given to have a smaller AG core group to include present members, but not IPs, to provide advice to UNAIDS and PEPFAR.
11. For the IP and project selection process, UNAIDS and PEPFAR should define program objectives first and the level of focus (global or country). At the country level, define clear criteria for country selection and then look at which IP would be best to deliver each component.
12. UNAIDS should provide a template for concept papers as early as possible for Phase II to ensure consistent information across IPs.
13. UNAIDS and PEPFAR should have as a goal to improve knowledge sharing between project stakeholders.
14. Recommendations on frequency and content of reporting include aligning reporting with the IP meetings and Advisory Group, increasing reporting frequency, and ensuring reporting aligns with the results matrix.
15. The first responsibility of monitoring lies with the IP to monitor if activities achieved (outputs) are translating into outcomes. Then UNAIDS and the Advisory Group core group can provide a critical and analytical assessment based on IP reports and their participation in certain events.
16. To ensure value for money and the efficient management of funds, UNAIDS and PEPFAR should allow for sufficient time for undertaking activities, provide more frequent payments, consistent approaches to overhead, and core Advisory Group oversight using a transparent mechanism for reallocation of funds.

Sustainability

17. Build sustainability measures at project design level through various mechanisms including working through country systems and institutions in a bottom-up approach.
18. Major stakeholders such as PEPFAR, UNAIDS and IPs should identify how they can ensure that results from this initiative are owned and internalized in their own organizations' programs and systems. PEPFAR, UNAIDS and IPs should work with country governments and FBOs and agree on a sustainability plan (linking with the MAISHA-type plan).

2 INTRODUCTION

ACT-for-Performance (ACT) was commissioned by UNAIDS to undertake an external independent evaluation of Phase 1 of the PEPFAR-UNAIDS Faith Initiative Strengthening Faith Community Partnerships for Fast Track.

FBOs are contributing significantly to the delivery of basic health care with a varying degree of quality of services and management, as outlined in The Lancet 2015 Jill Oliver paper. The role of FBOs is especially crucial working on prevention, education and early diagnosis through community outreach. The Lancet article[1] identified key areas of support and capacity development required by FBOs to become more effective partners to address HIV, and most importantly, recognized the need for more research in two areas: (i) scale, scope and reach; and (ii) overcoming potential contradictions between faith and equal access to services.

The United States President's Emergency Plan for Aids Relief (PEPFAR) was created in 2003 and has worked with FBOs since its inception. In April 2015, in order to meet UNAIDS' 90-90-90 goals by 2020,

[1] *Lancet* 2015; 386: 1765–75 July 15, 2015 : Faith-based health care 1

PEPFAR consulted 50 religious leaders from East Africa to clearly identify successes and challenges, such as reaching out to those most vulnerable who might not be adequately reached by religious leaders' outreach: sex workers, men who have sex with men (MSMs), people who use drugs (PWUD), etc. Further to these consultations, PEPFAR launched its PEPFAR 3.0 Agenda: *"PEPFAR 3.0 Controlling the Epidemic: Delivering on the Promise of an AIDS-free-Generation*[2].

In September 2015, PEPFAR and UNAIDS launched a two-year 4M USD initiative to respond to the Lancet recommendations to strengthen knowledge and capacity of FBOs. Five areas were prioritized:

1. Strengthen FBO leadership and advocacy
2. Collect, analyze and disseminate data on health care services provided by faith-based health services (FBHS)
3. Address stigma and discrimination in communities and health care settings
4. Create demand for service uptake and retention in care
5. Strengthen HIV and AIDS related service provision

The first year, the subject of this evaluation, started in April 2016 with a $2M USD budget working with five (5) faith-based implementing partners (IPs), two of them being a consortium. Projects at the global level and in two (Kenya and Zambia) of the four targeted countries have been undertaken with a total budget of $1.45M USD going to IPs, while a total of $0.55M USD (31.1%) was devoted to UNAIDS various management costs, including support to activities on the ground, M&E and UNAIDS overhead. Although the 2016-17 work plan categorizes funded projects under the first two prioritized areas, all five areas have been covered during the first year. The December 31st, 2016 *PEPFAR-UNAIDS Faith Initiative: Strengthening Faith Community Partnerships for Fast Track* progress report identifies activities delivered and results achieved for the 14 funded activities as well as initial lessons learned both from the content perspective and the efficiency/management perspective. The size of activities varied from $60,000 USD to $500,000 USD.

3 METHODOLOGY OF THE EVALUATION

3.1 Introduction

The evaluation took place starting in June 2017 (with the preparation of the Inception Report), with data collection in July and August 2017, and analysis, preparation of results, and report writing in August and September 2017. UNAIDS has put in place a Management Plan for this evaluation (see Appendix I) that clarifies roles and responsibilities between three (3) groups: HQ daily oversight, the Evaluation Steering Group, and the External Evaluation Senior Managers.

Given the ambitious goals of the UNAIDS Fast-Track Strategy and the contribution of this project, it was important for PEPFAR and UNAIDS to quickly get an independent evaluation mid-way through the implementation of this two-year project. The specific objectives of the mid-term evaluation were to:

- analyze the context and relevance of PEPFAR-UNAIDS Faith Initiative towards the achievement of 90-90-90 by 2020;
- identify key results achieved and analyse the likelihood that they will be sustainable;
- identify enabling factors, opportunities, challenges, and threats in implementing this initiative;
- identify lessons and good practices for each of the five priority programming areas;
- analyze the full integration of gender equality and human rights throughout the entire spectrum of the initiative and recommend any improvement if required;
- analyze the management of the initiative, from its governance down to the actual flow of money to partners;
- recommend concrete actions to be implemented rapidly as the Phase II is unfolding.

The evaluation covered all five selected FBOs included in this initiative and the two initial countries from Phase I: Kenya and Zambia.

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[2] PEPFAR-UNAIDS Faith Initiative fact sheet - January 20, 2017

The evaluation was guided by the United Nations Evaluation Group (UNEG) guidelines and used the Organisation for Economic Co-operation and Development (OECD) evaluation criteria: relevance, effectiveness, efficiency, sustainability, and gender. Impact evaluation was not reasonable at this stage, given the short lifespan of the project. The evaluation provided a sound assessment of results achieved so far at the output and contribution to outcome levels, assessed its management (from planning, selection of partners and initiatives to be funded, administration of funds, monitoring & reporting from beneficiaries), and assessed risks associated with the project. The evaluation provides lessons learned and actionable short-term recommendations to improve the second phase of the project and also provides recommendations with a longer-term perspective.

UNAIDS drafted a results framework which served as the basis for this evaluation. It is usually very challenging to relate small-scale initiatives (5 partners for a total of 14 projects) to be undertaken in a very short time-frame to a high-level, ambitious impact which is to achieve 90-90-90 by 2020. Evaluators have attempted to frame the logic model/theory of change in a logical framework, which appears in Appendix A.

3.2 Evaluation Criteria and Questions

Among the criteria set out in the Terms of Reference for this evaluation were those recommended by the UN Evaluation Group and the OECD Development Assistance Committee (DAC) for program evaluations, i.e. Relevance and Performance (Effectiveness, Efficiency, and Sustainability), as well as the cross-cutting themes Equity in Access and Gender equality. Evaluation questions were integrated in the Evaluation Matrix – see Appendix B.

OECD CRITERIA	SPECIFIC ASPECTS TO BE ANALYZED
Relevance	• Relevance to Kenya and Zambia HIV Strategies • Relevance to UNAIDS Strategy • Relevance to PEPFAR Strategy
Effectiveness	Quality of: • Advocacy • Mobilization • Leadership • Knowledge sharing • Contextual information and analysis
Efficiency	Quality of management: • Timeliness • Flow of money – value for money • Procedures • Output achievement • Monitoring • Quality of the governance structure and partnerships
Sustainability	• Implementing Partners (IPs) willingness and capacity to sustain activities • Contextual factors that may affect positively or negatively
Gender Equality and Human Rights	• Gender and human rights strategies used by IPs • IP strategies to integrate vulnerable groups • Availability of sex disaggregated data • Availability of data on vulnerable groups

3.3 Approach

This section describes the approach ACT for Performance took for the evaluation. The methodology was designed to respond to the issues presented in the RfP, the inception report, and to accommodate the timeframe. The team adopted a participatory approach, which helped to ensure that existing stakeholder

knowledge is shared and conclusions are verified. Those organizations that have the most to benefit from this evaluation, i.e. PEPFAR and UNAIDS decision-makers and IPs that benefit from this initiative, played an active role, particularly in shaping the actionable recommendations of this evaluation.

Once the Inception Report was approved, evaluation team members planned and conducted Skype interviews, continued document analysis, and one member planned for and conducted the field mission in Kenya and Zambia in July. This was followed by analysis and writing during the month of August, and a presentation to the Implementing partner and Advisory Group September 12 in New York City (which was also a chance to collect additional data). In addition, a member of the evaluation team attended the Interfaith Prayer Breakfast, in New York City on September 13th, 2017.

3.3.1 Theory of Change (ToC)

The Theory of Change approach is particularly well suited to the current evaluation given the importance of context in implementing the UNAIDS Fast-Track 90-90-90 strategy and the specific objectives of the Faith Initiative Strengthening of FBOs. Hence, the context was taken into consideration and stakeholders not only contributed but hopefully learned throughout this evaluation, as they reflected on the effective delivery of their outputs into immediate outcomes. Taking the context into consideration allowed the evaluation team to address the specifics of the two Phase I countries and produce findings and lessons learned and recommend sound actions to inform the implementation of the second phase. Assumptions and hypotheses on actors and factors influencing the processes underlying the intervention logic (inputs, process/activities, outputs, intended outcomes) were central to the process of a ToC. Mixed methods of qualitative data collection techniques (interviews, focus groups, and document analysis) were used, with the aim of collecting the most relevant, useful data with which to address the evaluation questions. Data from multiple sources (e.g. different groups of interviewees from Implementing Partners to donors to government staff and beneficiaries/attendees of consultations) helped to ensure robust data.

3.3.2 Evaluation Tools

The evaluation matrix (EM) was the main tool to organize the evaluation process and to compile all the collected data, and was formed on the basis of the evaluation criteria, assumptions, core questions and specific questions. The EM sets out the evaluation questions, criteria, indicators, data sources, and data collection techniques and serves the design of the data collection instruments and fed into the reporting on the evaluation findings. The Evaluation Matrix was developed, shared with the Evaluation Steering Committee and is included in Appendix B. Data collection tools included: documents from Implementing Partners (IPs), UNAIDS, PEPFAR and external sources; interviews (Face to Face in Kenya and Zambia) and over Skype; and the September meeting with the Advisory group, all organized as per the Evaluation Matrix (EM).

Additional data collection tools included the Report card designed by the Consultant to bridge the information gap from IPs, as most reports available were old and not up-to-date. A few IPs completed the chart and more progress reports became available later in the evaluation process. The evaluation team reviewed and analyzed the key factual information necessary to conduct the evaluation such as activities completed, their respective costs and number of participants (people participating in IP events) where available.

The other main evaluation tool was the interview guides to collect qualitative data (Appendix C).

3.4 Evaluation Activities

A Management Plan was put in place by PEPFAR/UNAIDS as following: 1) HQ information and oversight: daily management of the external evaluation and support to the Consultant; 2) Evaluation Steering Group to oversee the inception report, advise on key informants and review and comment on the draft report; and 3) senior managers of PEPFAR and UNAIDS to provide strategic inputs, comment on the draft report, accept the final report and provide UNAIDS/PEPFAR's response. Please se Appendix I.

The following describes both the evaluation methodology in more details and steps that took place.

3.4.1 Development of Inception Report

The Inception Report, including the EM, was developed in June 2017 and was reviewed by the External mid-term Evaluation Steering Group. Changes were subsequently made and a final inception report developed and provided on June 29, 2017.

3.4.2 Desk Review

A background document review was conducted in more-depth (initiated during the development of the Inception Report) to understand the context of the project. A list of documents can be found in Appendix D and includes concept papers, progress reports, and other documents provided by IPs.

3.4.3 Interviews with Various Stakeholders: by Skype and on Field Visits

Those identified in the stakeholder mapping in the Inception Phase were asked to participate in an interview, either in person (in Kenya and Zambia), or through Skype. Skype interviews were conducted with those stakeholders outside of Kenya and Zambia (e.g. UNAIDS, PEPFAR, IPs and other Advisory Group members (please see Appendix E)).

Some of these interviews were conducted as individual interviews, while others were conducted as focus groups. In addition, IPs were asked to identify workshop/conference participants to be interviewed, and these interviews were also conducted. In total, 31 people took part in 26 interviews by Skype (or in a couple cases by email).

The field missions took place between July 17 and July 28 to carry out face-to-face interviews in Kenya (July 17-24) and Zambia (July 25-28) with various stakeholders. In Kenya, 21 people took part in 11 interviews/focus groups; in Zambia, 10 people took part in 6 interviews/focus groups.

In total, across the evaluation, 62 people took part in 43 interviews/focus groups. Please see Appendix E for a full list of interviewees.

3.4.4 Data Analysis

The evaluators coded interview responses to questions to each of the relevant areas based on the evaluation matrix questions and indicators. Then, codes were analyzed into key themes arising from the data. Findings of the documentation review, the field study and interviews were compiled and documented using the evaluation matrix as the framework. We used NVivo for Mac (qualitative data analysis software) to facilitate the analysis of findings from the interviews. The Evaluation Team compared notes during analysis and discussed these preliminary findings and conclusions internally at the end of August.

The draft presentation of the evaluation was submitted to the Evaluation Coordinator prior to the September 12 validation workshop in New York.

3.4.5 Debrief/validation with the Advisory Committee

Good evaluation practice in any context ensures that the stakeholders have the opportunity to contribute to the evaluation's preliminary findings and report preparation. The Evaluation Team held a debriefing/validation session (with the above mentioned draft presentation) in New York on September 12, 2017 to gather more evidence, and to report back on main findings and recommendations. Questions, additional context, and areas of clarification were noted.

3.4.6 Final Report

One week after the New York meeting, a draft report was submitted to the Steering Committee for review. The Evaluation Coordinator consolidated all comments from the stakeholders documenting factual errors, summarizing the concerns and forwarding any proposed changes to the Evaluation Team Leader. The Evaluation Team then submitted this final report after receiving the consolidated stakeholder responses.

3.5 Limitations

There were a number of limitations in the evaluation. First, results are largely based on interview data, including people's subjective perceptions. However, this was addressed by conducting interviews with different types of stakeholders (e.g. Implementing Partners, government staff, PEPFAR and UNAIDS at global and country levels, beneficiaries and consultation attendees) to ensure triangulation of sources. Documents were also reviewed for triangulation of methods. However, when the evaluation started, only November 2016 progress reports from IPs were available, thus providing limited and out of date information. No other reports were expected until the final reports (which would be submitted after the evaluation). The contractors then developed the Report Card to be completed by IPs, and 3 out of 5 IPs completed the forms to a certain degree with the other 2 providing draft final reports. In early September, the contractors received additional progress reports (required by UNAIDS Programme Review Committee (PRC) to assess the quality of work and extent of progress made by each of the IPs before moving forward with the processing of Phase II draft concept papers and budgets).

Second, there were some challenges faced because of the timing of the evaluation (over the summer months). This made it more challenging to book interviews and receive documentation from IPs as interviewees had busy schedules including summer vacations. This was addressed by making multiple contacts with interviewees, ensuring flexibility in interview timing (e.g. late at night, early in the morning, weekends as needed) and following up by multiple methods e.g. email or telephone. In a few cases, typically due to internet issues, interviewees completed part or all of the interview guide by email.

Third, there was some lack of familiarity by some interviewees in terms of what activities and projects constituted Phase I. Hence, not all interviewees were able to answer all questions (including Implementing Partners who were very involved in Phase I), and many could only answer questions related to their particular activities. This was addressed by giving the interviewee opportunity to say they were not able to answer a question, so that they did not provide a response to areas that they were not familiar with. However, with 62 people taking part in interviews/focus groups, plus the validation exercise September 12th, 2017, a complete picture emerged with fulsome answers for each question provided by those who were most familiar with the particular components of the project.

Lastly, attribution is a challenge given that IPs have multiple activities, and it is not always clear to all stakeholders which activities are funded all (or in part) by this Phase I initiative. There are multiple spin-offs of projects as well. In addition, the Phase I timelines were short making it a challenge to assess outcomes and impact. Some Phase I projects (e.g. ACHAP's work) were just getting underway while the evaluation was taking place. This limitation is reflected in the quotes below and the results section below, as well as discussed further in the recommendations.

> *"Outputs haven't been finished let alone impact or KT (knowledge translation) – from my piece – I don't see that at this stage" (Implementing Partner)*

> *"We are just a year up and running, it is hard to connect anything of what we did – to what actually happened. Not enough time to conduct a good analysis. We didn't recognize how much time to get these activities up and running…This initiative can shed light on these, but cannot take credit for doing that at this time" (Global Staff)*

4 FINDINGS

This next section outlines the findings from the evaluation by section (relevance, effectiveness, efficiency, and sustainability).

4.1 Relevance

4.1.1 Extent design fits with needs and priorities of UNAIDS/PEPFAR (1.1)[3]

The initiative was generally viewed as relevant at the global UNAIDS and PEPFAR levels, through addressing stigma and discrimination, strengthening capacity of FBOs, and therefore helping to address the 2016-2021 UNAIDS strategy, Getting to Zero, and 90-90-90.

> *"The initiative is very relevant – if we look at what…it is about...stigma and discrimination, strengthening capacity of FBO themselves" (Implementing Partner)*

> *"What we are doing fits pretty well in to the PEPFAR agenda" (Implementing Partner)*

> *"It is broadly aligned with both (UNAIDS and PEPFAR)" (Global Staff)*

However, this viewpoint was not universal. A number of respondents felt that while the concept for the initiative was on the right track, the scale of the initiative was too small to make a large impact, and fragmented into multiple activities, lacking integration.

> *"It fits with the needs at the global level, (but I) don't think that the project is as large – (the) magnitude - that it needs to be. It is more like a pilot than a full-scale program....Conceptually it is right" (Implementing Partner)*

> *"It is rapid, short-term, (and) very difficult to show effectively, to measure, to evaluate robust effective change when you have a 6 month window to do that in…(The) thing that struck me – (it is a) very dispersed design – different groups working different aspects and elements" (Implementing Partner)*

> *"Perhaps our efforts are not consolidated enough – just bits and pieces…How do you convince religious leaders to come on board from one consultation?" (Implementing Partner)*

In addition, a few respondents were not able to assess the relevance of the initiative to UNAIDS and PEPFAR, or to the country level, because of lack of overall information on Phase I activities as their understanding of the initiative was limited to their pieces of work, and not the overall Phase I.

> *"I am not clear what is (overall) in Phase I" (Implementing Partner)*

4.1.2 Extent initiative fits with country HIV strategies/needs (1.2)

From a country level, overall it was felt that the initiative's objectives fit with the broad country policies, but that the initiative was not designed to work with existing institutions and mechanisms. Hence, the relevance of the project to the country level strategies was identified as a challenge by global and in-country respondents, given the top-down nature of Phase I and the lack of adequate consultation and involvement at the country level. Consultations with country level partners were not done until after the project had already been designed.

> *"There is no accountability measure in this Phase I – UNAIDS and PEPFAR are not connected on the ground" (In-country Respondent)*

> *"Our biggest fear was that it (the initiative) didn't align with national priorities and national sensitivities…It does not fit (with the country strategy) as it was conceived from Headquarters" (In-country Respondent)*

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[3] Numbers in brackets refer to the Evaluation Matrix.

"This time (Phase II) we want to be more from country up, instead of from global down. And ensure it meets country needs" (Global Staff)

"We spent a good bit of time to consult with the National AIDS Agencies first. But we should have had more consultations first" (Global Staff)

Hence, it was strongly identified that better engagement in-country, as well as integration with the country system and the National AIDS Control groups, was needed.

4.1.3 FBOs Role in HIV Response and Gaps (1.3)

Respondents were also asked about the overall role that FBOs play in the HIV response. While these are not specific gaps for the IPs to fill per se, these respondents provided a general context of the potential role of FBOs in the area of HIV.[4]

A number of key roles were identified, including that FBOs:

- Deliver a large proportion of health care services in sub-Saharan Africa,
- Have a large reach in the community,
- Can increase awareness with their congregation (e.g. on testing and treatment), and
- Enjoy community members' trust (keeping in mind that interviewees were largely staff of various FBOs)

"(People) trust FBOs and not the government – so it is important to ensure that you have links with FBOs. So for the UN in terms of knowledge creation and sharing and propagation – it is important" (Implementing Partner)

"90% of Kenyans belong to a faith – and the messages on HIV can reach them through FBOs and churches – they are reaching many people…A lot of care and treatment is provided by faith-based health services" (Implementing Partner)

On the other hand, respondents identified a number of gaps that remain within the general faith-based community AIDS response including ensuring that:

- stigma and discrimination is addressed,
- FBOS are inclusive and non-judgmental,
- roles in sexual and reproductive health and in reaching key populations (MSM, sex workers, PWUD, young people) are considered,
- concerns surrounding faith healers (e.g. discouraging people from taking their ARVs and "healing" people with HIV through prayer) are addressed (given the link to adherence of ARVs), and
- data from FBHS is reported through countries' national reporting systems

"Faith healing – more people are on 3rd line treatment because of treatment failure (as a result of information from some faith healers)" (In-country respondent)

"The fall off in the care continuum – drop out at all stages – is worrying and giving problems for the future. In the more 'mature' epidemics of Africa (Kenya , South Africa for example) there are the pressures of having to provide 2nd or 3rd line therapies and the cost implications this creates – and this is going to increase unless we solve adherence; the only models that have been shown to work are community based support (with regards to) this" (Advisory Group member)

[4] More details on the success of IPs in Phase I will be addressed later in the report.

4.1.4 Extent design informed by evidence and stakeholder needs (1.4)

Generally, respondents felt that the design of the initiative was informed by evidence (including the Lancet articles and the PEPFAR consultations in 2012 and 2015).

> *"A lot of the rationale for the work come from the key recommendations of the Lancet articles and the Lancet series" (Implementing Partner)*

Respondents also generally felt that the design was informed by stakeholder needs (particularly at the global level), including building on findings of the previous consultations done in 2012 and 2015 by PEPFAR.

It was noted that having more time and capacity for partners to be familiar with the previous literature and engage with each other as partners (e.g. with the Academic Consortium) may assist with ensuring that interventions are built on previous research and evidence.

> *"I am not sure we are drawing on this (previous literature/research) to inform design and activities and compare what they have done versus what others have done before" (Implementing Partner)*

Gaps also remain in the evidence on FBOs and HIV and this initiative can help to fill these gaps.

> *"Well thought out initiative – because you know there are issues of having hard evidence – and that is a need. This project has addressed it in a way that we are able to generate more evidence" (Implementing Partner)*

However, as noted, more consultation at the country level was needed to ensure buy-in and integration.

4.2 Current Trends (HIV Context)

Respondents were asked a number of questions about the HIV context globally and in Kenya and Zambia (the focus countries for Phase I) to get respondents' perceptions on the current HIV trends and embed the evaluation results in the present context.

4.2.1 Political Will (5.1)

Generally it was felt that country-level governments had the political will to continue addressing HIV. There was commitment in terms of country-level strategies and budgets, with politicians in countries continuing to speak on these issues.

4.2.2 Budget Allocations (5.2)

Respondents felt that funding and commitment to HIV has decreased globally, as HIV was viewed less and less as a priority by funders given advances in treatment. However, countries are still reliant on global funders (including PEPFAR) for HIV funding, including funding of ARVs, as more and more people are put on treatment.

> *"HIV is not a priority anymore. The assumption is with treatment, HIV is no longer an issue" (Advisory Group member)*

4.2.3 Access to ARVs (5.3)

In terms of access to ARVs, respondents noted that ARVs are expensive for governments to pay for, and access remains a challenge for some people. Funding is also required to support achieving the goals of 90-90-90. In addition, some respondents cited that ARV adherence remains an issue.

4.2.4 Stigma and Discrimination (5.4)

Many respondents felt that stigma and discrimination remain a major concern in many cases, particularly for key populations (MSM, PWUD, CSW). Some respondents noted that there has been some improvement in stigma and discrimination generally. It was noted that religion can play an important role in either increasing or decreasing this stigma and discrimination.

> *"Some progress, but it is still a battle especially for key populations" (Global Staff)*

In some cases, there is still some lack of understanding even among respondents on why stigma and discrimination is an issue for HIV, with people arguing that everyone is treated equally in terms of access.

> *"Everyone has access to health services – and everyone can receive treatment and prevention programs and intervention to stop the spread of HIV" (In-country respondent)*

4.2.5 Equal Access (5.5)

When asked about current trends with regards to all populations, including vulnerable populations, having equal access to prevention, early diagnosis, and care, a few respondents noted that access remains an issue, in particular for key populations. This is linked to stigma and discrimination, as key populations may avoid seeking care if they worry about how they will be treated.

> *"But vulnerable populations avoid health centres, diagnoses centres, treatment – that is why we need FBO health providers to fight stigma and be places of security or safe spaces so that (people) can go without fear or shame of being stigmatized" (Global Staff)*

4.3 Effectiveness

While it is too early to comment on longer-term outcomes of the initiative (e.g. the extent FBOs have increased their capacity for scaled up engagement of FBO providers of HIV testing and counselling (HCT), prevention and treatment (2b1); the extent selected FBOs have improved their leadership and advocacy for Fast Track and ending AIDS by 2030 (2b2)), the activities to date have contributed to early indication of:

- Increased engagement of FBOs generally in the initiative, and among US black FBOs
- Increased awareness of global players (WHO, pharmaceuticals, FBOs) of pediatric care challenges and best practices resulting in the development of action plans around pediatric care and the Start Free, Stay Free AIDS Free Framework by PEPFAR and UNAIDS
- Knowledge development and sharing through documenting what FBOs do, and specific care models
- Increased understanding and awareness of the important role that FBOs can generally play in addressing HIV
- Development of some common messaging for FBOs to use (e.g. sermon messages)

Many activities have taken place that are intended to contribute to overall outcomes of the initiative. These are discussed below.

4.3.1 Results Achieved (2, 4[5])

Increased High Level Commitment in pediatric treatment at global and country levels (CARITAS) (2a1)

[5] The results from the interview question on unintended consequences (4.1) are included throughout the findings in this section.

CARITAS achieved results at both the global and country levels with a focus on pediatric prevention, early testing and treatment.

At the global level, CARITAS was provided a 250 000 US grant to undertake a three-day consultation from April 11-13, 2016 in Rome with various officials from PEPFAR, UNAIDS, UNICEF, WHO, UNITAID, Global Fund to Fight AIDS, TB, and Malaria, government officials, scientists, clinical experts, religious leaders, and officials of engaged faith-based organizations from Zambia, Uganda, Papua New Guinea, Vietnam, Colombia and between 70 and 100 participants were expected according to the concept paper. No record of the number of actual participants were provided.

" Objectives of the Consultation were to:

a) Examine the epidemiological trends of HIV infection among children and the successes and further challenges or obstacles in early diagnosis and treatment of such children;
b) Survey the current state of research aimed at achieving greater access to affordable, accessible, and acceptable, "child friendly" diagnostic tools and treatment of pediatric HIV and related co-infections;
c) Share obstacles faced, good practices realized, and other lessons learned by faith-based organizations engaged in early diagnosis and treatment of children living with HIV;
d) Reflect on the underlying values and ethical imperatives for faith-based organizations engaged in provision of diagnosis and treatment of children living with HIV and of support to their families and other caregivers."

The over 100 participants (no precise indication of their number, nor the list of their institutions has been provided) committed themselves and their institution to a number of actions and developed a road map for future action. That road map, originally proposed as a "Super Fast Track for Children Living with HIV" was further refined and launched in July 2017 as the Start Free, Stay Free AIDS Free Framework by PEPFAR and UNAIDS. As a result of these consultations, strengthened language on pediatric HIV was taken into the negotiations for the Political Declaration on AIDS and an interim target for 2018 included in the political declaration.

In addition, although this was not originally planned in the concept paper, two high level dialogues took place with CEOs of major Pharmaceutical companies resulting in increasing their awareness of the need to produce palatable and affordable HIV drugs for children. Subsequently under the AIDS-Free working group WHO has established a group called the Global Accelerator for Paediatric Formulations – and a platform on pediatric care has been put together. These outputs (using UNDG definition of outputs) may translate into lasting outcomes should the dialogue with pharmaceuticals be maintained.

> *"CARITAS did a spectacular job in convening people, used their influence at the Vatican. They gave us an opportunity to get the pharmaceutical companies to think more about it and take action" (Global Staff)*

"In order to promote wider engagement of national and local faith-based organizations as well as national governments and pharmaceutical and diagnostic companies", a second activity was designed by CARITAS Internationales and approved by UNAIDS to organize a meeting in Abuja with participants from DRC, Nigeria, and Zimbabwe. These countries were chosen as they have a high burden of pediatric HIV and were potential candidates for Phase II. This meeting was preceded by three national meetings (funded through the UNAIDS activity funding for Phase I), which brought together stakeholders from the national government ministry of health, CARITAS and other FBO health service delivery partners and young people living with HIV. The three national delegations to the multi-country meeting in Nigeria were selected by the countries themselves and these delegations presented the national situation pertaining to pediatric HIV and challenges in scaling up pediatric HIV treatment to the regional meeting. This resulted in significant learning and knowledge sharing between country delegations, and the participating delegations subsequently developed national action plans for FBO engagement in national activities to strengthen pediatric HIV treatment.

FBO leadership and Advocacy for Fast-Track and End AIDS (WCC-EAA) (2a2)

The following activities were planned in Phase I related to the immediate and intermediate outcomes:

- Hosting an interfaith pre-conference at the International AIDS Conference (July 17-22, 2016) in Durban, South Africa
- Hosting the Interfaith Prayer Breakfast and participation in the UN High Level meeting on HIV (June 8-10, 2016) in New York City
- The call to action by religious leaders and faith-based organizations
- Leading by Example: religious leaders and HIV testing campaign

There is some indication from interviewees that as a result of these activities, Phase I work has provided forums for engaged, visible, and strategic FBO leadership and advocacy for Fast Track and AIDS at the global level.

> *"I think that (this outcome) is a real success. We have seen the call to action that came out from the Prayer Breakfast earlier in the year that took place in the spring – and also the political declaration – and that call to action – went out through EAA networks and to all churches…and we saw strong supportive advocacy at the high level meeting through EAA" (Global Staff)*

> *"2016 was the year of international advocacy – so we had a UN General Assembly high level meeting on ending AIDS" (Implementing Partner)*

> *"Bringing faith voice at the international arena, high level arenas, the conference, in a very visible level, the Prayer breakfast, the political commitments – at multiple platforms, multiple contexts. This has been made possible because of the funding" (Implementing Partner)*

Respondents noted that this work brought the faith community together and provided a platform to work together in a visible way.

Policy Changes supporting Comprehensive Sexuality Education (CSE) in schools, including FB schools in Kenya and Zambia (WCC-EHAIA and WYWCA) (2a3)

This work was to include mobilizing young people through national faith networks in Kenya and Zambia to advocate for comprehensive sexuality education (CSE) in state and faith-based schools.

Work did not progress in this area. WCC attempted initial conversations in Kenya with government representatives, but the reception was negative.

> *"(It is a) sensitive time where national Faith leaders just put their foot down on comprehensive sexuality education – so WCC was going to go in and start to address that – but because the initial consultation was difficult – and the government just had national leaders say 'no don't do this'. What was perceived was that external people were coming in. This is sensitive…" (Global Staff)*

The language "comprehensive sexuality education" is also deemed to be a challenge.

> *"It is unfortunate that language of CSE – I don't think it has found a lot of acceptance in the faith community in Kenya" (Implementing Partner)*

However, there was also some confusion amongst global staff on the status of this activity in Kenya, as illustrated by the following quotes, since some cited that the CSE work will now not be undertaken and others citing that it was an ongoing effort:

> *"(This was) put on hold. Therefore it was not done and now it has been reprogrammed" (Global Staff)*

> *"It is an ongoing activity and effort" (Global Staff)*

The work on CSE was not carried out in Zambia given that projects were put on hold following the challenges surrounding the in-country consultation (see below for more details).

Hence, no progress has been made on policy change to support CSE in schools given the sensitive nature of this work as noted above.

Increased Capacity for Joint Action between Religious Communities and PLHIV for Increased Uptake HCT/Retention in Care (WCC-EAA and WYWCA) (2a4)

The deliverables as part of this work entailed two national inter-generational dialogues/consultations (one in Kenya and one in Zambia), four trainings (in Kenya and Zambia) to promote HIV interventions with young people/Frameworks for Dialogues, and capacity building activities to strengthen interfaith networks with PLHIV to mobilize for uptake of HCT and retention in care.

There was mixed opinion on the extent of gains made in capacity for joint action between religious communities and PLHIV for increased uptake of HCT and retention in care[6]. Some felt there was no change, others noted modest success, and others felt there was an increase in capacity particularly given the opportunities for convening religious organizations and leaders together.

> *"There has been some gain, certainly in inclusion and non-discrimination of people living with HIV, but very modest gains" (Global Staff)*

> *"There is definitely an increase (in capacity). A lot was on convening religious actors on these issues. They have been convened systematically. Opportunities for convening have been magnified. This is the most important outcome of this initiative. It is very important" (Advisory Group member)*

There was some indication that one result was increased collaboration and communication in some cases amongst those who attended consultations in Zambia and Kenya.

> *"Consultations (in Zambia and Kenya) brought strong collaboration between PLHIV and religious communities" (Global Staff)*

There were some anecdotal stories on uptake of HCT, where people cited going to get tested. As well, WCC-EAA reported testing 550 adolescents during the Day of the African Child in Nairobi, Kenya.

> *"Whatever information we have it is all anecdotal. What was reported during the meetings – there were constraints from young PLHIV in terms of uptake of HCT – however there were some positive stories in terms of young people who actually then went (after the consultations) and got tested" (Implementing Partner)*

> *"550 adolescents, young people and religious leaders tested for HIV – during the awareness raising activities in preparation of the celebration of the Day of the African Child in Nairobi – Kenya (16 June 2017" (Progress Report, July 2017)*

The national consultations with key stakeholders in Kenya and Zambia faced many challenges (which will be reported in more detail later in the report).

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[6] This wording is that outlined in the outputs of the draft results framework developed by UNAIDS.

In terms of opportunities for improvement, some key respondents (including in-country partners) noted the importance of:

- ensuring that global tools that are used in the consultations are adapted to the country context
- greater reach was needed to help to reach outcomes, as consultations only included limited number of people
- more follow-up was needed to help to reach outcomes, including reporting on the consultation, following up after the consultations, and having a strategy to get people to make commitments to change moving forward

"There was no post-workshop report, no summary" (In-country respondent)

Mapping of HIV Service Delivery and Documentation of Effective Models of Care (Emory) (2a5)

The activities under this work were to include fiscal analysis of FBOs health services (in Kenya and Zambia), and mapping and analysis of service provision by FBOs (in Kenya and Zambia).

In Phase I, there has been mapping of HIV service delivery and documentation of effective models of care in Kenya. There are two outputs from this work that have been produced. The website with the mapping and analysis of service provision by FBOs in Kenya is now live (www.ihpemory.org), and there is an accompanying publication in an academic journal[7]. It was noted that this model provides a platform that could be used elsewhere.

"I think the platform they developed for Kenya is excellent…super model for other work" (Global Staff)

However, given the recent release of these outputs, no outcomes from this activity have been reported as of yet.

This mapping work was not done in Zambia as was originally planned given projects were put on hold following the consultation.

PEPFAR did not provide access to the data needed to complete fiscal analyses work of FBO health services as originally planned, and hence this activity has not been done.

In addition to the work above, Emory has also been working on an outcome evaluation for the Framework for Dialogues in Kenya[8], and evaluating the impact and outcomes from the Lea Toto program[9] as part of understanding effective models of care.

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[7] Blevins, John, Mimi Kiser, Emily Lemon, and Ahoua Kone. 2017. "The percentage of HIV treatment and prevention services in Kenya provided by faith-based health providers." *Development in Practice* 27 (5):646-657. doi: 10.1080/09614524.2017.1327027

[8] See 2a4 and 2a9 for more details on the Framework for Dialogues. The Framework for Dialogues are a WCC-EAA tool developed prior to the Phase I Initiative. They "build…upon the results of the People Living with HIV Stigma Index. It uses these results generated by the national network of people living with HIV – complemented by other evidence gathered in the country – as a basis for guiding dialogue participants (both religious leaders and people living with HIV) from informal to formal discussions and actions, and from bilateral conversations to comprehensive and inclusive dialogue and collaborations (http://www.frameworkfordialogue.org/about/index.html).

[9] The Lea Toto Program in Kenya is "a community-based care program of the Children of God Relief Institute (COGRI) that aims to improve the quality of life for the children with HIV in its catchment area " (p. 6) (https://www.crs.org/sites/default/files/tools-research/approaches-of-the-lea-toto-and-aphiaplus-nuru-ya-bonde-programs-in-kenya-.pdf)

Accountability and Visibility of HIV work of FBHS increased (ACHAP) and Strengthened Integration of Health and Community Systems to Deliver Quality HIV Services (ACHAP) (2a6 and 2a7)

ACHAP's work in Phase I was to include the development of an online monitoring and evaluation platform for Christian Health Associations (CHAs) to report on key indicators to their national health systems (and to monitor and share CHAs contribution), to strengthen two CHAs' institutional capacity to deliver HIV programs (via mentorship), and to have 20 faith leaders (in Kenya and Zambia) engaged to link communities and health facilities for HIV services. ACHAP also holds a biennial conference of CHAs, and this conference was used as a venue for learning and skills-building training sessions for ACHAP member faith based health service organizations.

ACHAP has undertaken a number of activities including a meeting among CHAs in Lesotho in December 2016 to discuss the approach/model for mentorship. Work has also begun on the monitoring and evaluation (M&E) plan and draft indicators for the online M&E platform. A draft counselling guide in HIV for religious leaders is under development. This activity has changed from the original plan to train religious leaders in HCT based on a request from Kenya's National AIDS Control Council (NACC) as this would provide longer-term benefits.

The ACHAP contract and start date was delayed and activities are not yet complete; hence, it is not yet possible to outline results from these activities.

> *"(I) can't say after a year (that) we would have any evidence" (Global Staff)*

> *"We are only just starting – (I) can only envision what we see happening" (Implementing Partner)*

Based on the work done to date, there was some belief that visibility has increased, while others did not agree that visibility has increased yet given the activities are just getting started.

> *"Visibility has definitely increased" (Advisory Group)*

> *"Visibility hasn't increased yet" (Global Staff)*

Increased Awareness and Understanding of the Global HIV Epidemic and the Role FBOs can play – especially US Black FBOs (BAI) (2a8)

BAI was brought into this initiative to increase awareness among US Black Faith leaders of the ongoing global challenges to reach the 90-90-90 goals by 2030 and the role they have historically played in the US and could play internationally. BAI ensured connection with the global HIV arena by participating in High level meetings (International Aids Conference in Rome (UNAIDS meeting in April 2016), Durban (July 2016), and New York (High level meeting in June and the Interfaith Prayer Breakfast in September 2016 and shared information with US Black Faith communities through a series of conferences (10) across the US, reaching 328 participants. An African Diaspora Roadmap was developed, presented at these meetings and shared widely.

BAI paid attention to the need to share the information widely and involved media at their events and ran public articles.

There was an unintended positive result from BAI participation to these high level meetings. BAI met with RHAMA at the Interfaith Prayer Breakfast, and helped RHAMA with the organization of the first national FBO HIV Awareness Day that took place in several US cities between the end of August and early September 2017 (not related to this project), with 150,000 participants.

However, there is no documented evidence at this point of a significant increased awareness/understanding

by US-based Black faith organizations and the international community of the important role US FBOs can play in the HIV response.

Increased Evidence on Reducing Stigma and Discrimination, Gender Inequalities, GBV in Communities (WCC-EAA, EHAIA, WYWCA, Emory) (2a9)

Respondents identified that tools were used including Contextual Bible Study and Frameworks for Dialogues, and safe spaces were created for discussion on stigma and discrimination in the consultations in Zambia and Kenya. Respondents noted that this was particularly focused on stigma and discrimination reduction for people living with HIV as well as adolescent girls (as opposed to a focus on other key populations such as men who have sex with men, people who use drugs, and commercial sex workers).

> *"The initiative created spaces where people listened to stories of people living with HIV – I think those spaces have been great in terms of bringing in people who speak publicly about their status…The fact that you are creating spaces for adolescents (too)" (Implementing Partner)*

> *"The Framework for Dialogue approach has really opened up the space to engage in stigma reduction in a way that has not been done before" (In-country respondent)*

Adolescent girls were involved in the consultations including the country consultations in Kenya and Zambia and in the Frameworks for Dialogues. While respondents noted that the focus of this work was not on other key populations, they did note that a few attendees of the country consultations included people from other key population groups.

See the section on gender and human rights for additional information.

Actions to Address Stigma and Discrimination in Communities and Health Care Settings Implemented (WCC-EAA, EHAIA, WYWCA, Emory) (2a10)

Emory's work in this area was to include a survey on stigma in FBO health care setting, and curriculum to address stigma in health care settings.

The purpose of the curriculum research is to identify best practices in working with key populations for future curriculum development to address stigma in healthcare settings. Work is underway in this area by St. Paul's University (one of the Consortium members) where qualitative data has been collected and data is being analyzed.

The survey on stigma in the FBO health care setting did not move forward as outlined in the original concept note. This decision not to move forward on this specific activity was made between the country partner (Christian Health Association of Kenya – CHAK) and Emory given sensitivities raised by CHAK of the context of working with particular populations (e.g. MSMs). Instead, it was decided to undertake a survey on providers' knowledge/skills working with key and vulnerable populations. The survey on providers' knowledge/skills working with key and vulnerable populations has now been completed and the data analysis is underway.

Given the stage of these activities (analysis of the data collected is currently underway), it is too early to comment on outcomes at this time.

One challenge the Academic Consortium faced in Phase I was the inability to secure ethical approval in Zambia for work involving key populations (e.g. men who have sex with men).

4.3.2 Knowledge Sharing (2a11)

Knowledge sharing has occurred between some implementing partners and in some of the broader

consultations (e.g. the global consultations, the Durban conference), as well as for some capacity purposes (e.g. between the Academic Consortium and some of the other IPs including ACHAP and WCC).

However, a number of respondents felt that knowledge sharing between IPs has been too limited.

> *"We have not been privy to a large (amount of) knowledge sharing – just the Rome meeting, and coordination at the New York breakfast" (Implementing Partner)*

In addition, a few respondents noted that external communication of the initiative overall and the work of Phase I would be useful to increase visibility of the work and encourage others to build on the work of the initiative.

> *"We should have developed a communication strategy on the initiative to give more visibility on all the work done and inspire similar activities from other organizations" (Implementing Partner)*

4.3.3 What Worked Well (3.1)

Respondents were asked what worked well in Phase I. In addition to the areas identified above, particularly some key activities (e.g. consultations, meetings, data collected for use in the next Phase); collaboration, communication, and engagement that had not occurred before, and alterations to plans made to adapt to the contexts, some felt that the right partners were at the table for what the initiative was trying to achieve. There was also a perception that it was the right timeframe to bring together FBOs to develop a large scale initiative and address the lack of data in this area.

There was determination amongst the various players to make this initiative work and *"to provide information in a way that PEPFAR and UNAIDS wanted it" (Implementing Partner).*

4.3.4 Challenges Faced (3.1)

A number of challenges were identified by respondents. As noted above, there were challenges identified in terms of the suggestion that it is too early to identify outcomes given that work has only been underway for a short period of time, that in some cases language (e.g. CSE) and working with certain key populations (MSMs) may prove to be issues when working with partners in-country, and that more sharing of knowledge between IPs and also externally would have been useful.

It was felt that not all key FBO players had been involved in the initiative. This included inclusion of all local key stakeholders, as well as limited involvement of non-Christian FBOs, resulting in insufficient inclusion of other faiths beyond Christian at all levels (global and national). While efforts were made during activities to include other faiths (particularly Muslim participants), many respondents indicated that it would be important to better involve other faiths.

> *"Holding these meetings at the Vatican may give the perception that it is organized by the Catholic Church for the Catholics, although other faiths were invited" (Advisory Group)*

> *"We need to look at even in SSA context – FBO Christian focus – Christianity is largest provider of FBHS in that part of the world -but we don't have partnerships to understand Islam and others – Year Two" (Implementing Partner)*

In Zambia, a few respondents felt that an Implementing Partner did not having sufficient contacts in the country to undertake its activities effectively.

As discussed above, country ownership and integration into current systems was a challenge in Phase I since:

- The planning process did not allowed for sufficient time to consult with national stakeholders.

- During implementation, some existing platforms, including National AIDS Councils and country level UNAIDS and PEPFAR, and some key FBO platforms, were not adequately involved. This resulted in many planned activities in Zambia not moving ahead given the challenges with the planning of the national consultation.
- There was lack of reporting back to attendees (and more broadly) on the country consultations, and lack of follow-up for action.

Lack of data to support the work of this initiative continues to be a challenge, from country health systems and from religious organizations, as they hesitate to release the data they have. PEPFAR also failed to provide needed data to the Academic Consortium for one of their key activities as noted above.

Some respondents noted there was too much rigidity with the funding, which did not allow for reallocation of funds based on needs. For instance, a few respondents thought that funds that were not used in Zambia could not be reallocated to their own work in Kenya.

A few respondents felt that there was insufficient funding for local partners who were subcontracted for some of the activities in Phase 1, which could have impact on the quality of the work done:

> *"(Difficult for) organizations like us to hold workshops when we have nothing to give the project officers who are running the programs – that is a huge gap and it compromises the quality of the program itself" (Implementing Partner)*

The challenge with the timing, namely the lengthy processes to get funding approved, then activities having to be implemented in too short of a timeframe, was also identified as a challenge.

Communications were also identified as more challenging when IPs were working in consortiums with multiple global or local partners on various activities.

4.3.5 Gaps in Activities (3.2)

Many interviewees mentioned that there were no gaps in terms of activities, and given the money available, it would not have been possible to add any additional activities.

However, a few gaps were mentioned by others, including:

- Local partners would have needed training and support to better support and implement activities
- More activities to involve and engage with other faiths at both country and global levels
- Training of Muslim women to provide care to their peers to be sensitive to their specific needs and religious culture
- Communication between projects undertaken by IPs and having dissemination activities on lessons learned, collected data, roadmaps, etc. for a wider informed public, both globally and in targeted countries
- Stigma and discrimination were not addressed sufficiently

4.3.6 Gaps in Partnerships (3.3)

Many interviewees mentioned that there were no gaps in terms of partnership, and that people were doing their best to work together given the multiplicity of stakeholders. Some others did not have an opinion.

However, a few gaps were mentioned, including:

- Needing to build program level coherence and better communicate between partners so that each partner knows how their work feeds into the bigger picture: *"We have a series of individual projects and we need to make them globalized" (Global Staff)*
- A disconnect between HQ and country offices and *"need to clarify how country level UNAIDS offices are part of the effort, if they are" (Implementing Partner)*

- Needing to be more inclusive (including for local FBOs) and develop a global approach to multiple faith involvement (as identified above). It was identified as an issue that most of the IPs were based in the North and were Christian-oriented, although a few noted some interfaith inclusion e.g. involvement of INERELA, ZINGO, and a few non-Christian attendees at consultations
- Needing UNAIDS Secretariat to bring in the convening power of UNAIDS, which is a multi-stakeholder organization, at both global and country levels

4.3.7 Gender and Human Rights (11)

Respondents were asked "In your opinion, how were gender and human rights addressed? What activities were undertaken to address gender and human rights? (e.g. including amongst marginalized/vulnerable/key populations including adolescents, MSM, PWUD, sex workers)? In your opinion, from these gender and human rights activities, were there any concrete results? If yes, what were these? How were results measured?"

The WCC had a focus on gender in their consultation work using contextual bible study (CBS), with the pastoral letter and talking points, and with the involvement of female adolescents from the WYWCA in consultations and recent male engagement work (July 2017). It was noted that a few stakeholders from key population groups also attended the consultations.

> *"Gender was front and centre in WCC's activities. It was not implied, it was a question of gender equity, and rethinking problematic teachings in religion" (Implementing Partner – not WCC)*

The research by St. Paul's University (discussed above) examines issues of stigma and discrimination for key populations. In addition, the research with ACHAP, CHAK and Emory will provide information to work with health service providers in Phase II.

> *"(We) plan to work with health facilities now that we see from this study – then we will be work towards helping health workers to have skills and knowledge to be able to help key populations" (Implementing Partner)*

It was also identified that health care services are provided by FBOs regardless of population, but that the terminology of human rights and gender might not be used (and might in fact be challenged):

> *"I may not talk HR and gender – but we offer all service to all people and we don't ask" (Implementing Partner)*

> *"Human rights discourse is met with resistance – even with faith-based partners who are advocates for human rights in general and would include that for women and sexual minorities such as LGBTQ. When (one) uses human rights to challenge religious teachings – religious communities will be resistant to some of those messages. This initiative helps to address these issues on an insider basis – by using religious teachings and practices to further human rights but using rhetoric of religion to do so" (Implementing Partner)*

Hence, as the quote above identifies, there were a few respondents who felt that some activities in Phase I employed religious teachings (e.g. WCC's work) to address these issues.

On the other hand, a number of respondents noted that gender and human rights was not a major focus for Phase I, and as such some IPs and global staff noted that limited results were seen in this area in Phase I.

> *"They have not been a particular focus of the pieces I have focused on" (Implementing Partner)*

> *"Not a primary focus of this initiative" (Global Staff)*

For some respondents, there is a limited understanding of what integrating gender and human rights means for this initiative. For example, including both males and females or key populations as participants in consultations was sometimes deemed by respondents as addressing gender and human rights.

> *"I think we included members of both sexes and all different vulnerable populations in our work – they were included" (Implementing Partner)*

It was clearly identified that major challenges still exist in FBOs engagement with key populations, particularly men who have sex with men (MSMs), people who use drugs (PWUDs), and commercial sex workers (CSWs).

> *"The other thing they (FBOs) are categorical about – they will never engage in, or be involved in advocating for rights of MSM or WSW (women who have sex with women) nor transgender and all that – that is not our space, we will never do that – we will not be involved in propagating the rights of that side of Key Populations – but the faith communities are open, come and worship - no one will close the faith community to you" (In-country respondent)*

In terms of concrete results, there were varying opinions about the extent of results from Phase I on gender and human rights, including:

- Human rights and gender were addressed through some of the activities to date,
- it was "too early to say" in terms of the work of gender and human rights (Global Staff),
- measuring the results of work on gender and human rights results is a challenge, and
- that respondents did not feel they could comment on the results with regards to gender and human rights as they did not have sufficient information

Sex-disaggregated data was not provided in reports, nor was gender and human rights a focus of reporting.

4.4 Efficiency

4.4.1 Governance (6.1, 6.2, 7.1)

This section covers the following topics: Roles and responsibilities between UNAIDS and PEPFAR, role of the Advisory Group and the Implementing Partner and project selection processes.

UNAIDS and PEPFAR

Most interviewees thought that the roles and responsibilities between the two organizations were clear, although they had not seen these clearly outlined on paper. First, it is clear between the two organizations that UNAIDS was selected by PEPFAR (initiator and funder) to manage this initiative and is therefore accountable to PEPFAR. The daily management lies with UNAIDS. All interviewees knew that daily, administrative and financial matters were under the responsibility of UNAIDS. However, on the technical aspects, opinions and perceptions varied as both organizations interacted directly with IPs on activities. Although this was not reported as being a major issue, it may be useful to delineate more clearly the roles and responsibilities of each organization.

Draft ToRs for the Advisory Group (AG) were presented at the Durban Advisory Group meeting in July 2016. They were never finalized as AG members did not provide comments. This document, provided to the Consultant late October 2017, provides an overall management plan. The section identified as "Monitoring of Reporting Modalities" has a sub-section on "Program Leadership and Oversight" that puts UNAIDS and PEPFAR at par to manage and coordinate the initiative. In other words, on paper, there is no distinction between PEPFAR and UNAIDS, and there is no description of roles and responsibilities regarding administrative and financial management.

Advisory Group

The role and responsibilities of the Advisory Group did not seem to be well understood by many of its members, although UNAIDS provided draft ToRs on July 18, 2016 at the Advisory Group meeting in Durban. No comments were received and that draft was never finalized. The Advisory Group did not seem to have functioned very well. A sample of key comments include:

- The role was not clearly spelled out, nor its composition
- Some members did not know there was an Advisory Group while others did not know they were part of it
- The group did not meet frequently or regularly – perhaps just one face to face meeting and a few Skype calls, but it was not clear that these were Advisory Group meetings or simply IP meetings
- It was unclear what the Advisory Group was advising on. It seemed to be more activity-oriented than looking at the big picture of the overall initiative
- The need to give more notice for meetings and ideally have a workplan and allocate some resources, especially for non-IP participants who do not have necessarily the resources to attend to Advisory Group activities
- Minutes from meetings should be provided

Some Advisory Group members did not know that IPs were required to prepare reports, and they have not seen any reporting.

IP and Project selection process

PEPFAR, in discussion with UNAIDS, decided on the needs that the initiative was addressing – basically to bridge the data and knowledge gap identified by the Lancet articles – and selected organizations they already worked with that could effectively undertake needed activities based on the following criteria:

- Range of relationships (global reach) and membership
- Convening power
- Geographic footprint
- Existing databases of contacts and academic data
- Previous working experience in partnership with PEPFAR and UNAIDS

Both organizations documented the selection of Implementing Partners to their respective authorities. However, the IP selection rationale was not explained to project stakeholders and many interviewees had the perception that it was a top-down and not a very transparent approach. IPs were told that they were chosen.

Phase I was meant to be mostly global, with activities in two countries: Kenya and Zambia. Activities were added in additional countries: Uganda, Rwanda, Nigeria (with participants from Rwanda, DRC and Zimbabwe). The country selection criteria were not very clear, other than they should be selected among PEPFAR focus countries.

4.4.2 Management (7.1, 7.2, 7.3, 7.4)

This section covers the overall management of the initiative in general, the project approval process, communications, reporting and monitoring.

Overall management: PEPFAR contracted the UNAIDS Secretariat to manage this initiative. This proved to be difficult at the beginning as the UNAIDS Secretariat is not necessarily experienced in project management. The level of daily management required is disproportionate to the size of grants as 2 million USD is split between five (5) organizations, including consortiums and 14 different sub-projects. In September 2016, a consultant was added to help the senior technical adviser with the workload.

The project approval process was led by UNAIDS, going through their internal Project Review Committee (PRC). No guidelines were provided upfront to the IPs on the concept paper development, who did not know UNAIDS' requirements. This resulted in much back and forth to respond to PRC comments. The entire process seemed a bit cumbersome to most respondents and took three (3) months from start to finish. The PEPFAR technical team also made comments on all proposals and budgets.

Internal communications between IPs and UNAIDS for ongoing daily management were generally very good. IPs received timely responses and this was much appreciated. As noted earlier, communications between UNAIDS and its country offices and PEPFAR and its country offices were quite insufficient as they were not informed of Phase I in a timely manner. Communications with country partners were also problematic.

> *"I think interpersonal communication with in country partners could be better – that caused huge problems, didn't take the time to sit down and engage properly – we are doing exactly same things for Phase 2 – (it is a) manic rush" (Implementing Partner)*

Reporting was perceived as being sufficient by most stakeholders, but some suggested more frequent reporting on activities, as one report at mid-point and one final report almost a year later proved to be insufficient for the needs of the evaluation, and for the need of reviewing Phase II concept papers. Hence, a third report was requested by UNAIDS at the last minute. From the document analysis, it is clear that the format provided by UNAIDS was not followed by all IPs.

Monitoring: When asked about monitoring, respondents usually referred to the daily management and this seems to have worked well in general.

> *"The work was done very closely with UNAIDS and PEPFAR, so there was no need for a secondary monitoring process. And they were able to monitor us in real time" (Implementing Partner)*

One IP mentioned that they would have preferred monthly check-ins.

> *"We should not have to wait till the end of year to find out what is going on" (Implementing Partner)*

4.4.3 Extent planned activities occurred and funded initiatives achieved the expected outputs within the expected timeframe (8, 9)

As outlined in sections above, most planned activities did occur during Phase I. However, there are still some activities that are underway (e.g. ACHAP activities noted above are in progress as the contract was signed late and activities began late as a result; the Academic Consortium is analyzing data to support the work of the curriculum developed to address stigma in health care settings and the survey on providers' knowledge/skills working with key and vulnerable populations).

The main exception where activities were not completed lies with the Zambia projects. For example, the mapping and analyses of service provision by FBOs in Zambia (by the Academic Consortium) and the work on comprehensive sexuality education (by WCC-EHAIA) in Zambia was put on hold by UNAIDS/PEPFAR given the challenges stemming from the work led by WCC on the country consultation.

> *"All work stopped in Zambia – they (stakeholders in Zambia) wanted to do their own MAISHA plan – and decide priorities before external partners came in… Zambia said leave us to do our own thing" (Global Staff)*

Some of this funding was reallocated for UNAIDS in Zambia to work with the Zambian government to hold a

workshop to develop a MAISHA-type FBO plan[10] (NAC document outlining the faith sector's response to HIV) in August 2017.

In another case where an activity was not completed, data from PEPFAR was not obtained by the Academic Consortium to conduct the fiscal analyses of FBOs' health services. In Kenya, there was resistance from the Kenyan government to have an outside partner come in to work on Comprehensive Sexuality Education (CSE) as part of the work of WCC-EHAIA given the sensitivities on this topic in the Kenyan context.

Other changes to activities included a change made to the activities to reflect local FBOs' feedback. The Academic Consortium had a change in activities from conducting a survey on stigma in Kenya to conducting a survey on providers' knowledge/skills working with key and vulnerable populations as, in discussions with CHAK and Emory, the topic area was felt to be very sensitive and hence a mutually agreed upon way to proceed was discussed where clinical skills to provide quality care to key populations would be the focus.

Additional activities took place such as the Nigeria regional consultations on pediatric care undertaken by CARITAS. This was a reallocation of funds as the Rome meetings did not require the full amount of allocated budget given that additional partners co-funded the activity. In other cases, in-kind support was provided in addition to planned work. For example, Emory provided support for the Evaluation of Frameworks for Dialogue model of the Ecumenical Advocacy Alliance.

4.4.4 Value for Money (10.1, 10.2, 10.3, 10.4)

Value for money refers to the appropriateness of the management of financial resources, the efficient use of these financial resources and the efficient choice of activities.

Management of financial resources – efficiency and cost effectiveness. The lengthy approval process requiring a lot of detailed budgeting and delays to send the first payments created a huge problem, with significant consequences: some IPs had to pre-finance activities, others had to delay them or had to unfold them in a much shorter period. A look at funding agreements (see Annex F) demonstrates that sequencing of payments varied between IPs. The percentage of overhead varies for IPs between 5% and 7%. What falls under the overhead varies as well. In some cases, an audit is to be covered by the overhead, while in another case, it is a separate budget item under the activities. In the budget of activities, some IPs have included the time spent by their staff to manage and participate in activities, while others did not. Some respondents noted they received very little administrative costs to support sufficient staffing of the project.

"We have been incredibly frugal. We got a lot for our money with this little grant" (Global Staff)

A few respondents reported that there was not enough flexibility to move money around in line with evolving requirements. Requiring the approval of the UNAIDS finance department slowed things down. How decisions were made and communicated around the reallocation of unspent Zambia financial resources were reported as the greatest frustration in this area. However, some IPs did not report any difficulty in getting approval to modify some budget items.

Generally, budget management and reporting was considered fine. The overall percentage of funds allocated to overhead is impossible to calculate with accuracy as CARITAS overhead is not indicated in its financial reports and UNAIDS use of 334 159 USD allocated to project coordination, but also direct activities is not known to the Consultant. Between 13% and 15%, including 7% going to UNAIDS, is within standards for overhead (and generally on the low side by comparison to other similar international projects).

Efficient choice of activities: At the global level, many felt that it was the right fit for the needs. At the country level, many respondents noted that work should have been done in closer consultation with local

[10] http://nacc.or.ke/faith-based-organisations/

partners, NACs, and faith-based technical working groups (TWG) (where available), and country-level UNAIDS and PEPFAR.

4.5 Sustainability

Sustainability can be defined by the likelihood that activities will continue beyond this initiative and that outcomes will be sustained. Consultants analyzed sustainability using the following angles: likelihood that FBOs will sustain their activities beyond Phase I, that outputs and outcomes are likely to sustain themselves, the extent to which supporting systems are in place and finally, the organizational and contextual factors that affect the sustainability of this initiative.

4.5.1 Likelihood of FBOs sustaining activities given their human and financial resources and that outputs and outcomes can be sustained by themselves (12.1, 12.2)

With this initiative, some results achieved at the global level are more likely to be sustained than those at the country level. In some cases, activities are grounded in the institution, and are likely to continue. For example, respondents noted that curricula developed, roadmaps and databases developed, and testing campaign materials that are available and disseminated will continue to be used and influence how FBOs work even at the country level. Sometimes actions leading to attitudinal and language changes, as well as pressures put on faith or political leaders, can be effective while not requiring additional financial resources. While larger organizations are more likely to sustain activities as they integrate them into their regular strategies and work programs, others rely entirely on external funding. In these cases, it is unlikely that activities will be sustained after the end of the initiative.

However, the short-term nature of projects in Phase I (and moving to different countries in Phase II) could negatively affect sustainability.

At the country level, activities undertaken in Kenya and Zambia are much less likely to be sustainable as they were not undertaken with the country systems and institutions (and in the case of Zambia, limited activities were undertaken). Once capacity is built, demand of HIV/ AIDS services is built, and owned by congregations and National AIDS Councils, it gets picked up and work continues, although funding is needed for printing and reproducing tools. Turnover (staff, leadership) can be an issue for capacity that is built, so ongoing capacity building is needed.

Some activities (e.g. consultations) were viewed by in-country respondents as “one-off” with limited follow-up, resulting in no sustainability.

> *“Sustainability to me is a challenge – if consultations are on a one-off basis...(Participants) will say yes (we will) do it, ...but there’s no ownership there” (In-country respondent)*

Respondents noted that as the world is facing many new challenges, and the number of new HIV infection is decreasing as well as the number of people dying from AIDS, attention is elsewhere and funding for HIV is decreasing. However, HIV/AIDS related needs remain. Local organizations have to compete to get funding and sometimes present projects on other topics such as climate change and find a way to include HIV in order to get funding to address their work for HIV/AIDS. This is a serious challenge. FBOs are also working in several fields and HIV is not necessarily their focus area.

4.5.2 Extent systems in place to sustain the initiative (12.3)

UNAIDS and PEPFAR have been working with FBOs for more than 15 years. As recognized by the two

Lancet articles referred to earlier in this report, FBOs play a significant role in providing health services and can positively or negatively influence stigma and discrimination at the time when it is crucial to identify and provide treatment to key populations. 90-90-90 by 2030 will not be achieved unless all parties play their role.

At this time, not all systems are in place to ensure the sustainability of the results of this initiative. But initial steps have taken place, including gathering country-level data on health services of FBOs in Kenya. Kenya included FBOs in the preparation of their national HIV/AIDS strategy and put in place interfaith platforms. PEPFAR has a data collection system on the provision of HIV/AIDS related services by FBOs in their focus countries in place, but needs to revise it (mainly a coding issue) to fill identified gaps.

Institutions in developing countries increasingly integrate new language to reduce stigma and discrimination and new practices into their systems. This new language has to be taken on board by global organizations like UNAIDS and PEPFAR, in order to induce lasting results. Curricula in schools, including faith-based schools should integrate education about HIV prevention, care and work towards reducing stigma and ensure people are not afraid to get tested.

There are no existing mechanisms to ensure networking and sharing knowledge between all stakeholders at both global and country levels.

4.5.3 Enabling contextual and organizational factors (12.4)

It was felt by IPs that continued sensitization of religious leaders was needed, so that they can provide leadership and influence policy and address stigma and discrimination, and ensure HIV/AIDS becomes an important part of the mandate of the major FBOs, as it is not necessarily the case at the moment.

Ensuring integration of activities and interventions with country-level systems is key to long-term sustainability.

It was noted that there is a need to empower local organizations beyond IPs and build their advocacy capacity. It was felt that this requires minimal resources as it could be done as simply as bringing them together a day before an international conference so that they can build their position together.

5 ANALYSIS AND RECOMMENDATIONS

5.1 Analysis

5.1.1 What worked well

This initiative was timely to respond to a documented analysis that: FBOs generally play a key role in HIV/AIDS prevention and response and need to be more aware of their impact, FBOs need to change their language and practices to better address stigma and discrimination and to be better integrated into the country level systems. This initiative has clearly created the space for more interaction between the key FBOs that were selected as IPs, has started to engage more significantly the Black AIDS faith community, has successfully put more international pressure on pediatric prevention, diagnosis and care, involving major international players, and started to document what FBOs are doing on the ground and best practices. This initiative is relevant to the global objective to end HIV/AIDS by 2030 and to increase the relevance of PEPFAR and UNAIDS' work.

5.1.2 Challenges

Given the innovative aspect of this initiative and its short duration, there were key challenges that can be learned.

Knowledge sharing and communication:

There is a need for more systematic knowledge sharing opportunities. It is felt that this would assist in ensuring a more coherent overall initiative, versus more disparate, unconnected projects.

More systematic knowledge sharing requires planning and time to occur. The focus of this sharing could be on discussing: results, best practices, lessons learned, and synergies; to support each other's work; and for networking purposes.

Country ownership is key to engaging country stakeholders, ensuring alignment with their work, and ensuring sustainability. In addition, selecting IPs that are well connected on the ground in country is important. These are areas that need improvement for Phase II as outlined above.

Multi-faith involvement: Although many efforts were made by IPs to include other faiths than Christianity, and UNAIDS reinforced this, it remains the fact that the entire budget was allocated to Christian organization IPs, and this was perceived as problematic. It would be appropriate to include at least one global Muslim organization in Phase II as an IP.

Results management: A logic model for Phase I was suggested by consultants with the Inception Report. The draft results matrix for Phase II proposed by UNAIDS/PEPFAR does not reflect UNDG guidelines. Appendix A presents a revised version that is more aligned with UNDG guidelines. However, the evaluators maintain that these represent very ambitious expected outcomes, not commensurate to the size, scope or timelines of the evaluation. At the September 12, 2017 meeting with the Advisory Group, evaluators learned from PEPFAR that the goal of Phase I was to be a pilot project, to try different initiatives with different partners to see what may work well and could be scaled-up in future funding. This approach did not seem to have been communicated to project stakeholders, including UNAIDS, and would command a different results framework, aligned with this goal.

5.1.3 Governance

PEPFAR and UNAIDS respective roles and responsibilities: Although there were no significant problems reported, the reality does not seem to be aligned with what is on paper on both the draft July 2016 TORs for the Advisory Group, and the September 2017 concept note. Both papers call for no distinction between the two organizations. In reality, it seems that UNAIDS is the day-to-day manager and coordinator, while both organizations provide technical advice. These roles should be clarified.

Advisory Group: It became quite clear that the Advisory Group was not a success: in spite of attempts from UNAIDS, there has not been an agreement on its role, it did not meet regularly and there is no formal record of its meetings. Its composition is quite large and includes IPs, which makes it difficult to schedule meetings and avoid potential conflict of interest (although nobody raised this issue). Its role seems limited to providing technical advice, mostly on activity planning. Knowledge sharing was not addressed as an Advisory Group responsibility. Perhaps there should be consideration to having two versions of the Advisory Group: 1) a core group that would not include IPs, and 2) the Advisory Group+IPs as is the current situation. In reality, some documents provided by UNAIDS refer to both. The Advisory Group (core group) could then fully play its role as strategic advisor, review concept papers, reports from IPs, advise UNAIDS and PEPFAR on project allocation and reallocation, and meet bi-monthly (conference calls). The AG core+IPs would be more dedicated to knowledge sharing and meet quarterly. In any case, the Advisory Group should not advise on the details of each event, as it does not meet sufficiently frequently, either physically or virtually. Having an AG core group would also help avoid any conflict of interest.

5.1.4 Management

Overall management: There is nothing significant to report, other than the perception that it was a big learning curve to manage a series of small grants to 5 IPs with a total of 14 subprojects.

Project approval process: In reviewing concept papers, one realizes that they vary significantly from one another, both in terms of structure and quality of content. Although individual projects are part of a larger program, individual concept papers did not relate their specific objectives to the larger overarching program objectives. In addition, from the analysis of the documentation provided by IPs, there seems to be a limited understanding of basic logic model concepts and language.

By general international development organizational practices, it is not unusual to take three (3) months to approve projects. But given the total length of the Phase I – only 12 months – this reduced significantly the time available for the implementation phase. Some IPs like BAI had to spread their activities over a very short timeframe, while others seemed to be allowed much more time.

Communications: The evaluation clearly demonstrated that communications between project stakeholders (IPs, UNAIDS, PEPFAR) should be improved, both vertically, between UNAIDS and PEPFAR headquarters to their field offices, and between UNAIDS and PEPFAR country offices, and between UNAIDS/PEPFAR and IPs to ensure that there is a stronger understanding of the overall initiative.

Reporting: UNAIDS requirements were not sufficient to allow good reporting, but more importantly, it was probably difficult to report on results achieved when these had not been well identified in the first place. There were lists of wrongly labelled outputs and deliverables – and no outcomes in the concept papers. UNAIDS provided a list of indicators, but they were not related to any specific outcomes, nor outputs. Many IPs did not report the number of participants involved in their activities, but some, like BAI, did. In some cases, IPs tried to evaluate their activities by having participants complete evaluation forms. However, the results of these evaluations were not provided in the IP reports. The Framework for Dialogue conducted an impact assessment of their process in Kenya and further work on this is being undertaken by Emory. No IP provided any sex disaggregated data – nor was it required by UNAIDS. However, this analysis is based on the main bodies of IP reports only, as the annexes to IP reports were not provided to the Consultant. Frequency of reports should be aligned with the frequency of Advisory Group meetings and UNAIDS/PEPFAR check-ins.

Monitoring usually refers to performance based monitoring or results based monitoring. There is no evidence that this happened as expected results were not clearly defined (both at program and project levels) when projects were being planned and there is very little reporting on results. In the end, there was no performance reporting as reports were mostly activity based. It would have been difficult for UNAIDS or PEPFAR to 'check-in' on results achieved. However, with a multiplicity of relatively small (budget-wise) projects with multiple stakeholders at various levels, it is challenging to have the right level of monitoring that will not overburden IPs, yet still providing the right information at the right time to take corrective measures if required.

Were planned activities achieved? In most cases, planned activities were achieved, with the exception of important parts of planned activities in Zambia (as noted above). There were delays in a few other cases, such as the signing of the ACHAP contract and hence their activities. There were additional activities undertaken, such as CARITAS' second project, which allowed for consultations in Nigeria with a few countries in preparation of Phase II, which is very positive. It would have been preferable though to document how decisions were made related to budget reallocation and the undertaking of new activities and how they contributed to the initiative overall objectives. There is limited evidence that activities achieved (deliverables) resulted in any significant outputs (defined by short-term change in targeted populations by UNDG definition (from event participants and their organizations)) but some respondents noted that not enough time had passed since the start of the initiative. But activities at the global level show higher signs of results achieved (see the results section for more information on results).

There were indications that some activities were redesigned based on needs at the country level, adapting to the context. However, for other activities, challenges were met when the needs of the country level were not adequately considered. More time will be needed to understand the full impact of Phase I on outcomes.

The consultant wonders if it was it cost-effective to initiate new activities, while some existing activities in

Kenya, for example, would have needed more financial support to produce sustainable results.

Value for money: Although it is not possible to establish the precise amount of funding that was allocated to IP activities versus management and overhead, the choice of activities were usually relevant, particularly at the global level. In addition, there was good control over expenses. We can conclude that overall, there was good value for money. However, in the future, it would be preferable to have more consistent payment schedules throughout IPs, and ensuring that they have sufficient funding to undertake their activities. Their management fee should be the only cost left to the final payment. In addition, identification of costs to be included in the overhead versus the activity budget should be consistent across all IPs.

5.1.5 Sustainability

It is very difficult, and premature, to assess the sustainability of such a short term and small initiative, divided between five (5) IPs, including two consortiums and 14 sub-projects. However, there are indications, as mentioned in section 4.5, that parts of this initiative can become sustainable, should there be further support (Phase II), a modified approach to activities at the country level and a more general buy-in and integration of knowledge, roadmaps, and new language with regards to stigma and discrimination with all project stakeholders (UNAIDS and PEPFAR, IPs, and FBOs they work with.

5.2 Recommendations

Below are recommendations from the consultants based on the findings and analysis. The recommendations from this report should be reviewed by UNAIDS and PEPFAR for decisions on next steps as they relate to Phase II as well as future work. UNAIDS and PEPFAR staff may already be addressing some of these recommendations for Phase II. Given the short-term nature of the project and the fact that planning of Phase II is well underway, many recommendations are high priority and short-term (within next two months at most).

#	Recommendation	Priority (High, Medium, Low)	Timeframe for Implementation (Short, Medium, Long-Term)
	Relevance and Effectiveness		
1	There is a difference in opinion between PEPFAR and UNAIDS on the scope of work. UNAIDS and PEPFAR should clarify the scope of this initiative – including Phase II. If it is meant to pilot and innovate to learn how to scale up in the future, expected results and activities should be aligned accordingly.	High	Short-term
2	UNAIDS and PEPFAR should ensure sufficient time to address concerns from Phase I before starting Phase II to ensure Phase I challenges are addressed, including ensuring adequate time on needs assessment and consultation with countries to ensure: • PEPFAR and UNAIDS at country level engaged • National AIDS Councils are involved (and linked to FBO framework if applicable) • Implementing Partners connect with all relevant FBOs in countries, including interfaith connections • Flexibility from IPs to adapt tools and processes based on country needs • Rationales for why each country is chosen, and whether it is better to stay in Phase I countries (to try to achieve outcome/impact) versus moving on to new countries and risking lack of continuation • Transparent processes for selecting IPs	High	Short-term

#	Recommendation	Priority (High, Medium, Low)	Timeframe for Implementation (Short, Medium, Long-Term)
	○ Consideration for activities that will have a longer-term impact, such as staying longer in a country and developing local capacity Note that these results were discussed at the September 2017 Advisory Group meeting, and PEPFAR and UNAIDS committed to continuing to address issues moving into Phase II.		
3	UNAIDS and PEPFAR should ensure timelines and resources match with expectations including adequate time for Phase II activities to realize outputs and short- and medium-term outcomes. Schedule payments to IPs do not need to be exactly the same, but should ensure that IPs, particularly the small ones, do not have to pre-fund activities. It should suffice to hold back their management fee subject to approval of the final report. It is expected that while the initiative would contribute to higher level outcomes, attribution becomes more difficult the more longer-term the outcomes, and this needs to be clear in the results matrix.	High	Short-term
4	UNAIDS and PEPFAR, along with the IPs, should better communicate project results and lessons learned to the outside world for greater impact. This would include a communication strategy in all projects specific to the targeted audience to disseminate project results, knowledge, and lessons learned. Tools like media and social media, organizations' websites, in-country press conferences, etc. should be used and messages should be specific to the audience and user-friendly.	Medium	Medium-term
5	UNAIDS and PEPFAR, along with the IPs, should find additional ways to ensure interfaith is addressed in a comprehensive way (beyond Christianity).	High	Short-term
6	UNAIDS and PEPFAR should encourage the development or alignment with MAISHA-type plans in countries for interfaith networking and engagement.	Medium	Medium-term
7	While some activities are incorporating gender and human rights, UNAIDS and PEPFAR, working with IPs, should continue to find more systematic ways to address gender and key populations across the initiative's activities and in monitoring and evaluation. This may include having further discussions with the Advisory Group on the challenges faced in working with key populations (as discussed in the September 2017 meeting in New York) and the development of a strategy on challenges, opportunities for framing, and ways forward.	Medium	Medium-term
8	UNAIDS and PEPFAR, along with the IPs, should address faith healing in relevant countries (e.g. Zambia and Kenya, and other Phase II countries where this is identified) given the potentially negative impact on ARV adherence.	Medium	Medium-term
	Efficiency		
9	PEPFAR and UNAIDS should detail their respective roles and responsibilities, including those of the country offices, for this initiative and communicate this to IPs and other stakeholders.	High	Short-term

#	Recommendation	Priority (High, Medium, Low)	Timeframe for Implementation (Short, Medium, Long-Term)
10	**Advisory Group (AG):** UNAIDS should clearly spell out the roles and responsibilities of the Advisory Group and communicate it to all its members to ensure a common awareness and understanding of its role. Consideration should be given to have a smaller AG core group to include present members, but not IPs. Suggested role: • Informing the program level – and elaborating a program results matrix from the onset of Phase II (as per UNDG) • Review IP concept papers and reports • Provide advice to IPs on their activities at a higher level ensuring that key messages and adequate language to address stigma and discrimination is included • Advise UNAIDS and PEPFAR on project re-allocation as applicable UNAIDS could plan Advisory Group activities and decide on bi-monthly meetings, mostly conference calls. UNAIDS should dedicate additional funding to Advisory Group meetings if needed, especially for non IP participants The Advisory Group (AG core + IPs) would have a limited mandate: ensure there is a common understanding of the overall initiative and provide a knowledge sharing forum. Quarterly meetings should be sufficient. Should it be decided not to have the core group, then the AG would remain as is, with its role limited to communication, knowledge sharing and general technical advice. A stronger role could lead to conflict of interest for the IPs.	Medium	Medium-term
11	**IP and Project Selection Process:** UNAIDS and PEPFAR should define program objectives first and the level of focus (global or country). At the country level, define clear criteria for country selection and then look at which IP would be best to deliver each component.	High	Short-term
12	UNAIDS should provide a template for concept papers as early as possible for Phase II to ensure consistent information across IPs (see Annex G).	High	Short-term
13	**Communications:** UNAIDS and PEPFAR should have as a goal to improve knowledge sharing between project stakeholders. Internally, this would entail establishing a mechanism to have more regular dialogue between project stakeholders (all IPs, in-country UNAIDS and PEPFAR staff, UNAIDS Secretariat), such as bi-monthly conference calls supported by bi-monthly simple activity-based progress reports (see reporting below).	Medium	Medium-term
14	**Frequency and content of reporting:** • Reporting should be aligned with timelines regarding meetings between IPs and UNAIDS/PEPFAR and the Advisory Group. • Given the need to better communicate between projects, consideration should be made to have bi-monthly very	Medium	Medium-term

#	Recommendation	Priority (High, Medium, Low)	Timeframe for Implementation (Short, Medium, Long-Term)
	short reports (e.g. one page long). • Mid-term report and a final report should include results achieved based on the results matrix. See Annex H for sample report formats and content.		
15	**Monitoring:** • The first responsibility lies with the IP to monitor if activities achieved (outputs) are translating into outcomes. They should follow-up with participants on what they have learned from their participation to an event and how participants intend to integrate this into their work and systems. • Then, UNAIDS and the Advisory Group core group can provide a critical and analytical assessment based on IP reports and their participation in certain events.	Medium	Medium-term
16	**Value for money – efficient management of funds – choice of activities.** UNAIDS with PEPFAR should: • Allow sufficient time to undertake activities – factoring in the availability of funds • Provide more frequent payments and leave no more than 10% for the final payment, ideally the equivalent of IP overhead • Pay attention to what is included as overhead and what is not and what IPs can charge in terms of time spent by their staff on these projects, and have the same approach for all IPs • The Advisory Group core group should recommend reallocation of funds if and when required or establish a clear, quick and transparent mechanism to decide on reallocation of funds	High	Short-term
	Sustainability		
17	Build sustainability measures at the project design level: • Ensure that participants in the various events develop action plans/commitments to address issues and apply new knowledge to encourage sustainability • Work with country systems and institutions in a bottom-up approach as noted above • Address local capacity (e.g. FBOs) if possible. Consider if it is in fact better to work in fewer countries and ensure that action follows • Better communicate knowledge in a user-friendly manner so that it is internalized and used as noted above	High	Short-term
18	Major stakeholders such as PEPFAR, UNAIDS and Implementing Partners should identify how they can ensure that results from this initiative are owned and internalized in their own organizations' programs and systems; e.g. PEPFAR should modify its data gathering system to address gaps identified in Phase 1. PEPFAR,	High	Medium-term

#	Recommendation	Priority (High, Medium, Low)	Timeframe for Implementation (Short, Medium, Long-Term)
	UNAIDS and IPs should work with country governments and FBOs and agree on a sustainability plan (linking with the MAISHA-type plan).		

APPENDIX A RESULTS MATRIX AND LOGIC MODEL

ablishing a logic model at the program level should precede the selection of Implementing Partners, projects and countries where
) initiative will take place. As this has not been the case, there has been attempts to build one afterwards. The results framework I
e Annex 3 of UNAIDS mid-term report to PEPFAR, December 2016) did not follow UNDG Results Guidelines (Impact level results
ıtified as Outputs) and was developed for a full scale multifaceted program rather than a modest, short term project piloting diffe
roaches to enhance FBO organizations knowledge, leadership and advocacy to better address needs of key populations, w
ancing gender equality. As mentioned in the main body of the report, the nature of this initiative (pilot initiative or not) should
ified and the results matrix should be defined accordingly.

ft results matrix prepared by UNAIDS address many things simultaneously: six (6) UNAIDS Strategy Result Areas, have five (5) fo
as, and address six (6) UNAIDS UBRAF outputs in addition to the program own outcomes and outputs. Although these vari
ectives do not add-up as they overlap one way or another, this should be streamlined into one set of coherent outcomes and outp
ails to illustrate this multiplicity of objectives:

ne **Impact** level, the FB initiatives relate to (although in relation to the project scale) to the following 6 UNAIDS Strategy Result Area

1) **Target 1:** 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV v knows their status are receiving treatment and 90% of people on treatment have suppressed viral loads – 90-90-90 vision.
2) **Target 3:** 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV
3) **Target 4:** 90% of women and men, especially young people and those in high-prevalence settings, have access to combination prevention and sexual and reproductive health services.
4) **Target 5:** 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sex and reproductive health services for men.
5) **Target 6:** 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transger people, and prisoners, as well as migrants, have access to HIV combination prevention services.
6) **Target 8:** 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education workplace settings.

expected that this initiative will contribute over time to the achievement of six (6) outcomes (based on most relevant UBRAF outpu
nnovative and targeted HTC programmes (1.1); systems that enables children and adolescents to meet 90-90-90 (1.3); 2) cou
acity to meet the HIV related health and education needs of young people and adolescents (3.2); 3) Evidence base services for
ulations implemented (4.1); 4) Actions to address and prevent all forms of GBV (5.2); 5)) Constituencies mobilized to eliminate
) in HC (6.3); and 6) Decentralization and integration of HIV related services (8.1).

the five (5) focus areas are: 1) Collect, analyze and disseminate data; 2) Address stigma and discrimination; 3) Create demand
vice uptake and retention in care; 4) Strengthen HIV and AIDS related service provision; and 5) Strengthen FBO leadership
ocacy.

will find below a reconstruction of Phase I logic model building it from existing documents, and as presented in the Inception Repor
ition to the logic of outputs and outcomes, the 5 focus areas for this initiative are identified in parenthesis.

ne **Intermediate Outcome** level results could be formulated as follows:

- Improved policies addressing specific needs of children, adolescents, women, men, sex workers, men having sex with m migrants, people who inject drugs and prisoners.
- Improvement in addressing needs and improved access of vulnerable groups.
- Reduction of stigma. (area 3)

ne **Immediate Outcome** level, the results are separated in two areas, as follows:

a 1: Strengthened leadership and advocacy (area 1)

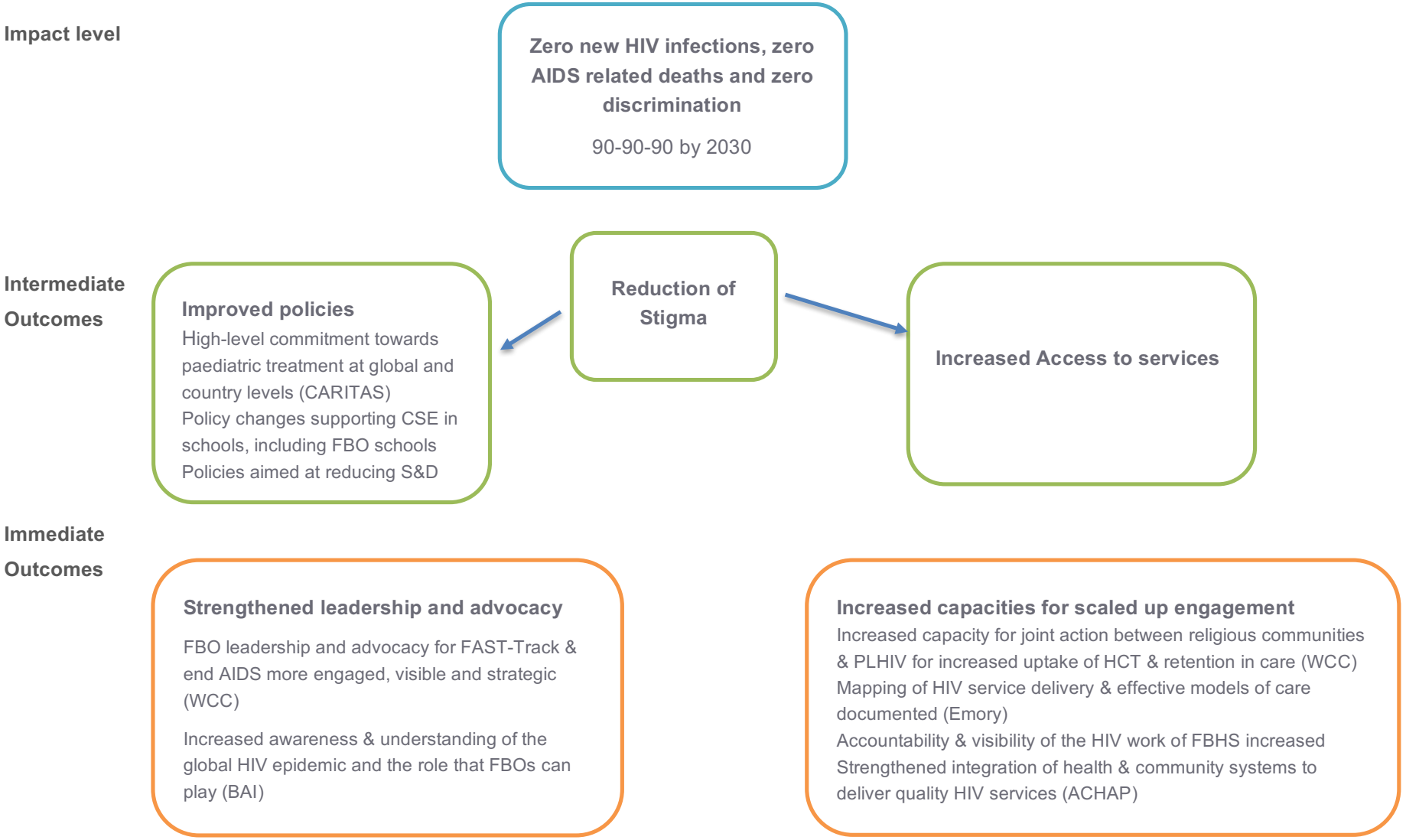
- High level commitment towards addressing pediatric treatment at global and country level (Caritas International)
- FBO leadership and advocacy for Fast-Track and end AIDS more engaged, visible and strategic (Ecumenical Advocacy Allia (EAA))
- Policy changes supporting CSE in schools, including FB schools (Ecumenical HIV and AIDS Initiatives and Advocacy (EHAIA World Young Women's Christian Association (WYWCA)
- Increased awareness and understanding of the global HIV epidemic and the role that FBOs can play (US Black FBOs) (Bl AIDS Institute (BAI))
- Accountability and visibility of the HIV work of FBHS increased (African Christian Health Association Platform (ACHAP))

a 2: Increased capacities for scaled up engagement of FBO providers of HIV Counselling and Testing **(HCT), prevention** a **ıtment** (area 5)

- Increased capacity for joint action between religious communities and people living with HIV (PLHIV) for increased uptake of H and retention in care (EHAIA & WYWCA) (area 4)
- Mapping of HIV service delivery and effective models of care documented (Emory) (area 2)
- Strengthened integration of health and community systems to deliver quality HIV services (ACHAP)

ne following pages you will find 1) the logic framework for Phase I as presented by consultants with the Inception Report; and 2
ults Matrix for Phase II presented in the UNDG recommended format based on the draft Workplan - Annex A of Phase II.

Draft Project (Phase I) Theory of Change (Logic Framework)



Output	**CARITAS** - Robust language in the PD to address paediatric treatment **WCC** -Call to Action by Religious leaders and FBOs - High level interfaith events held to engage religious leadership in advocacy… - Joint pastoral messages on WAD covering PLHIV & youth needs - Analysis of stigma related data available - US based Black FBO commit to a global call for action - Two national inter-generational dialogues implemented - Advocacy & action plans for young people developed **BAI** - Relationship built between US based Black FBOs and Global FBOs - BAI Diaspora Forum roadmap available	**CARITAS** - FBOs Action Plan developed for paediatric treatment - Partnerships brokered & actions implemented to scale up ART service delivery for children in at least 2 countries Capacity building to strengthen networks of FBHS providers to reach more marginalized populations in at least 2 countries **WCC (EAA)** - Initiatives to decrease S&D in communities implemented in at least 2 countries **WCC (EHAIA & WYWCA)** - 4 trainings to promote HIV interventions with young people carried out in at least 2 countries - Capacity building to strengthen interfaith networks with PLHIV to mobilize for uptake of HCT & retention in care implemented **Emory** -Mapping of HIV service delivery and effective models of care documented : fiscal analysis of FBOs, mapping & analysis of service provision in two countries, survey on stigma in FBO health care, and Curriculum to address stigma in health care settings available **ACHAP** - Online M&E platform developed - Two CHAs with strengthened institutional capacity to deliver HIV programs - 20 faith leaders in Kenya and Zambia engaged to link communities & health facilities for HIV services

DRAFT Results Matrix – PEPFAR/UNAIDS FBO Initiative – Phase II

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
Ultimate Outcome 1: High level political (*focus on S&D and paediatric*) commitment towards Fast Track and ending AIDS as a public health threat by 2030 maintained and supported by visible and strategic advocacy from FBOs and religious leaders (*from all faiths*)	# of policies and strategies modified in X number of countries to address S&D				
Outcome 1.1 FBO leadership and advocacy for Fast-Track and ending AIDS as a public health threat is more engaged, visible and strategic.	# of FBO organizations advocating for Fast-Track, and				
Outputs					
1.1.1 Regional AIDS conference ICASA (Media reports, briefings);				**WCC-EAA**	
1.1.2 Evidence of engagement of religious leaders in HIV testing campaign- 'Lead by example' in Phase II countries;				**WCC-EAA**	
1.1.3 FBO advocacy action takes place at key International events/occasions e.g. Human Rights Council/World Health Assembly etc.;				**WCC-EAA**	

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
1.1.4 Black faith community bridges policy and faith space around AIDS in the US national AIDS conference	Media reports of National AIDS events, including webinars to inform Black faith community and call to action			**Black AIDS Institute**	
1.1.5 High level event hosted in Europe [*add expected # of participants from which faiths*] (e.g. Wilton Park, Bellagio). Media and advocacy messages [on S&D] for FBOs or Religious leaders	# of participants Media attendance Messages	Event records Reports in media and social media		**UNAIDS**- with WWSO and Anglican Communion	
1.1.6 Prayer Breakfast to maintain commitment to HIV New York.	advocacy messages f*rom* FBOs	Media reports-		**WCC-EAA** with UNAIDS/DU4	
1.1.7 High-level event hosted in Rome focused on shared Paediatric treatment goals				**Caritas Internationalis**	

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
Ultimate Outcome 2 Increased FBO capacities for scaled up engagement in HIV related testing, prevention, treatment, care and reduced S&D in FBO communities and health care settings [*add the countries – otherwise too large]*					
Outcome 2.1 Partnerships brokered and actions implemented to scale up ART service delivery for children in at least 2 African Countries	# of partnerships evidence of scale up ART				
Outputs					
2.1.1 Action plan for strengthened engagement of FBO health service providers in national Start Free, Stay Free, AIDS free plans in two countries (*Nigeria, DRC) developed and implemented.*				**Caritas Internationalis**	
Outcome 2.2 Strengthen integration of health and community services, to deliver quality HIV services [*this is a large scale outcome – perhaps need to precise mor*e]					
Outputs					

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
2.2.1 CHAs (two in Phase I and two in Phase II strengthened institutional capacity to deliver HIV programmes)				**ACHAP**	
2.2.2 Online Data and M&E platform developed *and disseminated*				**ACHAP**	
2.2.3 Activities to build clinical skills and address stigma in health care settings implemented [*not acceptable as an output – too vague and does not give any idea of where and how many people*]				**ACHAP**	
Outcome 2.3 Document effective models of HIV health service delivery, including quantitative and qualitative data collection and evaluation of innovative service delivery models and identify financing challenges and opportunities that are common and distinctive for faith-based providers.					
Outputs					

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
2.3.1 Country case studies/literature review-review of the evidence – papers on the scale, extent, and models of care. (2 countries in Phase II) [*countries should be identified and also the scale of results – approx. how many case studies – how does it build from phase 1 results?*]				**Academic Consortium/EMORY**	
2.3.2 Production of the final Gap report on the faith response to HIV [*previously 2.6 – but this is more an output than an outcome and has to fit under knowledge building and sharing – so this seems to be the most logical place to fit it*]				Academic Consortium UNAIDS	

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
Outcome 2.4 Develop strategic guidance and advocacy/training initiatives in collaboration with faith communities and FBO service providers on reducing HIV stigma and discrimination in: • a) faith communities and • b) health care settings and assuring patient rights					
Outputs					
2.4.1 Framework for Dialogue consultation reports (2 countries in Phase II) (EAA) Analyses of stigma index reports from a faith-centric angle in selected countries. (2 countries in Phase II				**WCC-EAA**	
2.4.2 Action plan to address stigma in faith communities developed and implemented in 4 countries.				**WCC-EAA**	
2.4.3 Research report on impact of stigma and uptake of testing and action plan				**WCC-EAA**	

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
2.4.4 Research report on criminalization of HIV transmission and action plan for training *produced, disseminated [where]*				**WCC-EAA**	
2.4.5 Research report on impact of stigma on uptake of testing- and action plan *completed and disseminated [WCC-EEA are also doing one – need to clarify difference between the two]*				**Academic consortium** and ACHAP	
2.4.6 Curriculum to equip FBOs to work effectively with stigmatized communities. (ACHAP)				**Academic consortium** and ACHAP	
Outcome 2.5 Increase demand for HIV testing, uptake of services and retention in care and build capacity for joint action between communities of people living with HIV.					
Outputs					
2.5.1 Curriculum on faith healing in French and English				**WCC-EHAIA**	

Results	Indicators	Means of Verification	Risks and Assumptions	Role of Partners	Indicative Resources
2.5.2 Report of workshops and evidence of action to address patriarchy and promote positive masculinities. [*the goal of this activity is not to produce a report but to start changing some perceptions and attitudes – so something like X participants have acknowledged the need to change perceptions… and commit to actions* – also need to be more specific in terms of where and scope]		Report [*should ensure that the report demonstrates a change of perceptions*]		WCC?	
2.5.3 Two curricula on masculinities for men and for women [*are developed – where?*]				WCC?	
2.5.4 Database of CHA contacts and focal points [*as formulated, it is a very limited output – is there more to it?]*				WCC EHAIA AC-ACHAP	

APPENDIX B EVALUATION MATRIX

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
Relevance			
1. To what extent does this initiative fit with UNAIDS, PEPFAR, implementing countries strategies?	1.1 To what extent does the design of the initiative fit with the needs and priorities identified by UNAIDS & PEPFAR at the global level? 1.2 To what extent does this initiative fit with Kenya and Zambia's country HIV/AIDS strategies and needs? 1.3 What is FBOs role in the HIV response? Any remaining gaps? 1.4 To what extent is the design of the initiative informed by evidence and stakeholder needs (e.g. two Lancet publications, 2015 PEPFAR Faith-Based Consultation Recommendations)?	Perception of UNAIDS & PEPFAR staff on the fit with needs and priorities (interviews) Perception of IPs on the fit with needs and priorities (interviews) Alignment of initiative with UNAIDS/PEPFAR strategy (document analysis) Perception of government and in-country stakeholders on fit with country strategies and needs and role of FBOs (interviews) Alignment of initiative country strategies (document analysis)	UNAIDS & PEPFAR staff PEPFAR and UNAIDS strategic documents Kenya and Zambia country HIV strategies Kenya and Zambia Government staff In-country stakeholders, including FBOs Implementing partners (IPs) Lancet publications and other relevant publications including 2015 PEPFAR Faith-Based Consultation Recommendations
Effectiveness (Immediate and Intermediate Outcomes Achieved)			

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
2a. To what extent were results achieved those that were intended to be achieved? 2b. To what extent did achieved activities translate into immediate outcomes?	2a.1) To what extent has there been an increase in high level commitment towards addressing pediatric treatment at global and country level? (CARITAS) 2a.2) To what extent has FBO leadership and advocacy for Fast-Track and end AIDS become more engaged, visible and strategic? (WCC-EAA) 2a.3) To what extent has there been policy changes supporting CSE in schools, including FB schools in Kenya and Zambia? (WCC-EHAIA &WYWCA) 2a.4) To what extent has there been increased capacity for joint action between religious communities and PLHIV for increased uptake of HCT and retention in care? (WCC-EHAIA &WYWCA) 2a.5) To what extent has there been mapping of HIV service delivery and documentation of effective models of care in Kenya and Zambia? (Emory) 2a.6) To what extent has accountability and visibility of the HIV work of FBHS increased? (ACHAP) 2a.7) To what extent has there been strengthened integration of health and community systems to deliver quality HIV services? (ACHAP)	Perception of internal and external stakeholders on increased capacity for scaled up engagement (interviews) Documentation outlining activities, outputs, and outcomes related to capacity for scaled up engagement (document analysis)	Workplan 2016/2017 (Annex 2); Draft results Framework 2016/2017 (including indicators and deliverables) Budgets; Concept Notes; Progress reports from IPs; Interim Progress Report for the Initiative UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs Select Participants in Consultations

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
	2a.8) To what extent has there been increased awareness and understanding of the global HIV epidemic and the role that FBOs can play (US Black FBOs)? (BAI) 2a.9) To what extent has there been increased evidence on reducing stigma and discrimination, gender inequalities and gender-based violence in communities (including adolescents, MSM, PWUD, sex workers)? (WCC-EAA, EHAIA & WYWCA, Emory) 2a.10) To what extent have actions to address stigma and discrimination in communities and health care settings been implemented? (WCC-EAA, EHAIA&WYWCA, Emory) 2.11 To what extent has knowledge sharing been effective between all project stakeholders? 2b.1 To what extent have selected FBOs increased their capacity for scaled up engagement of FBO providers of HIV testing and counselling (HCT), prevention and treatment? 2b.2 To what extent have selected FBOs improved their leadership and advocacy for Fast Track and ending AIDS by 2030?	Perception of internal and external stakeholders on FBOs improved leadership and advocacy for Fast Track and ending AIDS by 2030 (interviews) Documentation outlining activities, outputs and outcomes related to improved leadership and advocacy for Fast Track and ending AIDS by 2030 (document analysis)	Workplan 2016/2017 (Annex 2); Draft results Framework 2016/2017 (including indicators and deliverables) UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs Select Participants in Consultations

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
3. What challenges, facilitators, and gaps arose in Phase I?	3.1 What challenges were faced? What worked well in Phase I? What did not work well in Phase I? 3.2 What gaps, if any, are evident in terms of activities? 3.3 What gaps, if any, are evident in terms of partnership?	Perceptions of internal and external stakeholders on challenges, facilitators, and learnings from Phase I (interviews) Perceptions of internal and external stakeholders on gaps in activities and partnerships (interviews)	UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs
4. Were any unintended results achieved?	4.1 What, if any, unintended consequences (either negative or positive) have occurred?	Evidence of unintended consequences (interviews and document analysis)	Workplan 2016/2017 (Annex 2); Draft results Framework 2016/2017 (including indicators and deliverables) UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs Select Participants in Consultations Budgets; Concept Notes; Progress reports from IPs; Interim Progress Report for the Initiative

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
5. What contextual factors (e.g. country level, donor level) may positively or negatively influence the *achievement of results* of the initiative? (influence of context on effectiveness)	5.1 What are the current trends in terms of governments' political will to address HIV? 5.2 What are the current trends in terms of national (Kenya and Zambia) and international aid agencies budget allocations for HIV? 5.3 What are the current trends in terms of access to ARVs, including costs? 5.4 What are the current trends in terms of stigma and discrimination (e.g. vulnerable populations)? 5.5 What are the current trends with regards to all populations, including vulnerable populations, having equal access to prevention, early diagnosis and care?	HIV Strategies outlining trends and budgets (document analysis) Perceptions of internal and external stakeholders on the current trends that may positively or negatively influence the achievement of results for this initiative (interviews)	Kenya and Zambia HIV strategies UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs Select Participants in Consultations IP Concept Notes and Progress reports
Efficiency: cost effective delivery of outputs – achievement of activities			

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
6. To what extent is the governance structure of the initiative appropriate?	6.1 To what extent are the mutual roles and responsibilities of PEPFAR and UNAIDS clear and well understood as it relates to this initiative? 6.2 How well has the Advisory Group functioned in its role?	Documentation on roles and responsibilities (document analysis) Documentation on FBO and project selection (document analysis) Documentation on Advisory Group (e.g. Terms of Reference, minutes) (document analysis) Perceptions of stakeholders on effectiveness of governance of the initiative (including Advisory Group) (interviews) Perceptions of internal and external stakeholders on clarity and understandability of the roles and responsibilities of PEPFAR and UNAIDS (interviews) Perceptions of internal and external stakeholders on the efficiency and transparency of the FBO and project selection and approval process (interviews)	UNAIDS and PEPFAR staff Advisory Group members (including IPs) Documentation on roles and responsibilities Documentation on FBO and project selection Advisory Group documentation
7. To what extent was Phase I effectively managed?	7.1 To what extent is the FBO and project selection and approval process efficient and transparent? 7.2 To what extent were communications appropriate (timely and sharing the right information)? 7.3 To what extent were reporting requirements appropriate? 7.4 To what extent was monitoring appropriate?	Selection process and criteria to approve initiatives (document analysis) Frequency and rigour of the monitoring of IPs (document analysis) Perceptions of internal (UNAIDS/PEPFAR) and external stakeholders (IPs) on the project selection and criteria, management of the initiative (e.g. monitoring of projects, reporting) (interviews)	Guidance materials (if available) Selection materials UNAIDS and PEPFAR staff Advisory Group members (including IP members)

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
8. To what extent did planned activities occur? 9. To what extent did funded initiatives achieve the expected deliverables (outputs) within the expected timeframe?	no sub-question	% of planned activities achieved	IPs reports Reporting table designed by evaluators Budgets; Concept Notes; Progress reports from IPs; Interim Progress Report for the Initiative
10. To what extent does this initiative provide value for money?	10.1 To what extent is the management of financial resources appropriate (timely, efficient, transparent, flow or money)? 10.2 To what extent were the activities the most efficient choices of activities? 10.3 Would it have been possible to achieve the same outcomes in a more cost effective way? 10.4 To what extent does the size of the grants and number of partners represent an efficient use of budget?	Perceptions of internal and external stakeholders on efficiency including the value for money of the initiative, management of financial resources, if outcomes could have been achieved in a more cost effective way, and the size of grant/number vis-à-vis efficiency (interviews) Adequacy of resource allocation (human, financial etc.) with respect to the initiative (document analysis)	Budgets; Financial reports and progress reports/final reports UNAIDS and PEPFAR staff Advisory Group members (including IP members) Kenya and Zambia government staff
Gender and Human Rights			

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
11. To what extent did activities attempt to address gender and human rights within the faith community?	11.1 What activities were undertaken to address gender and human rights? 11.2 What evidence is there that these activities in gender and human rights had concrete results? How were results measured? 11.3 To what extent do reports identify and demonstrate that gender and human rights were taken into consideration? 11.4 To what extent do reports provide sex-disaggregated data?	Perceptions of internal and external stakeholders on how gender and human rights were addressed, and the results (interviews) Evidence of gender and human rights considerations in concept notes and progress reports (document analysis)	UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs Select Participants in Consultations IP Concept Notes and Progress reports
Sustainability			
12. To what extent is the work from Phase 1 sustainable?	12.1 To what extent are selected FBOs likely to sustain activities beyond the initiative, given their human and financial resources? 12.2 To what extent are the outputs and outcomes from the activities that have occurred in Phase 1 likely to be sustained beyond the initiative? 12.3 To what extent are systems in place to sustain the effects of the initiative in the longer term? 12.4 What are the organizational and contextual factors that affect the sustainability of the initiative?	Perception of stakeholders on sustainability of activities and the initiative (interviews) Evidence of strategies for sustainability (document analysis)	UNAIDS and PEPFAR staff Advisory Group members (including IP members) Kenya and Zambia government staff Concept Notes and Progress reports; Interim Progress Report for the Initiative
Recommendations			

Questions	Sub-questions	Evaluation Indicators/tools	Data Sources
13. What are the changes, if any, that are needed to improve the initiative for Phase 2?	No sub-question	Perception of stakeholders on what is working and what needs to be changed, if any, moving from Phase I to Phase II (interviews)	UNAIDS and PEPFAR staff Advisory Group members (including IPs) Kenya and Zambia government staff In-country stakeholders, including FBOs Select Participants in Consultations

APPENDIX C INTERVIEW GUIDE

Background and Objectives:

ACT-for-Performance (ACT) has been commissioned by UNAIDS to undertake an external independent evaluation of Phase 1 of the PEPFAR-UNAIDS Faith Initiative Strengthening Faith Community Partnerships for Fast Track.

In September 2015, PEPFAR and UNAIDS launched a two-year 4M USD initiative to respond to the Lancet recommendations to strengthen knowledge and capacity of FBOs. Five areas have been prioritized:

1. Strengthen FBO leadership and advocacy
2. Collect, analyse and disseminate data on health care services provided by faith-based health services (FBHS)
3. Address stigma and discrimination in communities and health care settings
4. Create demand for service uptake and retention in care
5. Strengthen HIV and AIDS related service provision

The specific objectives of the mid-term evaluation are to:

- analyze the context and relevance of PEPFAR-UNAIDS Faith Initiative towards the achievement of 90-90-90 by 2020;
- identify key results achieved and analyse the likelihood that they will be sustainable;
- identify enabling factors, opportunities, challenges, and threats in implementing this initiative;
- identify lessons and good practices for each of the five priority programming areas;
- analyze the full integration of gender equality and human rights throughout the entire spectrum of the initiative and recommend any improvement if required;
- analyze the management of the initiative, from its governance down to the actual flow of money to partners;
- recommend concrete actions to be implemented rapidly as the Phase II is unfolding.

Process and use of information: As part of this work, we are conducting interviews with internal and external stakeholders including field visits in Kenya and Zambia. The interview will take approximately one hour. I will be typing notes during the interview, but I am not recording the interview. Information collected will be used to develop this mid-term report. While you will be named as a key informant of the study overall in our list of consulted stakeholders, your specific contribution to the study will be anonymous. We will not associate your name with anything specifically included in this report.

Do you have any questions before I begin?

(Note: The stakeholders listed for each questions should be considered as a suggestion only. We will make a qualified judgment on what questions should be asked).

Phase	Number	Interview questions/Themes	Sub-questions
Warm-Up	**0**	Your involvement/role with the UNAIDS/PEPFAR FBO initiative	0. Please tell me about your involvement/role in this UNAIDS/PEPFAR FBO initiative.
Relevance	**1**	Fit with UNAIDS, PEPFAR, implementing countries strategies	**UNAIDS, PEPFAR, IPs:** 1.1 In your opinion, to what extent does the design of the initiative fit with the needs and priorities identified by UNAIDS & PEPFAR at the global level? 1.4 To what extent is the design of the initiative informed by evidence and stakeholder needs? **COUNTRY GOV'TS and FBO STAKEHOLDERS:** 1.2 In your opinion, to what extent does this initiative fit with Kenya and Zambia's country HIV/AIDS strategies? And 1.3 In your opinion what is the particular role that FBOs can play in the HIV response? Any gaps?
Effectiveness	**2a**	Extent results achieved were those that were intended to be achieved	**CARITAS, UNAIDS, PEPFAR, KEY CONSULTATION STAKEHOLDERS:** 2a.1) In your opinion, to what extent has there been high level commitment towards addressing pediatric treatment at global and country level? (CARITAS) **WCC-EAA, UNAIDS, PEPFAR, FBO [12] and CONSULTATION STAKEHOLDERS, GOVERNMENTS:** 2a.2) In your opinion, to what extent has FBO leadership and advocacy for Fast-Track and end AIDS become more engaged, visible and strategic? **WCC-EHAIA &W YWCA, UNAIDS, PEPFAR, FBO and CONSULTATION STAKEHOLDERS, GOVERNMENTS:** 2a.3) In your opinion, to what extent has there been policy changes supporting CSE in schools, including FB schools? **WCC-EHAIA &YWCA, UNAIDS, PEPFAR, FBO and CONSULTATION STAKEHOLDERS, GOVERNMENTS:** 2a.4) In your opinion, to what extent has there been

[12] Asking questions of the key FBO stakeholders in Kenya and Zambia will depend on their involvement in which initiative. They will only be asked specific questions to the projects they were involved in as applicable. Key consultation stakeholders refer to those participating in select key consultations/events (for which a select few will be interviewed).

Phase	Number	Interview questions/Themes	Sub-questions
			increased capacity for joint action between religious communities and PLHIV for increased uptake of HCT and retention in care? **EMORY, UNAIDS, PEPFAR, FBO and CONSULTATION STAKEHOLDERS GOVERNMENTS:** 2a.5) In your opinion, to what extent has there been mapping of HIV service delivery and documentation of effective models of care? **ACHAP, UNAIDS, PEPFAR, FBO and CONSULTATION STAKEHOLDERS GOVERNMENTS:** 2a.6) In your opinion, to what extent has accountability and visibility of the HIV work of FBHS increased? **ACHAP, UNAIDS, PEPFAR, FBO and CONSULTATION STAKEHOLDERS, GOVERNMENTS:** 2a.7) In your opinion, to what extent has there been strengthened integration of health and community systems to deliver quality HIV services? **BAI, UNAIDS, PEPFAR, KEY CONSULTATION STAKEHOLDERS**: 2a.8) In your opinion, to what extent has there been increased awareness and understanding of the global HIV epidemic and the role that FBOs can play (US Black FBOs)? **WCC-EAA, EHAIA&YWCA, Emory, UNAIDS, PEPFAR, KEY CONSULTATION STAKEHOLDERS, GOVERNMENTS:** 2a.9) In your opinion, to what extent has there been increased evidence on reducing stigma and discrimination, gender inequalities and gender-based violence in communities (including adolescents, MSM, PWUD, sex workers)? **WCC-EAA, EHAIA&YWCA, Emory, UNAIDS, PEPFAR, KEY CONSULTATION STAKEHOLDERS, GOVERNMENTS:** 2a.10) In your opinion, to what extent have actions to address stigma and discrimination in communities and health care settings been implemented? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 2.11 In your opinion, to what extent has knowledge sharing been effective between all project stakeholders?
Effectiven	**2b**	Extent achieved	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR,**

Phase	Number	Interview questions/Themes	Sub-questions
ess		activities translated into immediate outcomes	**KEY FBO STAKEHOLDERS, GOVERNMENTS:** 2b.1 In your opinion, to what extent have selected FBOs increased their capacity for scaled up engagement of FBO providers of HIV testing and counselling (HCT), prevention and treatment? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, KEY FBO STAKEHOLDERS, GOVERNMENTS:** 2b.2 In your opinion, to what extent have selected FBOs improved their leadership and advocacy for Fast Track and ending AIDS by 2030? Please describe an example.
Effectiveness	**3**	Challenges, facilitators, and gaps from Phase 1	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, KEY FBO STAKEHOLDERS, GOVERNMENTS**: 3.1 In your opinion, what challenges were faced? What worked well in Phase I? What did not work well in Phase I? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, KEY FBO STAKEHOLDERS, GOVERNMENTS:** 3.2 In your opinion, what gaps, if any, are evident in terms of activities? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, KEY FBO STAKEHOLDERS, GOVERNMENTS:** 3.3 In your opinion, what gaps, if any, are evident in terms of partnership?
Effectiveness	**4**	Unintended consequences	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, KEY FBO STAKEHOLDERS, GOVERNMENTS**: 4.1 In your opinion, what, if any, unintended consequences (either negative or positive) have occurred?
Effectiveness	**5**	Contextual factors that may positively or negatively influence the *achievement of results* of the initiative (influence of context on effectiveness)	**ALL (ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, KEY FBO AND CONSULTATION STAKEHOLDERS, GOVERNMENTS)**: 5.1 What are the current trends in terms of governments' political will to address HIV? **ALL**: 5.2 What are the current trends in terms of national (Kenya and Zambia) and international aid agencies budget allocations for HIV? **ALL**: 5.3 What are the current trends in terms of access to ARVs, including costs?

Phase	Number	Interview questions/Themes	Sub-questions
			ALL: 5.4 What are the current trends in terms of stigma and discrimination (e.g. vulnerable populations)? **ALL**: 5.5 What are the current trends with regards to all populations, including vulnerable populations, having equal access to prevention, early diagnosis and care?
Efficiency	**6**	Appropriateness of governance structure	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 6.1 In your opinion, to what extent are the mutual roles and responsibilities of PEPFAR and UNAIDS clear and well understood as it relates to this initiative? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 6.2 In your opinion, how well has the Advisory Group functioned in its role? How well has the overall governance of the initiative been?
Efficiency	**7**	Effective management Phase I	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 7.1 In your opinion, to what extent is the FBO and project selection and approval process efficient and transparent? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 7.2 In your opinion, to what extent were communications appropriate (timely and sharing the right information)? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 7.3 In your opinion, to what extent were reporting requirements appropriate? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR,** 7.4 In your opinion, to what extent was monitoring appropriate?
Efficiency	**10**	Value for Money	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 10.1 In your opinion, to what extent is the management of financial resources appropriate (timely, efficient, transparent, flow or money)? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 10.2 In your opinion, to what extent were the activities the most efficient choices of activities? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR:** 10.3 In your opinion, would it have been possible to achieve the same outcomes in a more cost effective way?

Phase	Number	Interview questions/Themes	Sub-questions
			ADVISORY GROUP (including IPs), UNAIDS, PEPFAR: 10.4 In your opinion, to what extent does the size of the grants and number of partners represent an efficient use of budget?
Gender and HR	**11**	Gender and human rights addressed	**ALL**: 11.1 In your opinion, how were gender and human rights addressed? What activities were undertaken to address gender and human rights? (e.g. including amongst marginalized/vulnerable/key populations including adolescents, MSM, PWUD, sex workers)? **ALL**: 11.2 In your opinion, from these gender and human rights activities, were there any concrete results? If yes, what were these? How were results measured?
Sustainability	**12**	Overall sustainability of partnership	**ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, GOVERNMENTS:** 12.1 In your opinion, to what extent are you/selected FBOs likely to sustain activities beyond the initiative, given your/their human and financial resources? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, GOVERNMENTS:** 12.2 In your opinion, to what extent are the outputs and outcomes from the activities that have occurred in Phase 1 likely to be sustained beyond the initiative? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, GOVERNMENTS:** 12.3 In your opinion, to what extent are systems in place to sustain the effects of the initiative in the longer term? **ADVISORY GROUP (including IPs), UNAIDS, PEPFAR, GOVERNMENTS:** 12.4 In your opinion, what are the organizational and contextual factors that affect the sustainability of the initiative?
Recommendations	**13**	Recommendations from Phase 1 for Phase 2	**ALL**: 13. What are the changes, if any, that are needed to improve the initiative for Phase 2?
Cool-down	**n/a**	Additional comments and closing	**ALL:** Do you have any additional comments that should be taken into consideration for this work? **ALL:** Do you have any documents that you think are key for

Phase	Number	Interview questions/Themes	Sub-questions
			me to review as part of this work? **ALL:** Would you be willing to answer further questions (by email or by telephone) if we have additional questions or need further information?

APPENDIX D DOCUMENT LIST

Academic Consortium

- Academic Consortium. (2016). Academic Consortium to Support Programmatic Efforts of a Joint Initiative between UNAIDS and PEPFAR to Strengthen Partnerships with Faith-Based Organizations: Budget.
- Academic Consortium. (n.d.). An Academic Consortium to Support Programmatic Efforts of a Joint Initiative Between UNAIDS and PEPFAR to Strengthen Partnerships with Faith-Based Organizations: Concept Note.
- Academic Consortium. (n.d.). PT.17.06a Progress Report to be Submitted to UNAIDS under PEPFAR/UNAIDS FBO Initiative.
- Academic Consortium. (2017). Ethics Protocol: Understanding the scope of HIV prevention, treatment, and support services provided by faith-based organizations in Kenya.
- Academic Consortium. (2017). Summary of Year One Activities.
- Academic Consortium. (2017). HIV Services in Kenya by Faith-Based Health Providers. http://ihpemory.org

ACHAP

- ACHAP. (2016). Concept Note for Health Systems Strengthening.
- ACHAP. (n.d.). ACHAP HSS Project - Systems strengthening project: Final Budget.
- ACHAP. (2017). Progress Report July 2017.

BAI

- BAI. (2017). Final Report to be submitted under Programme Funding Agreements: Final Narrative Report.
- BAI. (n.d.). Consultation to Promote UNAIDS-PEPFAR Fast-Track Faith-Based Initiative (FBO) -Co-Organized by UNAIDS and the Black AIDS Institute (BAI): Concept Note.
- Black AIDS Institute. (2016). UNAIDS Budget.

Caritas International

- Caritas International. Regional Consultation: Conference on Early Diagnosis and Treatment for HIV-positive Children - Strengthening Engagement of FBOs - Abuja, Nigeria – 10-12 May 2017 - Concept Paper.
- Caritas International. (2016). PT.17.06a Progress Report to be Submitted to UNAIDS under PEPFAR/UNAIDS FBO Initiative.
- Caritas International. (2016). Consultation Report on: Early Diagnosis and Treatment for Children and Adolescents Living with HIV: Strengthening engagement of Faith-based organizations.
- Caritas International. (2016). Early Diagnosis and Treatment for children living with HIV: Strengthening engagement of Faith-based organizations - Concept Paper and DRAFT Agenda Outline
- Caritas International. (2016). Conference on Early Diagnosis and Treatment for HIV-positive Children - Strengthening Engagement of FBOs.
- Caritas International. (2017). Early Diagnosis and Treatment for Children Living with HIV - Strengthening Regional Engagement of FBOs - 14-16 June 2017 - Overall Projected Budget as of 6 April 2017.

World Council of Churches

- Barstow, David. (2017). Framework for Dialogue Process in Kenya Impact Assessment. WCC.
- WCC-EAA. (2016). PT.17.06a Progress Report to be Submitted to UNAIDS under PEPFAR/UNAIDS FBO Initiative.
- WCC-EAA. (2017). *WCC-EAA led activities – Detailed Interim Report* November 2016-July 2017.
- WCC-EAA. (2016). *World Council of Churches Concept Note: PEPFAR and UNAIDS Phase I (May 27)*.
- World Council of Churches. (2016). WCC budget UNAIDS PEPFAR.
- World Council of Churches. (2016). Zambia: "On HIV, we do not compete. We work together.". Retrieved from https://www.oikoumene.org/en/press-centre/news/zambia-201con-hiv-we-do-not-compete-we-work-together.201d
- World Council of Churches. (2016). Kenya: Voice of faith communities crucial in overcoming HIV. Retrieved from https://www.oikoumene.org/en/press-centre/news/kenya-voice-of-faith-communities-crucial-in-overcoming-hiv
- World Council of Churches. (2016, June 28). Churches Recommit to Accelerate HIV Response
- World Council of Churches. Zambia Consultation: Lusaka, Zambia: 19 – 21 October 2016: Follow up responses
- World Council of Churches. (2017). Framework For Dialogue Impact Assessment Meeting Between Religious Leaders, Adolescents, Youths And People Living With HIV. February 7-8, 2017 (Summary Report).

UNAIDS and PEPFAR Documents

- Munyaneza, J. (2016). UNAIDS Community Mobilization Division Update for Faith-Based Organizations responding to HIV. UNAIDS.
- The United States President's Emergency Plan for AIDS Relief. (2017, January 20, 2017). PEPFAR-UNAIDS Faith Initiative: Strengthening Faith Community Partnerships for Fast Track. Retrieved from https://www.pepfar.gov/press/265876.htm
- U.S. Department of State. (2014). PEPFAR 3.0: Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation.
- U.S. President's Emergency Plan for AIDS Relief. (2015). Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between PEPFAR and Faith-Based Organizations to Build Capacity for Sustained Responses to HIV/AIDS. Washington, DC.
- U.S. President's Emergency Plan for AIDS Relief. (2017). PEPFAR-UNAIDS Faith Initiative: Strengthening Faith Community Partnerships for Fast Track. Retrieved from https://www.pepfar.gov/press/265876.htm
- UNAIDS. (2014). 90-90-90: An ambitious treatment target to help end the AIDS epidemic.
- UNAIDS. (2016). Interim Progress Report Phase I: PEPFAR-UNAIDS Faith Initiative - Strengthening Faith Community Partnerships for Fast Track: 31 May 2016 to 16 December 2016.
- UNAIDS. (n.d.). UNAIDS Strategy 2016-2021: On the Fast-Track to end AIDS. UNAIDS: Geneva.
- UNAIDS. (2017). Independent Evaluation of Phase I: PEPFAR-UNAIDS Faith Initiative Strengthening Faith Community Partnerships for Fast Track - Request for Proposal (RFP-2017-03).
- UNAIDS Kenya. (2017). Accelerating achievement of Fast Track targets in high burden counties in Kenya through male engagement : Preliminary findings of community focus group discussions to identify structural and gender equality-related issues affecting uptake of and access to HIV services by men in Homabay and Siaya Counties, 10-14 July 2017.
- No author. (2016). Minutes of brief consultation meeting on PEPFAR, UNAIDS-WCC Faith Sector initiative, held at Hilton on August 11, 2016.

Other Documents

- Mahon, C. (2016). Treatment access masks wider barriers to 2020 targets. *AVERT.* Retrieved from https://www.avert.org/news/treatment-access-masks-wider-barriers-2020-targets
- Olivier, J., Tsimpo, C., Gemignani, R., Shojo, M., Coulombe, H., Dimmock, F., . . . Wodon, Q. (2015). Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet, 386*(10005), 1765-1775. doi:10.1016/S0140-6736(15)60251-3
- Tomkins, A., Duff, J., Fitzgibbon, A., Karam, A., Mills, E. J., Munnings, K., . . . Yugi, P. (2015). Controversies in faith and health care. *Lancet, 386*(10005), 1776-1785. doi:10.1016/S0140-6736(15)60252-5
- United Nations Evaluation Group. (2014). Integrating Human Rights and Gender Equality in Evaluations. UNEG: New York.
- Government of Zambia. (n.d.). National HIV/AIDS Strategic Framework (NASF) 2017-2021.
- National AIDS Control Council. (n.d.). Kenya AIDS Strategic Framework. 2014/15-2018/19.
- National AIDS Control Council. (n.d.). Faith Sector Response to HIV and AIDS in Kenya: Action Plan 2015/2016-2019/2020.

APPENDIX E LIST OF INTERVIEWEES

Skype calls and emails: 31 people in 26 interviews/focus groups

#	Name	Organization	Format/Location
External Evaluation Senior Managers			
1	Sandra Thurman	PEPFAR	Skype: US (Atlanta and Washington)
2	Cornelius Baker	PEPFAR	Skype: was in New York
3	Mariangela Simao	UNAIDS	Skype: Geneva
Staff			
4	Sally Smith	UNAIDS	Skype: Geneva
5	Julienne Munyaneza	UNAIDS	Skype: Geneva
Advisory Group/Implementing Partners (see field mission for additional)			
6	John Blevins	Emory University	Skype: Atlanta, US
7	Nyambura Njoroge	WCC EHAIA	Skype: Geneva
8	Manoj Kurian	WCC- EAA	Skype: Geneva
9	Isabel Phiri	WCC	Skype: Geneva
10	Francesca Merico	WCC- EAA	Skype: Geneva
11	Susan Landskroener	Emory University	Skype: Atlanta, US
12	Mimi Kiser	Emory University	Skype: Atlanta, US
13	Jill Olivier	University of Cape Town	Skype: Cape Town, South Africa
14, 15, 16	Father Robert J. Vitillo Stefano Nobile Amparo Alonso	CARITAS (past) CARITAS (current)	Skype group: Geneva
17, 18	Nkatha Njeru Mike Mugweru	Christian Health Association of Kenya (ACHAP)	Skype group: Nairobi, Kenya
19, 20, 21	Phill Wilson	Black AIDS Institute (BAI)	Skype group: Los Angeles,

#	Name	Organization	Format/Location
	Wendell Miller Jami Cox		US
22	Azza Karam	UNFPA	Skype: New York, US
23	Phumzile Mabizela	INERELA	By email: Johannesburg, South Africa
24	Julian Hows	Global Network of People Living with HIV	Skype: Amsterdam
25	Rita Muyambo	World YWCA	Skype: Geneva
26	Ezra Chitando	WCC	By email: Zimbabwe
27	Beatrice Ahere	YWCA (Kenya)	Skype: Nairobi, Kenya
Consultation Attendees/Beneficiaries (see field missions for additional)			
28	Kadijha Abdulla	Participant in the Interfaith Prayer Breakfast	Washington
29	Debra Boudreaux	Participant in the Interfaith Prayer Breakfast Buddhist Tzu Chi Foundation https://www.tzuchi.us/hq/	US
30	Dr. Jonathan Kiliko-Meds	Participant at ACHAP Conference	Skype: Nairobi, Kenya
31	Nadege Uwase	WYWCA participant at International AIDS Conference last year in Durban	Skype: Kigali, Rwanda

Kenya Mission (July 17-24) : 21 people in 11 interviews/groups

#	Name	Organization	Format/Location
1	Maxwell Marx	PEPFAR	Field Mission: Nairobi, Kenya
2	Breeann McCusker	US State Department	Field Mission: Nairobi, Kenya
3	Esther Mombo	St. Paul's University	Field Mission: Limuru, Kenya
4, 5, 6	Jantine Jacobi Ruth Laibon Masha Harriet Kongin	UNAIDS	Field mission: Nairobi, Kenya

#	Name	Organization	Format/Location
7, 8, 9, 10, 11, 12	Emmy Corey Shari Chana Madkins Satoya Beckles Madeline Ruth Plaster Raven Hinson Sabrina Thomas	Emory University	Field mission: Nairobi, Kenya
13	Bathsheba Osoro	NACC	Field mission: Nairobi, Kenya
14	Jane Nganga	INERELA	Field mission: Nairobi, Kenya
15	Pauline Njiru	WCC	Field mission: Nairobi, Kenya
16, 17, 18	Peter Kang'ethe Jameson Wanjiru Kariuki Rahab Kariuki Mugwe	Orthodox Church University of Nairobi – student Anglican Church of Kenya Attended WCC Consultation in Nairobi	Field mission: Nairobi, Kenya
19	Sister Mary Owens	Nyumbani, Children of God Relief Institute	Field mission: Nairobi, Kenya
20, 21	Samuel Mwenda Cyprian Kamau	CHAK	Field mission: Nairobi, Kenya

Zambia Mission (July 25-28): 10 people in 6 interviews/focus groups

	Name	Role/Organization	Location
1, 2	Medhin Tsehaiu Kenneth Mwansa	UNAIDS	Field mission: Lusaka, Zambia
3, 4, 5	Lenganji Nanyangwe Arlene Phiri Bethany Baxter	PEPFAR	Field mission: Lusaka, Zambia
6	Yorame Siame	CHAZ (participant in Learning and Skills Building Training Session at Biennial Meeting of ACHAP)	By telephone: Lusaka, Zambia
7	Daliso Mumba	NAC Zambia	Field mission: Lusaka, Zambia

	Name	Role/Organization	Location
8, 9	Pastor Teddy Mwananshiku Khondwani Malita Satourni	Independent Churches of Zambia Young Women Christian Association Attended WCC Consultation in Zambia	Field mission: Lusaka, Zambia
10	Julie Baratita-Esmeralda	ZINGO	Field mission: Lusaka, Zambia

APPENDIX F BRIEF FINANCE AND ADMINISTRATIVE ANALYSIS

IP	Total Budget	Overhead	Payment Schedule	Completion Date on Funding Agreement	Total paid to date	Comment
ACHAP	99 069 $	5% 4 717,71$	50% on signature 50 % after final report	March 31 2017	49 535 $	mistake on p.4 where the name EMORY appears instead of ACHAP final payment on Sept 17 but activities not completed?
BAI	150 000 $	5,8% 8 268$	50% signature 25% interim report 25% final report	March 31 2017	131 000 $	last payment split in two given lengthy process for approval of report by PEPFAR 18 500 $ remaining
CARITAS	152 101 $ 121 829,53$ total 273 930,53$	not specified	62% on signature 38% final report (C1) 52% on signature 48% final report	June 30 2016 no information on project 2	152 101$ 64 021$ total 216 122$	64 021 $ in process financial reports in euros, funding agreement in $
EMORY representing an academic	500 000 USD	6,1% 28 785$	50% on signature 20%	March 31 2017	350 000 USD	payment schedule in the funding agreement is wrong as 100% would be provided

IP	Total Budget	Overhead	Payment Schedule	Completion Date on Funding Agreement	Total paid to date	Comment
consortium			20% 10% balance with final report according to funding agreement [but there should be no balance]			before getting the final report.
WCC	450 000 USD	30 607$ 7,2%	50% on signature 40% interim report 10% final report	March 31 2017	405 000 USD	overhead includes audit costs: 7 627$, when eliminated, overhead goes down to 5,4%

Appendix G Suggested Concept Paper

Project Title:

Name of organization:

Consortium members (*if applicable*):

Date of the document:

Duration (with start and end dates):

Budget:

1. Introduction:
2. Rationale – relevance:
   2.1. Describe how the proposed project will contribute to the overall program objectives
   2.2. Describe the rationale for selecting the proposed countries
   2.3. Describe why the organization is a best fit for this project

3. Describe the starting point – where Phase I ended – results achieved (briefly) and remaining challenges to be addressed in Phase II

4. Project description
   4.1. Project objectives, expected outcomes, and outputs with their indicators and relate them to the program expected outcomes
   4.2. Risk analysis
   4.3. Activities and work plan

5. Knowledge sharing and Communication Strategy (*a paragraph or two explaining how knowledge will be shared between key stakeholders and more widely with the public (using media, social media and own organizations websites*).

6. Sustainability Strategy *(a paragraph or two explaining how activities were planned to ensure that results will last, or activities will continue after the end of the project)*

7. Administrative deliverables: reports to be provided with timeline

8. Monitoring: how will the IP ensure that expected outputs and outcomes have occurred? *Given that there will be an overall and detailed program results matrix, it is not necessary for each project to have its own. Each IP can refer to the overall results framework.*

9. Resources required - budget

APPENDIX H SUGGESTED REPORTING

Introduction

Frequency and content of reports should align with the program management requirements and frequency of meetings (virtual or face to face (F2F)) between IPs and PEPFAR/UNAIDS (on a bi-monthly basis).

The following provides a model for bi-monthly reports and the semi-annual and final reports.

Suggested Format for the Implementing Partner Monthly Report

NAME OF ORGANIZATION		**REPORTING PERIOD**		**DATE OF REPORT**	
Related Outcome:					
Planned Activities for the reporting period[13]	Activities achieved	# participants if applicable (M/F)	Status *(indicate a % completion rate)*	Budget and % spent	Issues to be discussed
Related Outcome					
Planned Activities for the reporting period	Activities achieved	# participants if applicable (M/F)	Status *(indicate a % completion rate)*	Budget and % spent	Issues to be discussed

[13] adding a column for cumulated activities achieved. Thus, each report would gradually build up the total picture and the final monthly report could be annexed to the final report. Same with the mid-term report.

Suggested Mid-term and Final Reports Template

Project title:

Name of organization:

Consortium members (*if applicable*):

Reporting Period:

Date of the report:

1. **Introduction**: project background and objectives

2. **Key Achievements***: provide a brief summary of key achievements (outputs and outcomes when possible) from the period under review – using bullets.*

3. **Relevance**: *describe briefly if the project is still relevant, if there has been any change at the global and/or country level that would require attention, some modification.*

4. **Activities and Outputs Achieved**: *describe activities achieved, whether they have resulted in the expected outputs. Refer to evaluations done by participants. Signal any action undertaken by participants after the event and indicate if these are likely to contribute to the achievement of outcomes.*

5. **Gender equality and human rights:** *in this section, there should be a special mention of how activities were planned, managed to ensure full participation of women, key populations and have addressed human rights. Addressing stigma and discrimination should also me mentioned here.*

6. **Challenges and lessons learnt:**
    a. *Referring to risks identified in the results matrix, identify if any of these risks materialized, what has been the mitigation strategy?*
    b. *Were there any additional challenges? How were they addressed?*
    c. *What are the key lessons learnt?*
    d. *Are there concerns that the activities will exceed the timeline of the SOW/funding?*

7. **Recommendations – next steps** (for mid-term report only)

Annexes (as appropriate)

- Workplan
- Latest bi-monthly report
- Results framework – portions related to this specific project
- Meeting reports
- Publications
- Case Studies
- Web stories
- Press releases

ANNEX I: MANAGEMENT PLAN OF THE PEPFAR/UNAIDS FBO MID-TRM EVALUATION PHASE I

Management Plan of the PEPFAR/UNAIDS FBO Mid-term Evaluation Phase I

A Mid-Term Review management plan has been developed to detail how decisions related to the review will be made and who will be expected to play key roles.

	Description	Who's involved	Timeframe
External evaluation senior managers	Role: · Provide programmatic and strategic inputs to the review team · Review and comment on the draft report · Accept final report and provide UNAIDS/PEPFAR response	PEPFAR- Sandra Thurman and Cornelius Baker UNAIDS Mariangela Simao and Joel Rehnstrom	3 opportunities to advise 1) Inception meeting 2) Presentation of draft report 3) Final Report and Response
External mid-term evaluation steering group	Role: oversee management of the review process including: · Inception briefing of the consultant team · Overview of the review methodology (including methodology and review questions) · Overview of inception report · Advice on Identification of key informants · Review and comment on the draft report	PEPFAR: John Palen, UNAIDS Evaluation- Elisabetta Pegurri. FBO liaision Sally Smith. Independent – Sophie Dilmitis	Four conference calls 1) Initial briefing 2) Inception report 3) Presentation of draft report 4) Review of first draft final report.
External Review – HQ Oversight	Oversee the review process including: · Management of the RFP process · Manage review team's contract (APW) · Prepare background documentation (desk review) · Support to global key informant interviews · Convening of meetings/conference calls · Convening of Review Findings Briefing · Distribution of the final report	Sally Smith with Elisabetta Pegurri	Throughout