The PEPFAR Local Capacity Initiative Evaluation Methods in Uganda

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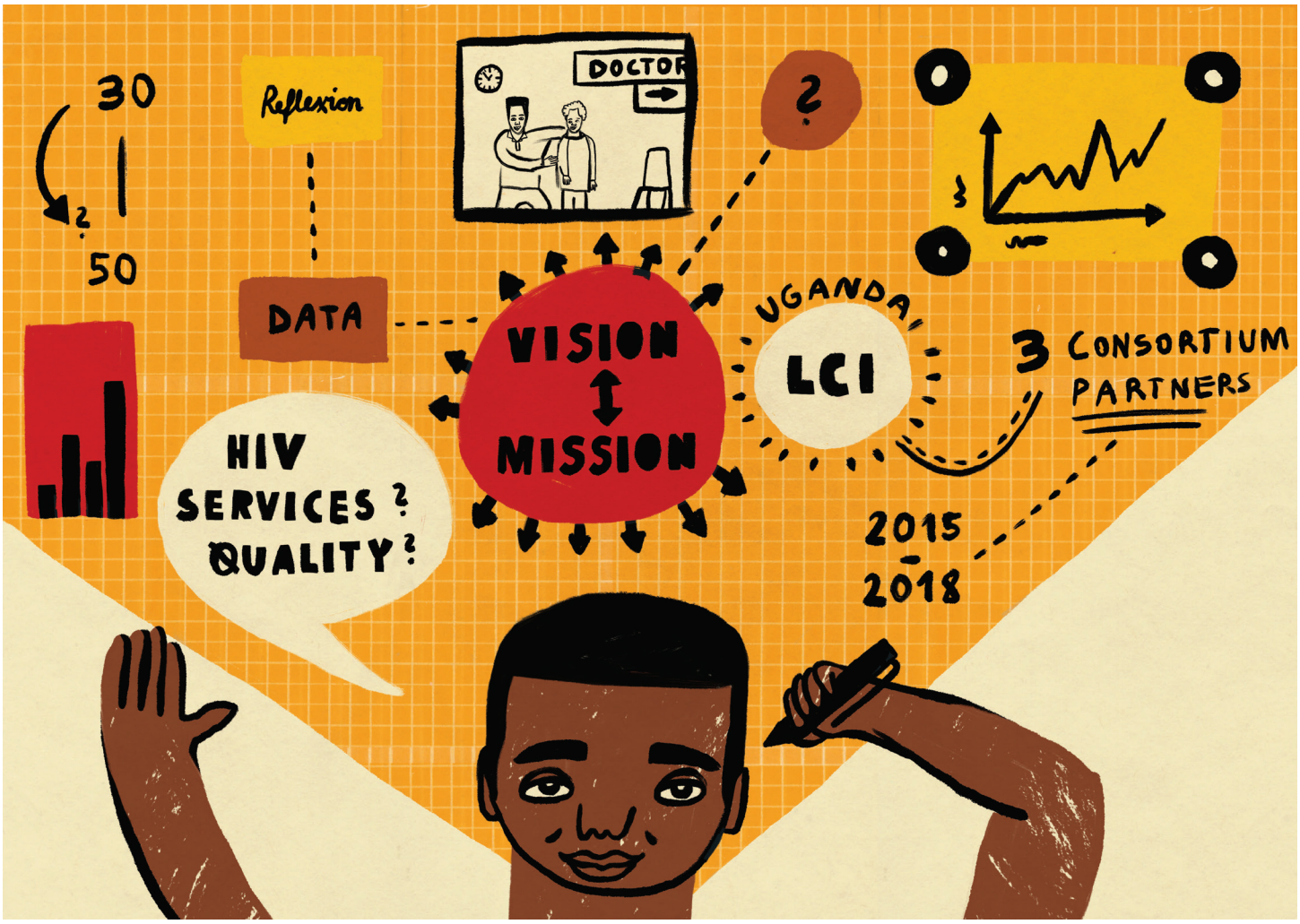
The Local Capacity Initiative (LCI) strengthened the capacity of civil society organizations (CSOs) to support policy advocacy, with the ultimate goal of improving health services for key populations (KPs) affected by the HIV epidemic.[1] The United States President's Emergency Plan for AIDS Relief (PEPFAR) funded the initiative from 2013–2018 to help local CSOs create an enabling environment for PEPFAR's objectives.

[1] Key populations include men who have sex with men, sex workers, people who use injectable drugs, and transgender people.

Under the LCI, the United States Centers for Disease Control and Prevention (CDC) worked in Uganda between 2015 and 2018 to strengthen the policy advocacy capacity of CSOs that worked with men who have sex with men (MSM), transgender women, and sex workers and develop the capacity of public health officials (PHOs) to consider gender and sexual diversity issues. MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and PEPFAR, conducted an evaluation of LCI Uganda (referred to hereafter as LCI) between 2017 and 2018.



This brief provides an overview of the methods that the evaluation team used to measure change resulting from LCI's work. Additional briefs summarize the main interventions that LCI employed to create an enabling environment for HIV policy,[2] provide overviews of work to develop organizational capacity through coalition building,[3] and an overview of the community scorecard (CSC) strategy to improve HIV clinical services in Uganda.[4]

The evaluation of LCI in Uganda assessed the mechanisms by which policy advocacy engagement supported the uptake of high-quality HIV services for KPs. LCI includes multilevel interventions, a long causal chain, emergent intermediate results, susceptibility to external factors, such as the political environment, and outcomes that are difficult to measure.[5] Policy advocacy programs must be highly flexible so they can meet unanticipated needs and benefit from unexpected opportunities. The evaluation accommodated the initiative's complexity through a mixed-methods design with cross-sectional and longitudinal components. It relied on surveys, in-depth interviews, and secondary analysis of participatory program data.

Evaluation Design

LCI built the advocacy capacity of CSOs in 14 countries, based on the following theory: if an international donor can foster an enabling environment that empowers local CSOs to conduct KP advocacy among local and national health system administrators, KPs' access to good-quality HIV services will improve. Advocacy is any legal process that attempts to change government or private-sector policy.[6, 7] It requires an act on behalf of a population to secure or retain social justice.[8] As policy has become more international and multileveled, and civil society has become more diverse, the need for diverse advocacy activities has also increased. Specific strategies respond to differing social, cultural, institutional, and economic circumstances. The following are tactics that CSOs deploy to share knowledge and expertise: building and participating in coalitions, grassroots organizing, messaging campaigns aimed at educating and engaging the public, and direct lobbying.[9, 10, 11]

Evaluating a policy advocacy program requires a study design that accounts for a large range of tactics or activities. Some of these tactics will be known at the outset of a program, and others may emerge in response to an opportunity. Programs are considered complex when they tackle a problem with a broad spectrum of activities, owing to low certainty or lack of agreement on how to solve the problem.[12] Complex programs are necessarily flexible and responsive and require complex impact evaluation methods. Historically, complex programs have lent themselves to retrospective methods of evaluation using case studies that gather emergent outcomes and plausibly tie them to interventions, using triangulation. The LCI evaluation expanded on this traditional evaluation design by using a prospective theory-driven mixed-methods case series. Grounded in a participatory ethos and employing several data collection methods, the evaluation collected data through mixed methods at the start-up phase of the program and at its close. Evaluators worked with program implementers to develop a theory of change that described the intended causal chain. An initial case study of early interventions captured the intermediate outcomes and identified emergent opportunities and interventions. The follow-up case study reassessed the potential effects of interventions identified at baseline and studied connections along the long causal chain.

The LCI evaluation employed methods carefully tailored to the complex context and program. A strong theory of change shaped the study design—outlining the progression from capacity building, to policy advocacy engagement, to uptake of services in a series of hypotheses. Results from a cross-country assessment of LCI informed development of the theoretical model. Figure 1 illustrates the LCI theory of change.

[2] Freyder, M., Namisango, E., Taylor, T., Glover, A., & Andrinopoulos, K. (2020). The PEPFAR Local Capacity Initiative Interventions in Uganda. https://www. measureevaluation.org/resources/publications/fs-19-362

[3] Andrinopoulos, K., Namisango, E., Taylor, T. Glover, A., & Freyder, M. (2020). The PEPFAR Local Capacity Initiative Supports a Coalition of Civil Society Organizations Serving Key Populations in Uganda. https://www.measureevaluation.org/resources/publications/fs-19-412

[4] Freyder, M., Namisango, E., Taylor, T., Glover, A., & Andrinopoulos, K. (2020). The PEPFAR Local Capacity Initiative Supports the Community Score Card to Improve HIV Services for Key Populations in Uganda. https://www.measureevaluation.org/resources/publications/fs-19-413

[5] USAID. (2013). Discussion note: Complexity-aware monitoring. Version 2.0 December 2013.

[6] Baumgarten, L. (2004). Building capacity for public policy advocacy. Paper presented at: Enhance2004.

[7] Roebeling, G. & Sarajevo, Bosnia and Herzegovina: Technical Assistance for Civil Society Organizations (TACSO).

[8] Donaldson, L. P., Matthews, V. E. & Washington, M. M. (2007). Advocacy by nonprofit human service agencies: Organizational factors as correlates to advocacy behavior. ***Journal of Community Practice,15,*** 139–159.

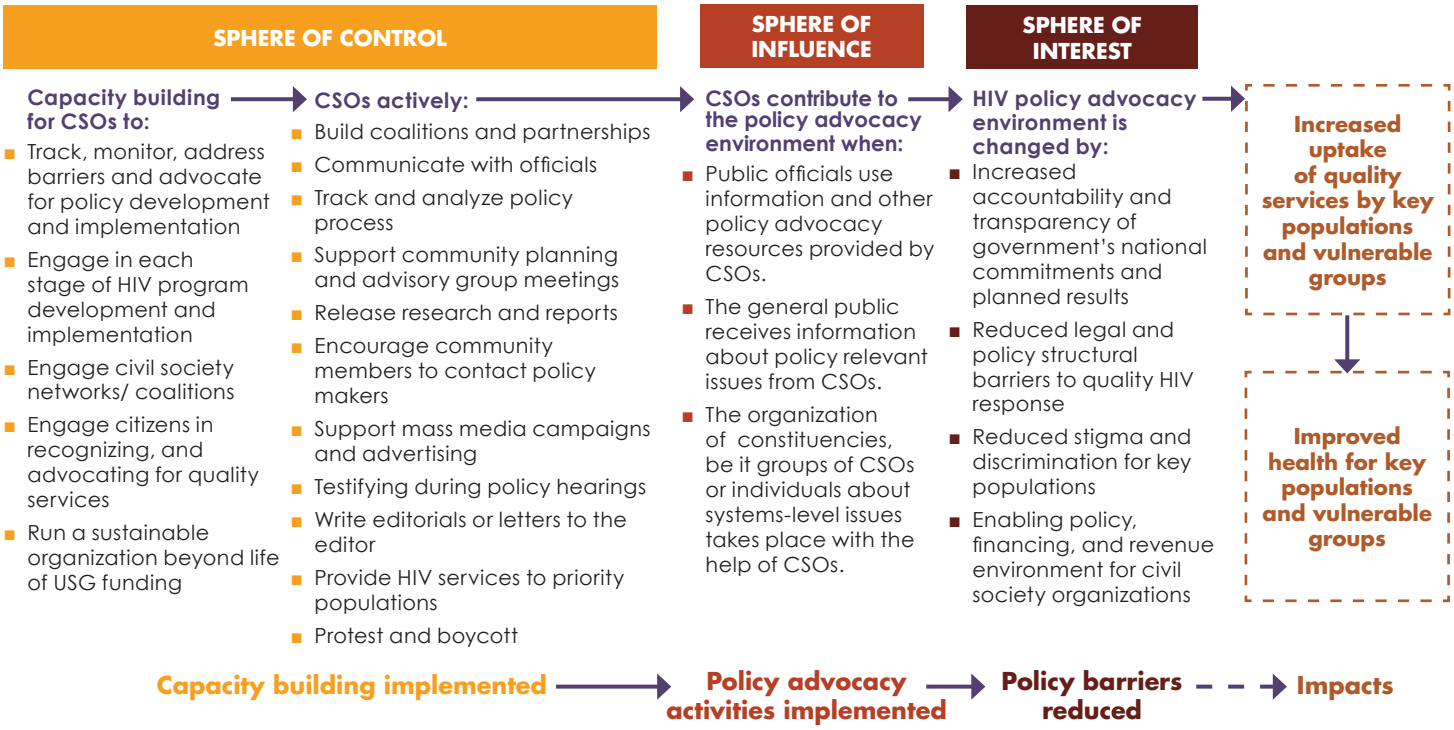
[9] Baumgarten, L. (2004). Building capacity for public policy advocacy. Paper presented at: Enhance2004.

[10] Sandfort, J. (2011). Enabling & constraining advocacy practices through human service networks. Paper presented at: Public Managment Research Association Conference 2011; Syracuse, NY, USA.

[11] Sandfort, J. (2012). Analyzing the practice of nonprofit advocacy: Comparing two human service networks. Washington, DC, USA.

[12] USAID. (2013). Discussion note: Complexity aware monitoring. Monitoring and evaluation series, version 2.0 December 2013.

Figure 1. LCI logic model on policy advocacy and capacity building



Evaluation Aims

The LCI evaluation set out to achieve the following four aims:

1. Demonstrate how a policy advocacy approach can be applied to achieve HIV-related goals for sex workers and MSM
2. Describe changes in the advocacy capacity and practices of CSOs in response to intervention activities
3. Assess the influence of policy advocacy activities on the knowledge and attitudes of public officials toward sex workers and MSM and HIV service provision for these groups
4. Examine trends in quality of HIV services provided to sex workers and MSM in LCI model facilities

Methods

As described above, this evaluation followed a prospective theory-driven mixed-methods case series study design. A case series design allows a story to be told over time, through the perspectives of diverse participants engaged in and affected by the program. Our application of this design drew from mixed methods to gather layered data that we used to triangulate results. This process led to results that were characterized both by breadth and depth.

Qualitative Methods

The LCI evaluation team interviewed 31 people; half were CSO workers or clinic workers, and half were engaged in health administration at the district or national level. The team collected traditional semistructured interviews with health administrators. CSO workers and clinic workers participated in a traditional semistructured interview and were then asked to provide a "story of change" related to LCI interventions. Respondents were then asked to participate in focus group discussions to review and rank each other's stories of change. The focus group discussions collected story rankings, criteria for the rankings, and a fully developed group story. The evaluation team conducted 60 in-depth interviews and three focus group discussions between February 2017 and May 2018.

The interviews were audio-recorded with the subjects' permission. Interview notes and transcripts were analyzed using NVivo to deconstruct and categorize data and synthesize themes. All traditional interview material and all stories of change underwent a theme analysis. Codes were developed a priori based on the research aims and in vivo as the analysis progressed.

Interview notes, rather than audio recording, captured information from focus group discussions. Storytellers shared their stories of change, collected in the

semistructured individual interviews, during the focus group discussion. Additional data and a participant analysis were collected during the focus group discussion via the rankings, the discussions about criteria for the rankings, and the development of a group story about the most significant change.

The most significant change methods used in this evaluation yielded data related to program outcomes, mechanisms of change, change makers, and attribution for change. Figure 2 presents a map of most-significant-change data collection and participatory analysis processes.

Quantitative Methods

The LCI evaluation drew on three sources of quantitative data: (1) surveys of individual CSO workers and PHOs (including providers at health facilities), (2) community scorecard facility assessments, and (3) an organizational survey including a networking module. These quantitative data supplemented findings from the qualitative data.

Surveys with CSO Workers and Public Health Officials

Individual surveys were collected using EPIdata and analyzed using Stata 13. Univariate analysis included frequencies and distributions for all variables at the 2017 baseline and 2018 end line. Bivariate analyses were conducted using chi-squared tests of association and two-sample t-tests.

All CSO workers engaged in LCI-related efforts at LCI-affiliated CSOs were invited to take part in survey rounds in 2017 and 2018. These survey rounds included 134 and 132 participants, respectively. Seventy-one CSO workers participated in both rounds, providing data for longitudinal analysis. Surveys covered the following topics: participant demographics and background; position and responsibilities; knowledge of and exposure to LCI; LCI-related training and mentorship; work activities; perceived results of advocacy work; task self-efficacy; work relationships; and feelings about work.

All PHOs listed by LCI liaisons as being within the project's sphere of intended influence were eligible to take part in surveys; 119 participated in 2017 and 120 in 2018. Eighty-six PHOs completed both survey rounds. Approximately two-thirds of the respondents were health facility providers and one-third were local or regional facility administrators. As in the CSO survey, the study design enabled cross-sectional analysis of PHO perspectives and practices and longitudinal assessment of how LCI may have affected PHOs' knowledge, attitudes, beliefs, and actions with respect to KPs and HIV policy. The PHO questionnaire included items related to knowledge, perceptions, and attitudes about KPs and vulnerable groups; stigma and discrimination and motivations for doing public service work; exposure to LCI policy advocacy activities; roles in changing policy; role of policy change in public health; and factors perceived as important to policy change.

Community Scorecard Data

The community scorecard (CSC) is a tool that assesses availability and accessibility of HIV and reproductive health services for KPs by healthcare providers and community

Figure 2. Data collection and participatory analysis

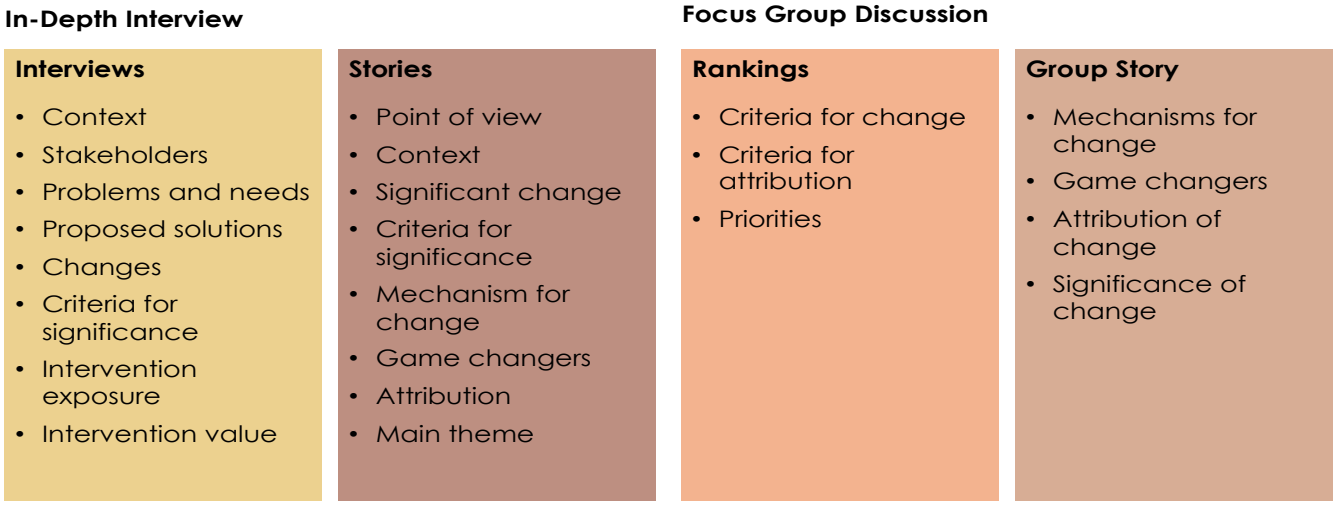
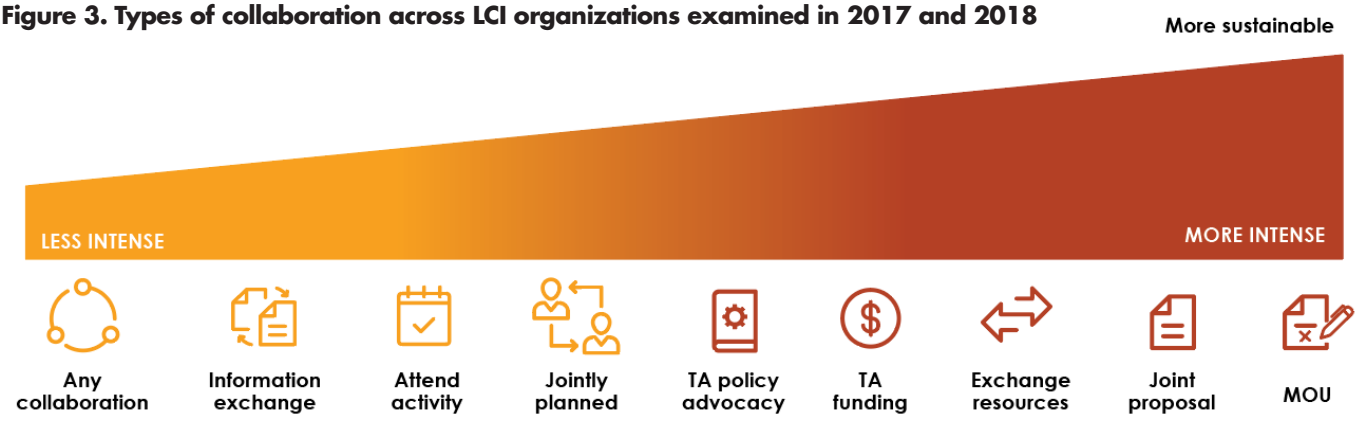


Figure 3. Types of collaboration across LCI organizations examined in 2017 and 2018



TA: technical assistance MOU: memorandum of understanding

members. LCI Uganda staff visited six health facilities quarterly for 15 months and measured progress in several important services: preexposure prophylaxis and other prevention services, HIV testing and counseling, and HIV treatment and reproductive health services. The evaluation also included a secondary analysis of these data.

Organization Level Survey

Coalition building was a key component of LCI, because these community connections improve collective impact of policy advocacy. Representatives from each of the 18 LCI CSOs were asked to complete an organizational assessment that included (1) basic characteristics of the organization; (2) characteristics of the coalition (leadership, cohesion, effectiveness); and (3) collaborations across LCI organizations that would support policy advocacy goals. Organizational surveys were completed by the executive director or other program leader in 2017 and 2018. Figure 3 illustrates the different forms of collaboration that were studied as part of the evaluation.

Lessons Learned

The unique evaluation strategy employed by the LCI study provided several opportunities for learning that can improve future evaluations of complex programs. First, the evaluation team found that sharing data from the start allowed program improvement and increased ownership of the data. These participatory approaches facilitated a culture of continuous improvement and adaptation in program delivery. Second, the evaluation team found that all dissemination was useful—even findings that may seem simple or obvious. The real added value was the opportunity to triangulate data and findings. Third, the evaluation team conducted a preliminary analysis workshop with the program participants. This workshop was key to data use because it allowed participants to visualize the impacts of this program. Qualitative data highlighted challenges that validated respondents' lived experiences, and this opened dialogue at the workshop.

For future evaluations, this team recommends that shorter survey instruments be employed. The surveys used in this evaluation were perceived as too long, and much of the content was not used at the local level. The team also recommends that future evaluations use a similar intensive qualitative inquiry process, because this and the network analysis were seen as highly useful for capacity building and staff development. Finally, the team thought that the case series evaluation was an appropriate design for this type of complex program evaluation and recommended its use for future evaluations.

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