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PERFORMANCE EVALUATION OF USAID/ANGOLA'S HEALTH FOR ALL PROJECT

June 2019

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USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment Number: 594

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This document was submitted by GH Pro to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.

ABSTRACT

The USAID/Angola Health for All (HFA) project works to increase the use of long-lasting insecticidal nets, improve malaria and family planning services, establish sustainable service provision for HIV/AIDS, and improve the capacity of municipal and provincial governments to manage health programs. This midterm evaluation of the HFA project has three objectives: (1) provide information about gaps and opportunities for the project; (2) understand the project's effectiveness in meeting intended results; and (3) identify areas for improvement. Evaluation methods include document review, key informant interviews, secondary analysis of program data, focus group discussions, facility observations, and organizational capacity assessments.

Key Findings

- There has been general adherence to HFA's technical approach of co-diagnosis, co-design, and co-implementation, although progress toward targets has been uneven.
- The malaria municipal supervision tool is a strength, although provincial and national supervision tools need considerable revision.
- HFA has a strong HIV index case program but an infrequent measurement of retention in HIV care.
- Current training and supervision systems do not assure voluntarism and informed choice in family planning counseling.
- Overall, organizational capacity gaps include (1) the implementing team's not maximizing collaboration, (2) an insufficient performance management system, (3) incomplete quality and quantity of local capacity building, (4) stagnant progress on local handover, and (5) low potential for technical and financial sustainability.

Recommendations

- Align training and supervision into an integrated capacity building approach.
- Jointly monitor health worker competence and performance with Government of Angola supervisors.
- Work with government counterparts to develop an HFA sustainability plan.
- Consider opportunities for integrating the community health worker role across service areas.
- Intensify local capacity building.
- Strengthen HFA's human resources to support operations.

ACKNOWLEDGMENTS

This report represents a collective effort and incorporates experiences, opinions, and observations from a wide community of individuals. The evaluation team would like to thank all the people who generously shared their time and insight for this evaluation. First, we would like to express deep appreciation to the leadership and staff of the Health for All (HFA) project for their openness and flexibility in sharing information and perspectives about the challenging work they do, and for the considerable logistical support HFA provided, which was irreplaceable. In addition, the team benefited immensely from the contributions of a number of HFA partners, including officials from the Government of the Republic of Angola; staff at national, provincial, district, municipal, health facility, and community levels; and staff from Linkages, the Procurement and Supply Management Project, UNITEL, the United Nations Children’s Fund, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The U.S. Government team who support and oversee HFA deserve special mention for their time and insights. We would like to thank Armando Cotrina, Chantelle Owens, Gisele Guimarães, and Joana Cardão for their direction, engagement, and flexibility in accompanying this evaluation.

Finally, the evaluation team would like to sincerely thank Kate Bartram, for her unrelenting support in all aspects of the evaluation; Melinda Pavin, for her technical guidance; and Laurie Chamberlain, for her expert editing and encouragement.

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ACRONYMS

ACT	Artemisinin-based combination therapy
ADECO	<i>Agente de Desenvolvimento Comunitário e Sanitário</i> (Community Health Worker)
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral (drugs or medication)
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
CLA	Collaborating, learning, and adapting
COP	Country Operational Plan
CSO	Civil society organization
DHIS2	District Health Information Software 2
DMS	<i>Directores Municipais de Saúde</i> (Municipal Health Directorate)
DNSP	<i>Direcção Nacional de Saúde Pública</i> (National Public Health Directorate)
DPS	<i>Dirrecção Provincial de Saúde</i> (Provincial Health Directorate)
DQA	Data quality assessment
FAS	<i>Fundo de Apoio Social</i> (Repartition of Ministry of Territorial Administration)
FGD	Focus group discussion
FP	Family planning
FY	Fiscal year
GAM	<i>Grupo de Apoio Mútuo</i> (Mutual Support Group)
GEPE	<i>Gabinete de Estudos, Planeamento e Estatística</i> (Office of Planning and Statistics)
GH Pro	Global Health Program Cycle Improvement Project
GoA	Government of the Republic of Angola
GPS	<i>Gabinete Provincial de Saúde</i> (Provincial Health Cabinet)
GTI	<i>Gabinete de Tecnologia da Informação</i> (Office of Information Technology)
HF	Health facility
HFA	Health for All (<i>Saúde para Todos</i>)
HH	Household
HMIS	Health Management Information System
HNQIS	Health Network Quality Improvement System
HQ	Headquarters
HR	Human resources

IC	Index case
ICAP	International Center for AIDS Care and Treatment Programs
iCCM	Integrated community case management
ICTT	Index case testing and tracing
IEC	Information, education, and communication
IIMS	<i>Inquérito de Indicadores Múltiplos e de Saúde</i> (Multiple Indicator and Health Survey)
INLS	<i>Instituto Nacional de Luta Contra a SIDA</i> (National AIDS Control Institute)
IP	Implementing partner
IPTp	Intermittent preventive treatment in pregnancy
IT	Information technology
ITN	Insecticide-treated net
KI	Key informant
KII	Key informant interview
LLIN	Long-lasting insecticidal net
M&E	Monitoring and evaluation
MASFAMU	<i>Ministério da Acção Social, Família e Promoção da Mulher</i> (Ministry of Social Action, Family, and the Promotion of Women)
MAT	<i>Ministerio da Administração do Território</i> (Ministry of Territorial Administration)
MCH	Maternal and child health
MEL	Monitoring, evaluation, and learning
MENTOR	The MENTOR Initiative
MOH	Ministry of Health
MSH	Management Sciences for Health
NHRD	National Human Resources Directorate
NMCP	National Malaria Control Program (<i>Programa Nacional de Control da Malária</i> (National Malaria Control Program or PNCM))
NPHD	National Plan for Health Development (<i>Plano Nacional de Desenvolvimento Sanitário</i>)
NUPAS	Non-U.S. Organization Pre-award Survey
OCA	Organizational capacity assessment
OD	Organizational development
OPM	<i>Oficial Provincial de Malária</i> (Provincial Malaria Official)
OPPM	Provincial Official for the Malaria Program
PAF	Patient assistant facilitator
PEPFAR	United States President's Emergency Plans for AIDS Relief
PMI	President's Malaria Initiative

PMP	Performance Management Plan
PSI	Population Services International
PSM	Procurement and Supply Management Project (GHSC-PSM)
PY	Project year
QA	Quality assurance
QI	Quality improvement
RDS	<i>Repartição Distrital de Saúde</i> (District Health Office)
RDT	Rapid diagnostic test
RFA	Request for Application
RH	Reproductive health
RMA	Rede Mulher Angolana
RMS	<i>Repartição Municipal de Saúde</i> (Municipal Health Repartition)
SASH	Strengthening Angolan Systems for Health (<i>Força Saúde</i>)
SBCC	Social and behavior change communication
SDP	Service delivery point
SEGEP	<i>Sistema Electrónico de Gestão do Paciente VIH+</i> (Electronic Patient Management System for HIV-Positive Patients)
SIMS	Site Improvement through Monitoring Systems
SOP	Standard operating procedure
TB	Tuberculosis
ToT	Training of trainers
USAID	United States Agency for International Development
USG	United States Government
VL	Viral load
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The purpose of the *Saúde para Todos* (Health for All, or HFA) project midterm performance evaluation is to: (1) provide specific information about the gaps and opportunities on which project staff and management staff from the United States Agency for International Development (USAID) can act during the remainder of the project; (2) understand the project's effectiveness in meeting the intended results; and (3) identify areas that need to be modified or improved to increase the project's likelihood of success.

Three questions guide this evaluation:

1. To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?
2. In each technical sector, what are the strengths and challenges to the program inputs, implementation of activities and processes, and the quality and sustainability of outputs?
3. What systems are in place to identify and remedy challenges on program management and structure?

PROJECT BACKGROUND

The HFA project is a five-year cooperative agreement (No. AID-654-A-17-00003) funded by USAID in Angola (USAID/Angola). The \$63 million project is implemented by prime partner Population Services International (PSI), with Management Sciences for Health (MSH) and The MENTOR Initiative as international partners and Rede Mulher Angola (RMA) as a local Angolan partner. HFA operates in 15 of Angola's 18 provinces.

HFA's goal is to support the transformation of USAID/Angola partnerships to strengthen the effective use of Angola's resources to meet the country's development needs. HFA focuses on three major health areas—malaria, HIV, and family planning (FP). These areas lay the foundation for the activity's five expected results:

- Result 1: Long-lasting insecticide net (LLIN) access and use increased by at least 30 percent
- Result 2: Malaria services throughout targeted municipalities improved
- Result 3: Sustainable model for providing high-quality HIV/AIDS services established
- Result 4: Strengthened, expanded, and integrated FP/reproductive health (RH) services at provincial and municipal levels
- Result 5: Capacity of municipal and provincial governments to plan, fund, monitor, and supervise health programs improved

EVALUATION DESIGN, METHODS, AND LIMITATIONS

This midterm performance evaluation comprises a process evaluation design, using mixed methods for data collection. Data sources include document review, key informant interviews (KIIs), secondary analysis of program data, focus group discussions (FGDs) with service providers and community health

workers (CHWs, also known as *Agentes de Desenvolvimento Comunitário e Sanitário*, or ADECOs), facility observations, and an organizational capacity assessment (OCA) of each HFA implementer. The team visited four of the 38 HFA-supported districts to gather qualitative data.

Limitations include the following: (1) since the evaluation used non-probability sampling methods to select districts, facilities, communities, and KII and FGD participants, the evaluation findings are not statistically representative of the larger population from which they are drawn; and (2) because key informants (KIs) constitute one of the primary sources of data, the information provided is subject to personal biases.

FINDINGS

Question 1: To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

Result 1: LLIN access and use increased by at least 30 percent (malaria)

HFA did not meet its Result 1 targets, according to the project's Performance Management Plan (PMP) Fiscal Year 2) In particular, HFA distributed 64 percent of the target number of LLINs, resulting in lower-than-targeted LLIN coverage at the household level (56 percent), among children under 5 years (53 percent), and among pregnant women (82 percent). However, the project reached 90 percent of the CHW training target on counseling in LLIN use.

Technical approach: KIs from the Government of the Republic of Angola (GoA), particularly central-level KIs from the National Malaria Control Program (NMCP), described their poor involvement in all phases of the LLIN mass distribution campaign cycle (situational analysis, planning, implementation, and monitoring). This could have contributed to problems registered during distribution, including:

- Lack of sensitization of/poor information to remote communities and activists managing the short implementation time frame;
- Changes in the availability of the LLINs;
- The number of provinces to cover; and
- Challenges with respect to coordination, communication, and collaboration, due to the new leadership of the National Public Health Directorate, the NMCP, and new governmental authorities at the Provincial Health Directorate (*Direcção Provincial de Saúde*, or DPS) and the Municipal Health Directorate (*Directores Municipais de Saúde*, or DMS) following the 2017 legislative elections.

To address these issues, HFA retains former key staff (provincial and municipal coordinators from Phase 1) to lead and coordinate the campaigns, and combines registration and distribution activities to streamline the process. The GoA is not involved with data collection at any level, nor does it have raw data, relying entirely on HFA's information system. Nevertheless, HFA provides regular reports on the results and progress of the LLIN distribution campaign and holds meetings at provincial and national levels.

Result 2: Malaria services throughout targeted municipalities improved (malaria)

Among HFA's six Result 2 training targets, according to the PMP Project Year (PY)2, the project fully achieved the target for malaria case management at community level and has exceeded the target for formative supervision (artemisinin-based combination therapy [ACT] use and malaria diagnostic). Targets on intermittent preventive treatment in pregnancy (IPTp), malaria diagnostics (rapid diagnostic testing [RDT] and microscopy), and malaria case management with ACT were met at between 70 and 77 percent of targets. The project exceeded formative supervision targets in Zaire and Lunda provinces; however, malaria provincial supervisors reported that there had been no formative supervision training, and that although updated supervision tools (municipal and provincial level) were in place, they were not able to fill them properly.

HFA partially adhered to its technical approach of “co-diagnosis, co-planning, and co-implementation,” as malaria training was co-implemented with the GoA at national, provincial, and municipal levels, but KIs did not report participating in co-diagnosis or co-planning. On the other hand, for integrated community case management (iCCM), all GoA respondents at national, provincial, and municipal levels reported their active involvement in all stages of HFA's technical approach and highlighted excellent collaboration in iCCM activities.

With respect to adherence to FY 2018 work plan activities, training for health workers (IPTp, case management, and malaria diagnostics) and ADECOs was carried out using NMCP-approved curricula. Municipal and provincial supervisors are using updated, NMCP-approved supervision tools (national, provincial, and municipal levels). On the other hand, formative supervision teaching materials and job aids have not been developed and refresher training for certified national laboratory trainers has not been implemented. Nevertheless, site visits at six health facilities (HFs) in Lunda Sul and Zaire indicated that the trained health workers (those interviewed) had good knowledge and skills in malaria case management, malaria diagnostics (microscopy and RDT), and IPTp. The main constraints/barriers for implementing the work plan have been (1) the low technical expertise of the trainers delivering the malaria training and (2) use of an inadequate supervision tool (too long and unwieldy) to monitor malaria services and health staff skills.

HFA decided, jointly with the NMCP/National Public Health Directorate (*Direcção Nacional de Saúde Pública*, or DNSP) to implement training of trainers (ToT), update the supervision tool (national, provincial, and municipal levels), postpone training activities in the third and fourth quarters, and reduce the number of staff to train for PY2. In Lunda and Zaire provinces, lists of trained staff are recorded at the DPS level. Since the Hospital Training Department (*Núcleo de Formação Permanente*) is functioning at Saurimo Provincial Hospital, all data are also recorded in this department. Nevertheless, there is no standardized database for health workers trained in both provinces. For formative supervision, HFA used its own checklist and stored the data in the HFA central database.

The document review and interviews (KIs and FGDs) indicated that HFA encountered no significant barriers to implementing iCCM intervention.

Result 3: Sustainable model for providing high-quality HIV/AIDS services established (HIV)

HFA met its Result 3 targets with respect to the number of testing services provided and the number of persons receiving antiretroviral treatment (ART). However, the project reached less than half its target numbers for *new* ART enrollees for the period and for ART patients screened for tuberculosis. Twelve-month retention levels, at 60 percent, were also below target.

According to GoA interviews, HFA worked in close collaboration with GoA counterparts at the HF level, but above-site KIs felt there was room for improvement with respect to the project's technical approach. Above-site KIs were interested in a formal exchange of experiences and greater involvement and capacity building of municipal/district staff.

Overall, HFA's service delivery approach has been implemented as described in the FY 2018 work plan, with a strategy based on deploying a team of patient assistant facilitators (PAFs) and community counselors based at HFs. PAFs support HIV services by counseling patients who have been newly tested HIV-positive, escorting them to HIV care and treatment, and following up with patients who miss clinic visits by phone or through home visits. Community counselors provide HIV testing to contacts of HIV-positive clients who consent to the process, and facilitate partner disclosure of HIV status. A third facility-based HFA staff member, the case manager, coaches the HIV/AIDS services team, guided by HFA senior staff based at the MSH office. These HFA staff support HFA-supported sites through intensive data management and analysis assistance, addressing gaps through case managers and acting as facility-based coaches. The evaluation team believes the large presence and central role of HFA staff in directing services may have had the unintended effect of reducing the management role of the GoA's facility-level HIV focal points.

Overall, HFA implemented its work plan activities as planned, with a few exceptions HFA perceived to be due to delays in GoA approvals (e.g., the referral/counter-referral pilot) and a directive from the United States President's Emergency Plan for AIDS Relief (PEPFAR), which requires another implementing partner (IP) to work at the above-site level. In some cases, vague work plan language did not allow the team to assess whether activities were implemented as planned.

Result 4: Strengthened, expanded, and integrated FP/RH services at provincial and municipal levels (FP)

HFA met its Result 4 project targets for numbers of ADECOs providing FP information, education, and communication (IEC). However, the project reached only 68 percent of its target with respect to percentage of U.S.-assisted HFs offering FP/RH services and 81 percent of its target for number of health workers trained in FP. The project also met only one of the four national protocols targeted for finalization and approval, which was contingent on GoA action.

Overall, GoA KIs scored their satisfaction with HFA's technical approach as high, with the lowest satisfaction level among provincial-level KIs. Above-site KIs who were not as satisfied with HFA's technical approach—and at least one who was satisfied—were interested in improved collaboration through joint activity planning and implementation. KIs from three levels of care recommended joint supervision visits, as well as an increased number of supervision visits.

Generally, HFA adhered to the service delivery approach outlined in its work plan, focusing on training implemented through a ToT approach and supervision, complemented by group and individual IEC implemented at HFs by ADECOs hired and trained by RMA.

HFA work plan activities that were not met include support for the implementation of District Health Information Software 2 (DHIS2), implementation of gender-based violence training for FP focal points, and broadcasting of FP/RH radio episodes.

Result 5: Capacity of municipal and provincial governments to plan, fund, monitor, and supervise health programs improved (malaria)

In FY 2018, HFA completed the DHIS2 expansion process in the six targeted provinces and surpassed its three annual selected targets: (1) training of Ministry of Health (MOH) staff in DHIS2 (central,

provincial, and municipal levels); (2) DHIS2 complete reporting rate; and (3) number of municipal authorities participating in Health Management Information System (HMIS) data analyses.

KIs at all levels (central, provincial, and municipal) indicated they were actively involved in all DHIS2 activities/processes (co-diagnosis, co-planning, and co-implementation) and reported excellent collaboration with HFA IPs.

Particularly at the beginning of DHIS2 activities, HFA encountered a number of constraints, such as a delay in starting implementation, a lack of equipment, low partner synergies, and low MOH staff capacity. The project allocated efforts to assure capacity building at national (NMCP and Office of Information Technology [*Gabinete de Tecnologia da Informação*]), provincial, and municipal levels, providing regular and qualified technical assistance and supervision visits, purchasing 46 computers to cover the municipalities (DMS) and six provincial DPSs, improving collaboration with all DHIS2 partners, and supporting MOH leadership.

Question 2: In each technical sector, what are the strengths and challenges to the program inputs, implementation of activities and processes, and the quality and sustainability of outputs?

Malaria: The team reviewed three USAID-identified tools—the LLIN Mass Distribution Campaign Toolkit, the Malaria Supervision Tool (national, provincial, and municipal), and the Health Unit Assessment Tool and Results. Strengths of the tools were user-friendliness (municipal supervision tool) and comprehensive content (campaign toolkit and municipal supervision tool).

LLIN Mass Distribution Campaign Toolkit:

- Strengths: A comprehensive tool, in line with the GoA Malaria Control Strategy (2016–2020).
- Challenges: Cost and time needed for developing curricula and teaching materials, defining profile, and establishing the right number of workers to train at all levels (central, provincial, and municipal).

Malaria Supervision Tool (national, provincial, and municipal):

- Strengths: The municipal supervision tool is user-friendly, comprehensive, and appropriate for the routine supervision.
- Challenges: Provincial and municipal tools are not user-friendly, lack differentiation, have incomplete content, and lack a scoring scale. The national and provincial tools are also not user-friendly, and the frameworks are not well-organized, have incomplete content, and lack a scoring scale.

Health Unit Assessment Tool and Results:

- Strengths: Allows identification of health worker training needs in a short amount of time.
- Challenges: Layout and organization.

HIV/AIDS: The evaluation team reviewed three processes identified by USAID—HFA’s approaches to index case testing and tracing, linkage to care, and retention.

- Strengths: HFA’s service delivery approach to all three processes were initiated with the predecessor project, Strengthening Angolan Systems for Health (SASH), and the transition to

HFA was smooth. HFA's implementation has been robust, with gap analysis of service data informing continual learning that is fed back to HF staff through case managers.

- Challenges: Despite this, some indicators remain low, including linkage to care and retention indicators. The intense involvement of HFA staff is the key weakness, as it may have allowed HF staff to focus on clinical work and reduce their management role. The heavy reliance on HFA staff as clinical managers, index case testing health workers, and health workers assuring linkage to care and defaulter tracing also translates into service delivery that is not self-reliant at this point in time.

Family Planning: The evaluation team reviewed the Health Network Quality Improvement Software (HNQIS), adapted for FP supervision, and the HFA approach to FP counseling.

HNQIS:

- Strengths: The tool assesses counseling and manual skills for seven contraceptives. Implementation using tablets may facilitate reporting.
- Challenges: Lack of assessment of voluntarism and informed choice in counseling. Apparent lack of guidance (or lack of confidence in the guidance provided) to the Municipal Health Repartition (*Repartição Municipal de Saúde*) or to HF supervisors on how to conduct supervision or what supervision tool to use until HNQIS is approved.

HFA approach to FP counseling:

- Strengths: Demand creation includes group IEC by ADECOs at FP clinics and other services, including services targeting men. Voluntarism and informed choice are included in training and understood by HF respondents. Job aids are used to communicate FP methods.
- Challenges: The training post-test does not assess health workers on the concepts of voluntarism or informed choice. If used correctly, the job aid *Album Seriado* would help assure comprehensible information on the risks and benefits necessary to make an informed choice, but this job aid was not reported to be available in sufficient quantity. The supervision tool, HNQIS, does not assess for voluntarisms and presumes the supervisor has comprehensive knowledge of contraceptive advantages and disadvantages; thus, it does not assure that supervisors are able to assess for comprehensible or accurate information on FP methods when job aids are not available. Not all GoA and HFA supervisors consistently supervise or observe FP services during supervisions visits. Overall, the current combination of tools does not assure that FP services adhere to the principles of voluntarism and informed choice.

Question 3: What systems are in place to identify and remedy challenges on program management and structure?

HFA is the largest USAID-funded activity in the country, and the USAID/Angola Mission is committed to its success, as demonstrated by its financial and human resource (HR) allocations, steady GoA partnership support, and diligent management of HFA performance. The HFA implementing team is also committed and actively working toward achieving results. PSI's emphasis on and attention to strong administrative and financial systems has had a contagious effect on its subcontractors, particularly RMA. The self-assessed average OCA rating of each implementer's structure and systems was as follows: MSH—3.8 out of 4; PSI—3.5 out of 4; The MENTOR Initiative—3.3 out of 4; and RMA—2.5 out of 4.

Nevertheless, the evaluation team observed a number of overarching external and internal factors limiting implementation, results achievement, and sustainability. Externally, HFA operates under various critical assumptions, corresponding to the Angolan context, the GoA and, to a lesser extent, the U.S. Government. Internally, gaps exist that are influencing or stemming from the current structure and systems weaknesses: (1) the implementing team's not maximizing collaboration; (2) inconsistent fidelity of PSI's approach (co-diagnose, co-design, and co-implement); (3) an insufficient performance management system; (4) incomplete quality and quantity of local capacity building; (5) stagnant progress on local handover; and (6) low potential for technical and financial sustainability.

Regarding structure, implementers are over-centralized in Luanda, with the exception of The MENTOR Initiative. For PSI, the current structure warrants immediate adjustments. With respect to systems, IPs cited gaps in program management, performance management, and organizational management and sustainability. With the exception of MSH, IPs have gaps in HR systems that include insufficient staffing levels, inability to determine optimal workforce headcounts, awareness of job descriptions and roles/responsibilities, recruiting, appropriateness of personnel, and retention.

RECOMMENDATIONS

Malaria

LLIN Campaign

- Focus on building NMCP capacity to plan, implement, and monitor LLIN distribution campaigns.
- Convene a Technical Working Group (GoA partners, NMCP/DNSP) to finalize the LLIN and social and behavior change communication national strategy, standardizing tools to facilitate the LLIN distribution campaign (plan and implementation training curricula and materials).
- Set up an appropriate monitoring and evaluation system and targets to monitor LLIN access, use, and behavior change.

Service Delivery

- Provide technical assistance to establish community case management of malaria to assure the quality of malaria diagnosis and build provincial- and municipal-level NMCP capacity for training and supervision of activities using the cascade approach.
- Integrate malaria training (IPTp, malaria in pregnancy, and case management of children under 5 years) into maternal and child health program training.
- Continue to train lab technicians and health workers, by category, in each targeted province.
- Support the NMCP to develop guidelines for laboratory quality assurance and formative supervision, as well as tools to operationalize these activities.
- Support the MOH and Ministry of Territorial Administration (*Ministerio da Administração do Território*) to coordinate integrated treatment.

DHIS2

- Continue to support DHIS2 technical assistance at municipal, provincial, and national levels, including data analysis for decision-making.
- Jointly develop a data quality assurance system with GoA partners.

HIV/AIDS

- Develop and implement a communication plan that articulates how HFA's learning and experiences will be shared with partners such as the National AIDS Control Institute (*Instituto Nacional de Luta Contra a SIDA*), Provincial Health Cabinet (*Gabinete Provincial de Saúde*, or GPS), RMS, District Health Office (*Repartição Distrital de Saúde*, or RDS), and the International Center for AIDS Care and Treatment Programs, including documents to be shared, meetings, and site visits.
- Facilitate joint development of a sustainability plan with GoA partners and IPs.
- Develop a hierarchy of HIV/AIDS service delivery dashboard of indicators that HF managers can independently collect and use to manage quality of care.
- Guide the Quality Assurance Committee to strengthen HF staff management.

Family Planning

- Improve joint planning with DNSP/GPS/RMS/RDS by sharing key planning documents to identify opportunities for collaboration.
- Align training and supervision content to assure voluntarism and informed choice.
- Develop an HR database to keep track of FP health worker training attendance, competence (assessed at training), and performance (assessed during supervision).
- Use provincial (GPS) monthly meetings of RMS staff to strengthen management and leadership

Question 3: What systems are in place to identify and remedy challenges on program management and structure?

At this midpoint in HFA implementation, there is ample opportunity for course corrections. The recommendations that follow are for USAID and IPs. The recommendations should be considered as options to spur corrective actions that will enhance the achievement of results.

- **HFA IP Team:** These recommendations seek to add value to the IPs' OCA action plans. As some have cost implications (e.g., structure, staffing, and material resources), PSI and USAID can assess the recommendations for relevance and cost feasibility and prioritize management actions in acting on them.
- **PSI:** Five key actions are recommended to strengthen PSI's current systems and structure: (1) decentralize the structure and reinforce field operations; (2) strengthen the HFA performance management system; (3) intensify local capacity building with RMA; (4) strengthen HR to support operations; and (5) improve strategic management of the HFA implementing team.
- **MSH, The MENTOR Initiative, and RMA:** Beyond carrying out individual OCA plans, all subcontractors should work with PSI to strengthen their structure and systems via the following improvement areas and actions: change management processes and contingency planning; sustainability planning; gender assessment and mainstream planning; and performance management standards and efforts (e.g., data collection and use).

I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this midterm evaluation is threefold: (1) identify gaps and opportunities that *Saúde para Todos* (Health for All, or HFA) project staff and USAID management staff can act on; (2) understand the effectiveness of the project in meeting its intended results; and (3) identify areas that need to be modified or improved to increase the project's likelihood of success.

U.S. Government (USG) technical and management teams in Angola will use the evaluation findings to understand gaps in implementation and make decisions and take necessary actions.

EVALUATION QUESTIONS

1. To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?
2. In each technical sector, what are the strengths and challenges to the program inputs, implementation of activities and processes, and the quality and sustainability of outputs?
3. What systems are in place to identify and remedy challenges on program management and structure?

In addition, the USG team requested a data quality assessment (DQA) to provide information about the level of confidence that can be placed on HFA data used to report on progress toward project targets, a question embedded in Evaluation Question 1.

II. CONTEXT AND PROJECT BACKGROUND

Angola has experienced substantial growth since the 27-year civil war ended in 2002. Currently classified as a lower-middle-income country,¹ Angola's gross domestic product has grown more than 47 percent over the previous decade,² estimated at \$124 billion in 2017. Its population of more than 28 million inhabitants² grew 37 percent over the same period.³

Despite progress in improving health outcomes,³ Angola still faces a number of challenges. Under-5 mortality is estimated at 68 deaths per 1,000 live births,⁴ higher than the regional average of 52. The maternal mortality ratio is estimated at 239 per 100,000 live births,⁴ below the regional average,⁵ but well above the average for lower-middle-income countries.⁶ At the same time, only 45 percent of the population has access to a public health facility⁷—a figure that belies wide urban–rural disparities in access—and Angola's literacy rate is estimated at 66 percent.⁸

In recent years, the government's ability to address social priorities has faced a number of challenges, including the 2014 drop in oil prices, paired with the country's over-reliance on petroleum and the 2017 legislative elections, which led to a change in government leadership, including the President, Cabinet of Ministers, Minister of Health, and National Public Health Directorate (*Direcção Nacional de Saúde Pública*, or DNSP) Director.

The National Plan for Health Development (NPHD) 2012–2025 states that malaria is responsible for 35 percent of curative care, 20 percent of hospital admissions, 40 percent of perinatal deaths, and 25 percent of maternal mortality in Angola.⁵ At the same time, only 31 percent households own at least one insecticide-treated net (ITN).⁹ While Angola's strategic plan recommends that suspected cases of malaria be diagnosed with a rapid diagnostic test (RDT) or through microscopy, the most recently available data indicate that less than a quarter (24.5 percent) of children under 5 years with a recent fever received any diagnostic test.¹⁰

¹ World Bank Atlas method.

² World Bank. World Development Indicators. <https://datacatalog.worldbank.org/dataset/world-development-indicators>.

³ Institute for Health Metrics and Evaluation. Global Burden of Disease, Institute of Health Metrics and Evaluation. <http://www.healthdata.org/angola>. Accessed January 5, 2019.

⁴ Instituto Nacional de Estatística (INE)/Ministério da Saúde (MINSÁ)/Ministério do Planeamento, e do Desenvolvimento (MINPLAN)/ICF International. Inquérito de Indicadores Múltiplos e de Saúde Em Angola, 2015-2016. Luanda, Angola and Rockville, Maryland, USA; 2017.

⁵ The maternal mortality ratio for Sub-Saharan African is estimated at 546 per 10,000 live births. Source: World Health Organization (WHO). Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division; 2015.

⁶ The maternal mortality ratio for lower-middle-income countries is estimated at 169 per 10,000 live births. Source: World Health Organization (WHO). Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.; 2015.

⁷ Ministerio da Saude/Republica da Angola. Plano Nacional de Desenvolvimento Sanitário 2012-2025. Vol I.; 2014.

⁸ Instituto Nacional de Estatística (INE) Ministério da Saúde (MINSÁ) e Ministério do Planeamento. Resultados Definitivos Recenseamento Geral Da População E Habitação – 2014.; 2016.

⁹ Instituto Nacional de Estatística (INE)/Ministério da Saúde (MINSÁ)/Ministério do Planeamento, e do Desenvolvimento (MINPLAN)/ICF International. Inquérito de Indicadores Múltiplos e de Saúde Em Angola, 2015-2016. Luanda, Angola and Rockville, Maryland, USA; 2017.

¹⁰ Instituto Nacional de Estatística (INE). Inquérito Integrado Sobre o Bem-Estar Da População (IBEP) 2008-20. Grelha de Indicadores. Vol. II. Luanda; 2011.

In 2013, the National Malaria Control Program (*Programa Nacional de Control da Malária*, or PNCM) adopted the policy that new intermittent preventive treatment in pregnancy (IPTp) be provided to all pregnant women at each scheduled antenatal care (ANC) visit (i.e., at least three doses of preventive treatment¹¹). The Multiple Indicator and Health Survey (*Inquérito de Indicadores Múltiplos e de Saúde*, or IIMS) survey found that only about one-third (37 percent) of pregnant women received two or more doses of IPTp. Barriers to facility-based case management include low population access to public health facilities (HFs), stockouts of RDTs and artemisinin-based combination therapy (ACT), and poor capacity of health workers and lab technicians.¹²

Along with malaria, HIV/AIDS is among the top five causes of premature death in Angola.² Driven by a generalized, primarily heterosexual HIV/AIDS epidemic, HIV prevalence is estimated at 2.0 percent among adults aged 15–49 years and 2.6 percent among adult women.¹³ Surveillance studies conducted in 2016 indicated that Luanda province has the highest burden of people living with HIV and key populations, with prevalence estimated at 7.8 percent among female sex workers and 2.4 percent among men who have sex with men and transgender men and women.¹⁴

According to the 2017 United States President’s Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan (COP),¹⁵ more than 50,000 persons tested HIV-positive in 2015, and 55 percent of adults (63 percent of children) were initiated on antiretroviral treatment (ART). Only 66 percent of HIV-infected pregnant women in Luanda received antiretroviral drugs (ARVs). Tuberculosis (TB) accounts for one in every three AIDS-related deaths globally, yet in 2015, only 48 percent of TB patients were tested for HIV in the Angolan health system.⁸ Co-infection rates are likely to continue to increase, as 2016 TB incidence rates represent a 25 percent increase from incidence levels in 2000.¹⁶

Family planning (FP) programs have contributed to decreased maternal mortality and reduced burden of high-risk births due to high parity and shorter birth intervals.^{17,18} Angola’s fertility rate of 5.7³ is higher than the regional rate of 4.8 and double the lower-middle-income country rate of 2.8.¹ Angolan women tend to start having children early. One in every three girls aged 15–19 years has begun childbearing⁴; as adolescents, they are at increased risk of pregnancy-related death.⁹ Contraceptive use has increased in recent years but remains low; 14 percent of married women use an FP method.¹⁹ At the same time, 38

¹¹ Fansidar (sulfadoxine and pyrimethamine)

¹² USAID. Projecto de Saúde para Todos (Health for All, or HFA) NFO No. RFA-654-16-000004.; 2012. doi:10.1164/rccm.201104-0679CI.

¹³ Instituto Nacional de Estatística (INE)/Ministério da Saúde (MINSÁ)/Ministério do Planeamento, e do Desenvolvimento (MINPLAN)/ICF International. Inquérito de Indicadores Múltiplos e de Saúde Em Angola, 2015-2016. Luanda, Angola and Rockville, Maryland, USA; 2017.

¹⁴ PEPFAR Angola. Strategic Technical Results (STAR) Process Alignment. Dominican Republic Country Operational Plan COP 2017 Strategic Direction Summary. 2017.

¹⁵ Ibid.

¹⁶ World Bank. World Development Indicators. <https://datacatalog.worldbank.org/dataset/world-development-indicators>.

¹⁷ Brown, W, Ahmed S, Roche N, Sonneveldt E, Darmstadt GL. Impact of family planning programs in reducing high-risk births due to younger and older maternal age, short birth intervals, and high parity. *Semin Perinatol*. 2015;39(5):338-344. doi:10.1053/j.semperi.2015.06.006

¹⁸ Gribble J, Haffey J. Reproductive Health in Sub-Saharan Africa. *Reprod Health*. 2008. <http://www.prb.org/Publications/PolicyBriefs/reproductivehealthafrica.aspx>

¹⁹ Instituto Nacional de Estatística (INE)/Ministério da Saúde (MINSÁ)/Ministério do Planeamento, e do Desenvolvimento (MINPLAN)/ICF International. Inquérito de Indicadores Múltiplos e de Saúde Em Angola, 2015-2016. Luanda, Angola and Rockville, Maryland, USA; 2017.

percent of married women wish to delay or stop childbearing, yet are not using a FP method.²⁰ The health system is not equipped to meet the demand: only 17 percent of HFs have staff trained and authorized to provide free FP services.²¹ Meeting the demand for FP and birth spacing would likely also contribute to a reduction in child and maternal mortality in Angola.

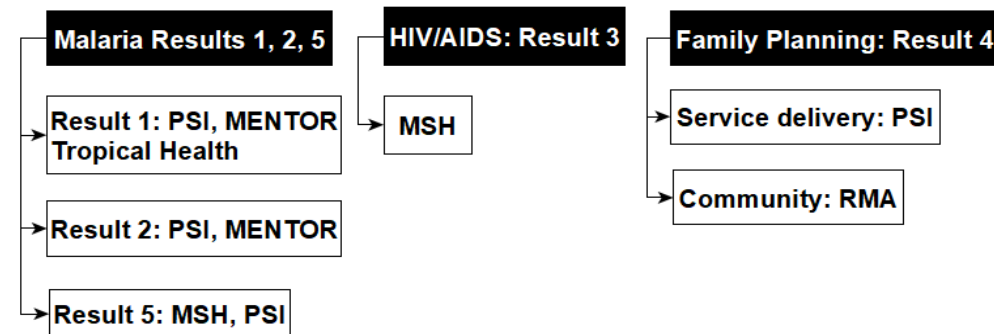
To support Angola’s NPHD²² to meet these challenges in community and facility-based malaria, HIV/AIDS, and FP and reproductive health (RH) services, USAID launched the HFA project in January 2017. Led by Population Services International (PSI), HFA is a \$63 million, five-year cooperative agreement (No. AID-654-A-17-00003, 2017–2022), implemented by a team of partners that also include Rede Mulher Angola (RMA), Management Sciences for Health (MSH), and The MENTOR Initiative. HFA provides technical assistance through a collaborative partnership with, and capacity building of, national, municipal, and provincial authorities and nongovernmental organizations in support of the national strategic plans for malaria, HIV/AIDS, and FP/RH.

HFA’s has five expected results:

- Result 1: Long-lasting insecticidal net (LLIN) access and use increased by at least 30 percent
- Result 2: Malaria services throughout targeted municipalities improved
- Result 3: Sustainable model for providing high-quality HIV/AIDS services established
- Result 4: Strengthened, expanded, and integrated FP/RH services at provincial and municipal levels
- Result 5: Capacity of municipal and provincial governments to plan, fund, monitor, and supervise health programs improved

Figure 1 shows the roles of HFA partners²³ leading service delivery technical assistance under the different expected results.

Figure 1: HFA implementing team members’ roles by project result at project launch



²⁰ Instituto Nacional de Estatística (INE)/Ministério da Saúde (MINSÁ)/Ministério do Planeamento, e do Desenvolvimento (MINPLAN)/ICF International. Inquérito de Indicadores Múltiplos e de Saúde Em Angola, 2015-2016. Luanda, Angola and Rockville, Maryland, USA; 2017.

²¹ USAID. Projecto de Saúde para Todos (Health for All, or HFA) NFO No. RFA-654-16-000004.; 2012. doi:10.1164/rccm.201104-0679CI

²² Ministerio da Saude/Republica da Angola. Plano Nacional de Desenvolvimento Sanitário 2012-2025. Vol 1.; 2014.

²³ Please note that a partnership with Tecnosaúde Angola, SA, was discontinued after project award.

HFA’s stated technical approach strategy is to engage the Ministry of Health (MOH), civil society, the private sector, and beneficiary partners to “co-diagnose fundamental barriers [and] co-design approaches to strengthen health systems.” HFA’s Capacity Building Framework (Figure 2), shows how this approach connects major actions to reach Results 1–5, in addition to contributing to the intermediate results (IRs) and development objectives (DOs) in USAID/Angola’s Country Development Cooperation Strategy. Table 1, below the figure, shows the geographic scope of the HFA project.

Figure 2: Health for All capacity building approach

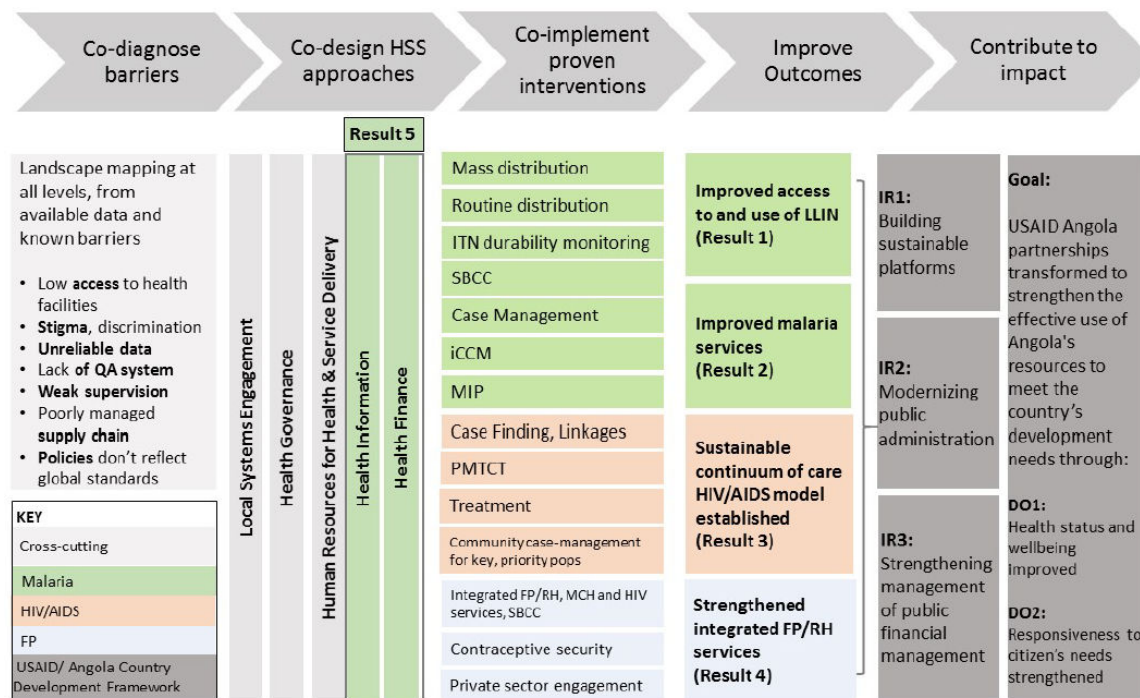


Table 1: Geographic focus for each HFA result

Result	Geographic Focus
1. Malaria prevention	<ul style="list-style-type: none"> • LLIN distribution campaign and strategy: nationwide • LLINs distribution in 15 provinces (Cunene, Namibe, Huambo, Cuando Cubango, Moxico, Lunda Norte, Lunda Sul, Zaire, Uige, Malanje, Kwanza Norte, Kwanza Sul, Bengo, Cunene, and Uige)
2. Malaria services	<ul style="list-style-type: none"> • 407 HFs in 24 municipalities in 6 provinces (Zaire, Uige, Malanje, Kwanza Norte, Lunda Norte, and Lunda Sul). • Integrated community case management (iCCM) through the ADECO system, in limited geographic areas or via pilot activity (currently in Zaire and Lunda Sul)
3. HIV/AIDS	<ul style="list-style-type: none"> • Nine priority clinics in Luanda province, with possibility of two more provinces
4. Family planning	<ul style="list-style-type: none"> • Luanda and Huambo provinces. During Quarter 1, jointly determine number, location of facilities with USAID, DNSP, and General Inspection of Health
5. Health information systems strengthening (DHIS2 and health digital systems)	<ul style="list-style-type: none"> • Nationwide • 60 municipalities and 6 DPSs (Malanje, Kwanza Norte, Zaire, Uige, Lunda Norte, and Lunda Sul).

III. EVALUATION METHODS AND LIMITATIONS

Evaluation Design: This midterm performance evaluation employed a process evaluation design using mixed methods for data collection. Annex II presents the detailed methodology, organized by evaluation question, that originally guided the evaluation. Logistical constraints led to adjustments, which are reflected in this section.

Document Review: The evaluation team reviewed HFA project documents, spreadsheets, and presentations; Government of the Republic of Angola (GoA) documents (e.g., national plans, guidelines, clinical manuals); and other documents related to Angola (e.g., donor strategies and plans, country surveys, journal articles, World Health Organization reports and guidelines). Annex IV contains a list of sources consulted (documents and interviews).

Key Informants (KIs): Data were collected from multiple stakeholders:

- USAID, HFA staff (PSI, MENTOR, MSH, and RMA), international partners, and IPs;
- GoA partners at the national level—MOH; Ministry of Social Action, Family, and the Promotion of Women (MASFAMU); Ministry of Territorial Administration (MAT);
- GoA partners at provincial, municipal, and district levels – Provincial Health Cabinet (*Gabinete Provincial de Saúde*, or GPS; formerly *Direcção Provincial de Saúde*); Municipal Health Department (*Repartição Municipal de Saúde*, or RMS), District Health Office (*Repartição Distrital de Saúde*, or RDS). GPS, RMS, and RDS KIs included health directors/managers, supervisors, a statistician, and focal points for malaria, HIV/AIDS, and FP;
- HF staff—HF directors/in-charges, administrators, lab technicians, doctors, nurses, and statisticians; and
- *Agentes de Desenvolvimento Comunitário e Sanitário* (ADECOS) – community health workers (CHWs) managed by the Repartition of Ministry of Territorial Administration (*Fundo de Apoio Social*, or FAS).

Sampling: The evaluation team conducted field visits for malaria, HIV/AIDS, and FP components in the provinces, DMS, and at HFs purposively selected with USAID guidance:

- For the malaria component (Results 1, 2, and 5), eight of the 82 HFs supported by HFA were selected in four municipalities in two target provinces—Lunda Sul (Saurimo and Cacolo) and Zaire (Mbanza Congo and Cuimba). Two HFs were selected in each municipality. HFs were selected with the following considerations: (1) heterogeneity with respect to more remote locations (i.e., more rural) versus less remote locations (i.e., closer to the provincial capital), as well as different levels of care; and (2) evaluation logistics (i.e., ability to reach sites in each province within a single week).
- For the HIV/AIDS component (Result 3), all seven HFs supported by HFA (100 percent) were included in the sample.
- For the FP component (Result 4), three HFs in each of the two provinces where HFA supports FP activities were identified for the evaluation, out of a total of 207 HFs. Selection criteria

included representation of different levels of care, evaluation logistics, and, in the case of Luanda sites, the presence of both service delivery technical assistance (PSI) and FP social and behavioral change communication (SBCC) activities (RMA).

In addition to these selection criteria, all site selection sampling decisions included the consideration of logistical constraints, given the limited time frame for data collection. In addition, HF KIs interviewed were those available on the day of a site visit, so, to an extent, they represent a convenience sample.

DATA COLLECTION METHODS

Data collection instruments are available in Annex III.

- **Semi-structured Key Informant Interviews (KIIs):** Individual KIIs were used for Evaluation Questions 1, 2, and 3. In addition, group KIIs were used for Results 3 and 4 during HF site visits to interview multiple staff members simultaneously due to their limited availability. Group KIIs involved administering the individual KII tool with more than one person at a time and documenting when different responses were elicited. Where possible, group interviews with management/supervisors were conducted separately from those with providers.
- **Focus Group Discussions (FGDs):** For Results 1 and 2 for the malaria component, FGDs were used with HF staff to gain more in-depth insight into open-ended questions. Unlike group interviews, FGDs guide participants through structured, purposeful, guided interaction, enabling participants to interact with each other's ideas.
- **Content Review:** For Evaluation Question 2, the team compared tools or processes against local or international standards or better practices based on professional experience/expertise, as well as a literature review.
- **Organizational Capacity Assessment (OCA):** For Evaluation Question 3, an OCA tool was tailored to the HFA partner organizations' performance targets and needs (first determined via KIIs). The methodology applied a maturity model benchmarking approach, in which key staff rated the level of maturity of their organization across key areas (e.g., strategic management, financial management, or information technology [IT]). The evaluation team also incorporated a capacity building approach into this methodology to identify champions and develop their ability to conduct a repeat OCA at another point in the HFA lifecycle.
- **Email Survey and Telephone Interview:** For Evaluation Question 1, and as directed by USAID, the malaria team conducted e-surveys for key GPS staff in Lunda Norte, Uige, and Cuanza Norte. KIs who did not respond to the survey received follow-up telephone interviews.
- **Group Flowchart Exercise:** For Evaluation Question 2, HFA case managers, community counselors, patient assistant facilitators (PAFs), and monitoring and evaluation (M&E) coordinators, teamed by HF, participated in a group exercise to jointly diagram a chart of their linkage to care services and barriers.
- **Rapid DQA:** Primary data collection was collected through interviews with HFA strategic M&E staff, as integrated under each HFA result area (malaria, HIV, and FP) using a semi-structured interview guide. Interview content included data collection (flow, storage), validation, and use supporting the production of target indicator data.

ANALYSIS PLAN

The main type of data collected for all three evaluation questions—semi-structured interview data—was analyzed using the same overall approach across evaluation questions. Data were first cleaned, and then key questions eliciting more complex responses or analysis were entered into Microsoft Excel sheets and tagged by respondent to facilitate comparison across KIs. Next, data collected on questions regarding the same question or topic were analyzed to identify patterns within and between stakeholder groups, triangulating when appropriate and feasible. Where there were sufficient data, the team conducted thematic analysis of qualitative interview data to identify patterns or trends. A similar process was employed for FGD data analysis.

- **Evaluation Question 1:** Responses by HFA staff (e.g., regarding technical approach, service delivery approach, and work plan activities) were compared with responses provided by GoA staff at national, GPS, and RMS/RDS levels, and by HF staff. Response data derived from different questions around the same topic were also triangulated to form a deeper understanding of the service delivery system and HFA’s technical assistance approach. With respect to the technical approach scores used for HIV and FP components, since group interviews were facilitated to identify different perceptions, response scores were averaged within each stakeholder group. Secondary analysis of outputs and beneficiary targets was conducted by comparing HFA program indicator data against fiscal year (FY) 2018 targets. Indicator data were extracted from quarterly reports and discrepancies discussed and resolved with HFA staff. For the DQA, information provided from the semi-structured interview was analyzed using a structured DQA checklist that assesses data around five criteria—validity, integrity, precision, reliability, and timeliness.
- **Evaluation Question 2:** Data from KIs with GoA staff (and flowcharts for Result 3) were triangulated to form an understanding of the tool/process design and implementation. Findings were then compared against best/better practices identified in the literature and drawn from the evaluators’ experience. For **Evaluation Questions 1 and 2**, the team developed relevant and actionable recommendations via gap analyses (gap between reality and desired outcomes).
- **Evaluation Question 3:** Findings were generated by two methods: (a) KIs with USAID, GoA, and international partners; and (b) the OCA Non-U.S. Organization Pre-Award Survey (NUPAS)²⁴ facilitated to the HFA implementation team (PSI, MSH, MENTOR, and RMA). The evaluation rolled out the OCA via a five-step process: (1) identify HFA organizational champions; (2) interview champions to tailor OCA tool and set performance improvement targets; (3) deliver organizational champion orientations; (4) conduct an OCA workshop with key staff from each HFA implementing organization; and (5) hold a culminating session, where champions could share strengthening plans and receive feedback.

ETHICAL CONSIDERATIONS

The evaluation team used a verbal informed consent protocol for all KIs and FGDs (see Annex III for the informed consent script). KIs and FGD participants were informed that their participation was voluntary, that they could opt out of particular questions or the whole interview, and that information

²⁴ USAID’s OCA-NUPAS was used for all implementing organizations for four reasons: (1) it is organization-neutral, easily accessible at USAID’s Learning Lab, (2) its purpose determines the “readiness” of a non-U.S. organization (e.g., RMA) for USAID funding; (3) it has more assessment areas than the OCA without NUPAS; and (4) uniform use with all implementers ensures response comparability.

they provided would be not attributed to them; information that could be directly linked to an individual would be summarized by stakeholder group or reported in such a way to mask the source. Finally, only members of the evaluation team and Global Health Program Cycle Improvement Project (GH Pro) would have access to the transcripts and raw data.

LIMITATIONS

- **Attribution:** As this is a performance evaluation, it is not possible to attribute changes in behavior, capacity, or health service delivery to the project.
- **Sample:** Given purposive sampling of evaluation sites, findings cannot statistically represent the larger population from which they are drawn. At the same time, because evaluation logistics were among the criteria for site selection, findings are drawn from the experience of HFs in relatively accessible communities.
- **Logistical Constraints:** Logistical constraints affected the evaluation in several ways. First, due to a compressed data collection schedule, field testing of the tools prior to data collection was not possible. Thus, tools were modified as necessary during the actual information collection process. Second, it was not possible to reach all HFs; the list of planned evaluation sites was reduced by two malaria sites, one HIV/AIDS site, and one FP site (in the latter two cases, with USAID guidance). See Annex II for a full list of participating sites. Third, the delayed data collection schedule caused some interviews to be scheduled on very short notice, particularly HIV/AIDS HF interviews. This had the effect of reducing HF staff availability for interviews. In some cases, key staff were not available on the day of the interview; in other cases, interviews were conducted when patients were waiting to be seen by the KI. As a result, selected questions were prioritized, due to insufficient time to implement full interview guides. Finally, there was limited time to discuss findings, conclusions, and recommendations with HFA and USAID. Additional time would likely have helped to further develop the recommendations.
- **Use of KIIs:** As the primary source of data for much of this evaluation originated from KIIs, findings are subject to personal biases.
- **Use of Group KIIs and FGDs:** Although group interviews and FGDs conducted at HFs were facilitated to elicit different responses to KII questions, particularly regarding HFA activities and performance, some residual inhibitions may have remained. Individual interviews generally allow for more open responses and are not influenced by how others answer or dominate the discussions.
- **Information Gaps, Data Quality Issues, and Unavailable Data:** Key data or information may be unavailable or of insufficient quality during the data gathering step. The evaluation triangulated data where possible to address this limitation.
- **Country Context:** The GoA's high level of centralization, bureaucracy, and formality led to significant delays in the team's access and ability to conduct interviews.
- **Rapid DQA:** Because the DQA was not originally planned as part of the evaluation scope of work, the team's methodology was less rigorous than for a stand-alone DQA.

IV. FINDINGS

Between October and November 2018, the evaluation team conducted 175 KIIs, 6 FGDs with 33 participants, 4 OCA sessions with 40 participants, a group exercise with 36 participants, and a malaria survey with 4 KIIs from Lunda Norte and Malanje. As previously mentioned, two malaria sites, as well as one HIV/AIDS site and one FP site were dropped from the evaluation due to logistical constraints.

The team interviewed KIIs across four provinces (Luanda, Huambo, Lunda Sul, and Zaire), conducting 19 IP interviews; 48 interviews with MOH staff at national, GPS, RMS, district, and HF levels; 38 interviews with HF staff; 9 interviews with USAID staff; and 10 interviews with international partners. FGDs were conducted in Lunda Sul and Zaire. OCA sessions were conducted in Luanda and Zaire.

Findings are organized by the three USAID/Angola evaluation questions.

EVALUATION QUESTION 1: TO WHAT EXTENT HAS THE PROJECT ADHERED TO THE INITIAL TECHNICAL APPROACH, SERVICE DELIVERY APPROACH, IMPLEMENTATION PLAN, OUTPUTS, AND BENEFICIARY TARGETS INCLUDED IN THE INITIAL TECHNICAL NARRATIVE? WHAT EFFORTS HAVE BEEN MADE TO MITIGATE BARRIERS OR CONSTRAINTS LIMITING PROGRAM IMPLEMENTATION?

Result 1: LLIN access and use increased by at least 30 percent

Background: In Angola, malaria still represents one of the main public health concerns. In the last six years, one of the most important GoA interventions to fight malaria has been the promotion and distribution of LLINs, through periodic campaigns and routine distribution to pregnant women at their first ANC visit and to children under 12 months in the majority of Angola's provinces.

Building on lessons learned and the results of past LLIN campaigns, PSI has worked with the NMCP to review the implementation approach and tools to make necessary adjustments for the Year 2 LLIN mass distribution campaign. The campaign has been implemented in phases in several provinces simultaneously—Phase 1 in FY 2017 and Phases 2 and 3 in FY 2018.

Outputs and Beneficiary Targets: Table 2 shows the progress for FY 2018. At the time of the evaluation, the LLIN distribution campaign (Phase 4) was still ongoing. The gaps detected regarding the proposed targets for FY 2018 in the eight selected provinces were due to the following reasons:

- In the HFA FY 2018 work plan, the target of 5.6 million LLINs distributed was an estimate. HFA had to establish a new target (3,910,000), based on the new availability of distribution funds and LLINs. USAID approved the proposed changes.
- No distribution of LLINs took place between January and April 2018, due to the need to reach stakeholder agreement on strategy, tools, and which LLINs to use for Phase 3, according to the PSI quarterly report.
- Prior performance management plans (PMPs) targeted distribution of ITNs, but the current PMP refers to LLINs; thus, there were no indicators to monitor the “*Communication Campaign to Support LLIN Distribution*.” The document review and KIIs noted that HFA has been supporting the NMCP to implement the national mass distribution campaign with the development of a national strategy and tools for LLIN distribution and communication to promote use of LLINs.

Table 2: Progress under Result 1 – LLIN access and use increased by at least 30 percent

Result 1 Indicators	Baseline		FY 2017			FY 2018			
	Year	Value	Target	Achievement	% Progress toward Target	Proposed Target	New Target	Achievement	% Progress toward Target
# of LLINs distributed in this reported fiscal year	2015	1,739,431	2,900,000	2,393,477	82.53	5,600,000	3,910,025	2,483,612	63.5
# of CHWs trained in counseling on LLIN use	2015	399	4,000	4,764	119.10	5,4000	4,653	4,175	89.7
# HHs with at least one LLIN for every two people	2015–2016	106,864	1,000,632	920,193	91.96	9,500,000	1,530,009	851,332	55.6
# of children under 5 years old covered with LLIN distribution	2015–2016	187,944	892,086	672,181	75.35	1,400,000	1,363,973	719,076	52.7
# of pregnant women covered with LLIN distribution	2015–2016	25,490	114,152	105,672	92.57	236,000	174,000	143,190	82

Rapid DQA: For Result 1, the evaluation team reviewed two indicators: (1) “# of ITNs distributed in this reported year” and (2) “# of community health workers (CHWs) trained in counseling and use.” Box 1 details analysis of data flow, collection and storage. The lack of verification and validation by supervisors, weak ITN storage system, and empty ITN packages found in the field office all point to significant data quality weaknesses that could contribute to weak information sharing with MOH.

Box 1: Analysis of Result 1 Data Flow, Collection, and Storage

Data Flow:

- *Supposed to:* A.I.I Household registry and data used for quantification and management purposes and distribution at micro area (community) → Government and HFA municipal level have data and data entry in Google Drive by HFA → HFA/NMCP national level have data at the same → Distribute cleaned figures to province.
- *What is happening:* Household registry and distribution at the same time → HFA municipal level summary data entry in Microsoft Excel → Send by email to HFA national level → Distribute to NMCP and provinces.
- *Weaknesses:* No data entry at municipal/provincial level. Municipal/provincial/NMCP do not have raw data; household registry data not being used for quantification; government at all levels receiving data from HFA national office.

Data Collection:

- The form captures all data required; however, the same form used for household registry is used for distribution which compromises comparisons. Captures the number of children under 5 years and number of pregnant women, but does not segregate the population reached by gender.

Data Storage:

- Data storage in municipalities does not adhere to beneficiary privacy rights.

HFA Implementation Fidelity

Technical Approach: Respondents at the NMCP (four out of five, or 80 percent), GPS (one out of six, or 16 percent), and RMS (one out of three, or 33 percent) mentioned that their involvement has been very poor in all phases of the activity cycle (situational analysis, planning, implementation, and monitoring). The main concern respondents expressed, particularly at national level, was poor communication and collaboration between the NPHD/NMCP and PSI. The HFA technical approach (co-diagnose, co-design, and co-implement) was not properly applied.

Service Delivery (Operational Strategy): Information gathered from the document review and KIs with MOH staff at national, provincial, and municipal levels (Lunda Sul and Zaire), IPs, and other stakeholders show that PSI used the same methodology/strategy as the past national campaign (2016–2017), with minimal changes. A proposed key improvement mentioned in COP 2017/PY2 was not applied and the planned testing for a new toolkit for the LLIN mass distribution campaign (developed by PSI and Tropical Health, LLP) was not implemented, because the toolkit is still under USAID evaluation.

Major Barriers/Constraints: In reviewing HFA quarterly reports and KIs with PSI staff, MOH, other IPs, and local partners, the evaluation team found that the LLIN mass distribution campaign encountered significant barriers, such as a short implementation time frame, LLIN procurement delay for Phase 3, and limited coordination, communication, and collaboration, due in part to limited local government engagement and new leadership of the NPHD, NMCP, and new provincial and municipal authorities (DPS and DMS) following the 2017 legislative elections. The limited collaboration reported by some

DMS and DPS KIs included lack of timely notification in remote communities about the timing of distribution and lack of follow-through on local government commitment to provide transportation.

To counterbalance the short time for planning and implementing the LLIN distribution campaign (FY 2018), PSI worked with field staff who had been engaged in Phase I, drawing on their experience in ITN distribution to streamline the implementation of activities and combine registration and distribution activities in all municipalities to optimize time and resources. Moreover, HFA agreed with the stakeholders (MOH, the Global Fund, USAID, and the President's Malaria Initiative [PMI]) to change the FY 2018 distribution time frame based on the availability of LLINs. The end of the distribution campaign was postponed to Quarter 1 of FY 2019.

Result 2: Malaria services throughout targeted municipalities improved

Background: The NMCP's main targets (2016–2020) for malaria diagnosis and treatment are:

- By the end of 2020, confirm 100 percent of suspected cases by laboratory (RDT/microscopy) before treatment at HFs and community level;
- By the end of 2020, 100 percent of confirmed malaria cases should be treated in accordance with national policy guidelines at all levels of the health pyramid, including the community; and
- By 2020, strengthen the institutional, technical, and managerial capacities of the NMCP at national, provincial, and municipal levels to implement activities related to the malaria control program.

Unfortunately, access to and quality of malaria services are still inadequate to meet these targets. Under Result 2, HFA will build on the National Malaria Strategic Plan to deliver high-quality malaria services in 24 municipalities in six provinces with hyper-endemic (Uíge, Malange, Cuanza Norte, Lunda Norte, and Lunda Sul) and meso-endemic stable (Zaire) malaria transmission (*2015–2016 Angola Multiple Indicator and Health Survey [IIMS]*).

Progress under This Result: Table 3 shows HFA results through September 2018. The gaps detected in planned training activities for FY 2018 were due to the following reasons: (1) revision of the initial PY2 targets and submission to USAID for approval; (2) the need to improve the supervision tools and strengthen the teaching skills of national trainers; (3) training implemented only in Quarter 3 and Quarter 4; and (4) a delay in obtaining NMCP and NPHD approval for HFA's proposed training plan.

The document review (Work Plan PY2 against quarterly reports, HFA IPs' provincial office files) noted that the planned assessment of health units and health HR in the 24 target municipalities (Work Plan PY2) was carried out in Quarter 1 of PY2 to identify the target audiences for training on malaria case management, diagnostics (RDT and microscopy) and IPTp. The project documents provided to the evaluators and at field level (HFA IPs, provincial offices in Zaire and Lunda Sul) did not include a detailed training plan for PY2, based on the assessment results, specifying the number and type of training events (ToT, refresher courses, health worker training) to be carried out and establishing targets for each professional category of health workers to be trained by province. It is therefore difficult to properly evaluate the results regarding the health worker categories trained and the number of HFs covered.

Moreover, the health assessment shows 373 functioning public HFs (24 target municipalities) and not 407, as reported in all HFA documents provided to the evaluators.

Table 3: Progress under Result 2 – malaria services throughout targeted municipalities improved

Result 2 Indicators	Baseline		FY 2017			FY 2018		
	Year	Value	Target	Achievement	% Progress toward Target	Target	Achievement	% Progress toward Target
# of health workers trained in IPTp with USG funds	N/A	N/A	300	374	124.67	407	306	75.2
<i>a) Number of health workers/lab technician trained in malaria diagnostics (microscopy) with USG funds in last year</i>	/	/	/	/	/	135	104	77
<i>b) Number of health workers trained in malaria diagnostics (RDTs) with USG funds in last year.</i>	/	/	/	/	/	1,542	1,109	72
# of health workers trained in case management with ACTs with USG funds	2016	2,868	1,000	1,083	108.3	1,000	699	70
# of health workers who received formative supervision on malaria diagnostics in last year	/	/	124	0	0	320	335	105
# of health workers who received formative supervision in ACT use	/	/	124	0	0%	320	335	105
# of CHWs (ADECOS) trained in malaria case management at community level	/	/	/	/	/	120	120	100%

Formative supervision monitoring

In line with NMCP guidelines, HFA's supervision objective is to assess the health workers' knowledge and good practices for malaria case management, diagnostics, and IPTp. Although the quarterly reports recorded the total number of health workers supervised and their knowledge of malaria good practices, the only PMP indicator for this activity is "number of [health workers] who received formative supervision"; this indicator is not very appropriate for monitoring the skills of health staff skills or assessing the improved knowledge and good practices of trained staff.

In Lunda Sul and Zaire (six selected HFs), KIIs with trained health workers indicated that 100 percent (28 out of 28) had good knowledge and skills in malaria case management, diagnosis (RDT and microscopy) and IPTp. FGDs indicated that suspected malaria cases were tested prior to treatment and, for negative tests, that health workers routinely assessed patients for other acute febrile illnesses. All HFs visited had ready access to malaria job aids necessary for treatment, diagnosis, and IPTp. Health workers reported that there had been a stockout of malaria drugs and reagents in the previous three months that lasted less than a week.

Supervisors (formative/municipal) and HFA provincial malaria officers (*Oficial Provincial da Malária, or OPM*) in both provinces reported difficulty in performing this activity, since a suitable supervisory system was not in place and they were not trained on formative supervision and not updated on routine supervision. They are using the new supervisory tools, but are not able to properly complete the forms. Furthermore, resources (vehicles, per diem, and personnel) allocated to implement regular supervision were not sufficient.

Rapid DQA: For Result 2, the evaluation team reviewed two indicators: (1) "# of CHW trained in IPTp with USG funds" and (2) "# of CHWs who received formative supervision in ACT use." Box 2 presents findings on data flow collection and storage. Training data is being used moderately to plan for HFA's future training offerings, and no data on staff receiving formative supervision exists.

Box 2: Result 2 Data Flow, Collection, and Storage

Data Flow:

- *Supposed to:* Training presence lists at municipal level → HFA/DPS – provincial level → HFA/NMCP – national level → Feedback to HFA/DPS by national level.
- *What is happening:* Training presence lists at training venue → HFA – provincial level → HFA – national level → Distribute figures to provinces.
- *Weaknesses:* No presence lists with RMS, DPS, and NMCP; government at all levels only receives figures of trained staff from HFA. Staff trained at each unit are known by unit staff, but there is no written record.

Data Collection:

- A1.2 and A2.1 – Presence lists used and capture all information including gender; however, no database is used as a backup.
- A2.5 – A formative supervisory form is used, but there is no instrument to collect data on who was supervised.

Data Storage:

- Presence lists are being stored in OPM offices in HFA field offices, in files without protection from unauthorized people.

HFA Implementation Fidelity

Technical Approach: All respondents at NMCP (three out of three, or 100 percent), GPS (four out of five, or 80 percent), and RMS (one out of three, or 33 percent) levels mentioned their active involvement only in training preparation and implementation. NMCP KIs highlighted that they had been involved in setting up the training calendar, appointing trainers, advising on tools and developing/updating teaching materials. GPS and RMS KIs noted that they had been involved in setting up lists of participants, providing the training venue, and supporting health assessments. The HFA technical approach (co-diagnose, co-design and co-implement) was partially applied, as the number of health workers to train was pre-established by PSI and USAID.

iCCM (ADECOS): All MOH KIs at national, provincial, and municipal levels (100 percent) mentioned their active involvement in iCCM and highlighted excellent collaboration and communication with PSI. The DNSP/MOH appointed an iCCM focal point. Good GoA leadership and ownership were detected at all levels. The HFA technical approach (co-diagnose, co-design, and co-implement) was fully applied.

Service Delivery (Operational Strategy): Findings based on the document review (work plan and quarterly reports) and data collected in Lunda Sul and Zaire indicate the following:

- Refresher courses for trained health workers and training of municipal and provincial quality control (QC) supervisors were not implemented;
- Regarding formative supervision, the provincial and municipal supervision teams in Zaire and Lunda Sul were using the new supervision tools developed by PSI and validated/approved by NPMC, but teaching materials, training curriculum, and job aids had not been developed or updated;
- Malaria case management and laboratory diagnosis training were carried out using the curricula jointly updated by PSI and NMCP; and
- Laboratory assessments were not implemented (COP17-Work Plan 2).

iCCM (ADECOS): Training of ADECOS in Lunda Sul and Zaire was carried out using the standardized and approved curriculum (DNSP/NMCP) and in close coordination with the NMCP and FAS.

Implementation Plan: A delay was registered given to the rescheduling of all training for health workers in Quarter 3 and Quarter 4, due to the need to improve the supervision tools and strengthen the capacity of national ToT for malaria.

iCCM (ADECOS): There was some delay at the beginning of the field activities, since ADECO contracts were not signed in a timely manner by FAS in Zaire and Lunda Sul provinces, and ADECOs supervisors were still waiting for transport.

The following main barriers/constraints were detected for Result 2:

- Difficulty obtaining the list of health workers for training in a timely manner, since GPS and RMS in the six selected HFA provinces do not have updated HR databases or HF mapping (type and services delivered);
- Provincial training body (*Núcleo de Formação Permanente Provincial*) not functional;
- Low technical capacity of malaria ToT trainers;

- Poor coordination/communication with key NMCP training staff to schedule training activities at provincial and municipal level;
- A long administrative process for paying training allowances (trainers and trainees);
- Delayed NMCP/NPHD approval of the training plan and some topics, due to the prioritization of response to and control of outbreaks (cholera, dengue, and malaria) in some provinces;
- A shortage of qualified trainers to guarantee the HFA planned training activities are delivered; and
- Poor integration between FAS/MAT and MOH (DNSP/PNCM/RMS) for assuring iCCM management.

PSI decided to halt further malaria case management training deliveries until national and provincial trainers received specific training to improve their capacity to effectively train service providers. PSI advocated with PNCM/DNSP to update the supervision tool and supported the management integration of iCCM between FAS/MAT and MOH (DNSP/PNCM/RMS). According to the health assessment results, PSI decided to reduce the health worker training targets, and USAID approved these changes.

Result 3: Sustainable model for providing high-quality HIV/AIDS services established

Background: HFA is one of two PEPFAR-funded mechanisms that are implementing a service model for a continuum of HIV/AIDS care at nine HFs in Luanda, with equal representation of facilities from primary through tertiary care. Initially focused on testing and linkage to care at all nine facilities, by late FY 2017, following PEPFAR guidance, HFA supported the full continuum of care at seven HFs. PEPFAR also instructed the International Center for AIDS Care and Treatment Programs (ICAP)—the other PEPFAR IP—to support HIV care and treatment to the remaining two sites and provide above-site technical assistance to the National AIDS Control Institute (*Instituto Nacional de Luta Contra a SIDA*, or INLS).

Consistent with the focus on developing a high-quality HIV/AIDS service model, the HFA HIV/AIDS team consists of four senior technical staff and an M&E coordinator based at HFA’s HIV/AIDS headquarters (HQ), in addition to 30 staff stationed at HFs—seven case managers, seven data analysts (M&E specialists), 16 PAFs, and 10 community counselors. The original program vision included gradual transition of some activities to the GoA and local partners by the end of Year 3.

Outputs and Beneficiary Targets: Table 4 shows progress toward FY 2018 targets through Quarter 3 (see Annex V for full indicator tables). Relative to the targets, HFA-supported sites made good progress on the volume of testing services provided at the end of Quarter 3. Having initiated ART service provision in Quarter 4 of FY 2017, by the end of FY 2018 sites were providing ART to the targeted number of persons, although reaching less than half the target number of new ART enrollees for the period. Site-level retention levels were low, identifying this as the area most needing improvement. Contextualizing events in FY 2018 include a nurses’ strike from October to December 2017 and the rollout of “Test and Treat” in February 2018.

Table 4: Progress under Result 3 – sustainable model for providing high-quality HIV/AIDS services established

Result 3 Indicators	Baseline		FY 2017			FY 2018		
	Year	Value	Target	Achievement	% Progress toward Target	Target	Achievement	% Progress toward Target
# of individuals who received HIV/AIDS testing and counseling services for HIV/AIDS and received their test results	2016	62,186	49,372	78,815	159.64%	43,845	54,034	123.24%
# of adults and children currently receiving ART	2016	19,189	25,417	24,201	95.22%	22,003	20,640	93.81%
# of adults and children newly enrolled on ART	2016	3,390	5,818	4,276	73.50%	7,543	2,875	38.11%
% of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy	N/A	N/A	80.0%	46.3%	57.88%	80.0%	–	40–67% per HF*

* HFA was not required to report on this indicator for this period, but facility-level 12-month retention data were shared for this evaluation. For FY 2018, facility-level 12-month retention was reported at 40 percent, 42 percent, 45 percent, 47 percent, 53 percent, 55 percent, and 67 percent.

Rapid DQA: For Result 3, the evaluation team reviewed two indicators: (1) “Number and proportion of HIV+ linked to care” and (2) “Number of ARV defaulters recovered.” Indicators were assessed using the three aspects shown in Box 3. Since the M&E lead and team check data for information consistency, completeness, and duplication, data confidence is moderate to high. Indicators are used for donor reporting, decision-making, and assessing the performance of PAFs. Indicators were also assessed against USAID’s five data quality standards (Annex VI).

Box 3: Result 3 Data Flow, Collection, and Storage

Data Flow:

- For both indicators data; recorded in HFs → HFA M&E Lead (MSH) visits each quarterly to collect data

Data Collection:

- Data Source – MOH Electronic Patient Management System for HIV-Positive Patients (*Sistema Electrónico de Gestão do Paciente VIH+*, or *SEGEP*) database: Data later entered into HFA Microsoft Excel form, Daily Clinical Form for Follow Up, for indicator (1)
- Data Source – MOH *SEGEP* database and MOH Active Search PAF Register: Data later entered in Microsoft Excel register tool for indicator (2)

Data Storage:

- Stored in the HF on HFA electronically and cleared. Every quarter, data from all seven HFs is de-identified and compiled by the HFA M&E lead. Data storage at all levels adheres to beneficiary privacy rights.

HFA Implementation Fidelity

Technical Approach: GoA KIs from the INLS, GPS, RMS, RDS, and HF levels were asked to score HFA on the extent to which it adhered to its technical approach of “co-diagnosis, co-design, and co-implementation,” using a scale from 1 (low) to 5 (high). Overall, KIs scored HFA at 4.2,²⁵ with an average score of 3.7 from above-site KIs and 4.4 from HF KIs. Several respondents needed to be assured that this collaboration score was independent from appreciation for and perceived quality of HFA’s support, since satisfaction with the latter appeared high.

Above-site KIs were less satisfied with HFA’s technical approach. A key concern was a lack of fora for gaining more detailed understanding of the project’s work. One KI expressed that even though HFA has good ideas, “it’s not transmitted [to the GoA]; they bring their own staff.” There was a perception that there were no meetings to show the project’s work, as the monthly PEPFAR meetings “are focused on themes.” This sentiment was reflected in a comment from another KI, who said there was no formal exchange of experiences.

When prompted for recommendations on how HFA could improve how it works with GoA, two above-site KIs said they would like greater involvement and capacity building of municipal/district staff to foster greater ownership of their management roles. On the other hand, HF KIs were generally satisfied with HFA’s collaboration approach. Recommendations for improvement focused on how technical assistance could better support gaps in quality of care, rather than on the technical approach.

Service Delivery Approach: Overall, HFA adhered to the service delivery approach laid out in its FY 2018 work plan, which was largely a continuation of the approach initiated under the previous project (SASH). KIs reported that the transition in IPs had been smooth, to the extent that some KIs considered

²⁵ One KI deliberately abstained from providing a score and opted to provide qualitative feedback instead.

the two projects to be the same. The approach starts with HIV testing through a growing number of testing points, including index case testing and tracing (ICTT), provider-initiated testing and counseling, testing of patients with TB and malnutrition, and key populations through the Linkages project. The approach also emphasizes linkage and retention to care through PAFs escorting patients, providing counseling, and providing defaulter tracing; as well as special focus on TB/HIV co-infection, key populations, support groups, and viral load (VL) services.

Currently, as HFA is in the intensive phase of developing a sustainable model for HIV/AIDS services, HFA staff engage in intensive analysis of program and patient-level data from the Electronic Patient Management System for HIV-Positive Patients (*Sistema Eletrónico de Gestão do Paciente VIH+*, or SEGEP)²⁶ to identify, understand, and respond to service delivery gaps, which are quickly communicated to case managers, who then direct changes at the HF. HIV/AIDS service delivery at HFA sites is largely driven and managed by HFA.

The central role of HFA staff in both data analysis and directing services appears to have had two unintended effects. First, it might have reduced the HIV/AIDS focal point's oversight role. Although interviews confirmed that case managers work closely with HIV focal points, several in HF leadership positions referred to the case manager as having the central role in leading changes and monitoring quality of care. As one HF manager expressed, the case manager is effectively an onsite HIV/AIDS supervisor.²⁷ The proactive leadership of the case manager, guided by clear directives from HFA's HIV/AIDS HQ team, has allowed the HIV/AIDS focal point to focus on clinical care of individual patients. This is a rather logical outcome, given that the case manager does not treat patients, and that KIs in at least two HFs reported an increased demand for services (i.e., greater demand for clinical staff). However, service delivery *management* is a key function of the service delivery system that HFA has directly replaced with its own staff, rather than using a strategy that emphasizes the strengthening of existing clinical staff's management capacity.

A second unintended effect of HFA's role is that HIV services appear to have been directed by PEPFAR targets, which sometimes may differ from public health or quality-of-care priorities. For example, the fact that HFA has had to reach targets for the number of adults and children newly enrolled on ART has guided efforts in the last year. On the other hand, HFA did not have to report on retention in HIV care until the end of FY 2018. When FY 2018 retention rates were shared, six out of seven HFs reported 12-month retention rates between 40 percent and 55 percent.²⁸ Given such low levels, retention in care should be a quality-of-care priority, one that should have been recognized and flagged earlier. Given the capabilities of the SEGEP database, retention levels should have been systematically available at the HF level on a regular basis to provide continuous feedback on retention efforts. Although there is no clear-cut answer regarding the right balance a health system should maintain between starting new patients on ART and retaining those on ART, it appears that HFA's commitment to PEPFAR targets could be driving the process, since analysis of retention in care data—an essential HIV/AIDS quality-of-care indicator—seems to have lagged.

²⁶ Selected longitudinal patient-level data are entered from medical records into the SEGEP database under a USAID-supported project effort implemented by Vertrou.

²⁷ The system is so heavily dependent on this role that one HF KI experiencing a case manager's absence due to illness was noticeably frustrated and, when prompted for recommendations, said an additional case manager was needed to handle the workload.

²⁸ At this level, the 12-month retention rate is lower than the estimated 36-month retention rate (65 percent) that a recent 2015 review of 15 Sub-Saharan countries reported. Patients with poor retention are at increased risk of dying, transmitting HIV to others, and acquiring ARV resistance.

A related issue concerns the selection of service delivery performance indicators for analysis. To manage quality of care, health managers need to understand performance across the continuum of care, which allows them to identify, prioritize, and address quality issues. Ideally, performance data would be available regularly and frequently so health managers could monitor whether quality gaps persist or improve. In the apparent absence of regular performance summary information,²⁹ six health managers at DPLS, RDS, and HF levels spontaneously referred to Site Improvement through Monitoring Systems (SIMS) results to support their assessments of service quality, relying on the SIMS framework. Managers cited SIMS data to express dissatisfaction with a performance area, to justify a staff replacement decision, and to express satisfaction with performance of HFA-supported sites (in the last case, it was also used to justify a suggestion to partially redirect HFA technical assistance to other HFs). This suggests that although the SEGEP database is available to health managers, the existing SEGEP reporting framework might not provide the information they need to understand the quality of care across the continuum of HIV/AIDS services.

Implementation Plan: GoA respondents verified most Result 3 activities described in the FY 2018 work plan as having been implemented. At the same time, respondents reported some exceptions. In some cases, work plan activities appeared to have been delayed or implemented on a schedule different than planned. For instance, staff at two HFs did not confirm the availability of a lab capable of conducting antibiotic resistance testing at the time of the interview, although INLS approval for use for this purpose is pending. Similarly, although HFs were to hold weekly case management meetings to assure linkage and retention of key population clients, three HFs reported monthly meetings.

Other planned work plan activities were not implemented due to structural barriers in which HFA was perceived to be operating. For example, HFA did not implement a planned referral/counter-referral pilot. HFA staff explained that to implement the pilot, the MOH would need to establish a referral/counter-referral policy and regulation, particularly one that would apply to HIV/AIDS. In addition, staff explained, the MOH, INLS, and the Ministry of Hospital Management had not yet approved a pilot referral/counter-referral form.

Another reason FY 2018 work plan activities did not take place was PEPFAR/Angola's assignment of ICAP as the IP that would provide above-site support to HFs. For example, HFA had originally planned to synthesize assessment findings on the strengths and barriers of the continuum of services at each HF and validate these findings with GoA, PEPFAR, and other stakeholders. According to HFA staff, due to the HFA/ICAP split, which took place two months after the work plan was written, this assessment was deemed "no longer necessary." In addition, although the work plan stated that plans to support the development and improvement of standard operating procedures (SOPs) to improve stock management, the FY 2017 Quarter 4 report indicates that under "PEPFAR guidance, the revision and development of SOPs to improve standards for HIV care and treatment services is the responsibility of ICAP."

Accordingly, the HFA team reported that they contributed to the development of SOPs as part of an initiative led by the Procurement and Supply Management Project (PSM). At the same time, when asked about the use of SOPs for stock management, HF KIs mentioned only MOH forms. Regardless of SOP development, staff from five HFs confirmed that HFA had helped assure the availability of stock at testing points.

²⁹ Review of presentation slides used to present an HFA quarterly data analysis indicated that presentations have tended to focus on progress toward PEPFAR targets or data corresponding to improvement efforts across the seven HFs, such as the ICTT program, TB/HIV, and linkage to care.

Finally, in some cases, the language used in the work plan was not detailed enough to evaluate whether a planned activity had been executed as envisioned. For example, the work plan noted that HFA planned to implement quality improvement (QI) interventions in three HFs. When asked what QI activities the work plan referred to, HFA staff explained that QI activities included continual supervision, quarterly training, weekly case manager meetings, implementation of the MSH Standard Quality Excellence tool and the quarterly SIMS tool, and an INLS-approved supervision guide used by the HIV focal point. By this definition, it is unclear which activities the work plan may have referred to, especially when several of these activities, such as supervision, took place at all HFs before FY 2018.

In another example, the work plan specified that HFA would pilot a mutual support group for adults (*Grupo de Adesão Mutua*, or GAM) on ART in one HF. Interviews with HFA staff, and confirmed with staff at all six HFs, indicated that GAMs had been established at all six. At two HFs, however, staff reported that the support group at their facility predated HFA support, making it unclear which GAM activities had taken place with HFA support at those HFs.

Result 4: Strengthened, expanded, and integrated FP/RH services at provincial and municipal levels (FP)

Background: Contrary to the high staff-per-facility ratio of the HIV program, the FP program has been supported by six HFA staff members, covering more than 208 HFs in Luanda and Huambo provinces. A key barrier the FP program faces is the procurement of contraceptives and related supplies (i.e., frequent stockouts), which is a GoA responsibility. HFA is responsible for assuring that contraceptives available at the provincial depot are available at the facility level.

Outputs and Beneficiary Targets: Table 5 shows FY 2018 progress through the end of Quarter 3. Based on these data, HFA appears to be on track, overall, to meet targets. Moreover, KIs reported a large FP training effort in Quarter 4 that is not reflected in the two training-related indicators. The target HFA is least likely to meet in FY 2018 is largely dependent on the MOH; only one of the targeted four national protocols have been finalized and approved to date. A national-level KI confirmed that three protocols were finalized but still pending approval.

It should be noted that for the indicator on the percentage of USG-assisted service delivery points (SDPs) that experienced a stockout of a contraceptive method, HFA has reported on the number of SDPs that experience stockouts of *all* contraceptive methods, rather than the number of SDPs that experienced a stockout of *any* contraceptive method at any time during the year, which is the international definition. Given that poor contraceptive supply is a widely acknowledged barrier to FP services, it is unclear how this indicator, as currently reported, could be helpful to HFA or USAID.

Rapid DQA: For Result 4, the evaluation team reviewed three indicators: (1) “percentage of USG-assisted SDPs offering FP/RH counseling or services”; (2) “percentage of USG-assisted service delivery points that experience a stockout at any time during the reporting period of a contraceptive method that the SDP is expected to provide”; and (3) “couple-years protection in USG-supported programs.” Since HFA obtains indicator data through MOH reports, it raises the potential for source and transcription errors. This, in addition to the lack of data verification and validation, places data confidence for all three indicators at a moderate level. Information is primarily used for donor reporting.

Table 5: Progress under Result 4 – strengthened, expanded, and integrated FP/RH services at provincial, and municipal levels

Result 4 Indicators	Baseline		FY 2017			FY 2018		
	Year	Value	Target	Value	Progress	Target	Value	Progress
(1) % of USG-assisted SDPs offering FP/RH counseling or services	2016	59.5%	59.5%	58.6%	98.49%	59.5%	67.9%	114.12%
(2) % of USG-assisted service delivery points (SDPs) that experience a stockout at any time during the reporting period of a contraceptive method that the SDP is expected to provide	2016	6.7%	6.7%	Not measured		6.7%	Not measured	
(3) Couple years of protection in USG-supported programs	2016	50,054	50,054	34,043	68.01%	59,054	57,190	96.84%
(4) # of health care workers who successfully completed an in-service training program	2016	192	26	42	161.54%	280	45	16.07%
(5) # of protocols finalized and approved	2016	4	/	/	0%	4	1	25%
(6) # of people trained with USG funds	2016	307	60	59	98.33%	400	188	47.00%
(7) # of USG-assisted CHWs providing FP information, referrals, and/or services during the year	N/A	N/A	N/A	N/A		30	30	100%

HFA Implementation Fidelity

Technical Approach: GoA KIs were asked to score HFA on the extent to which it adhered to the technical approach of “co-diagnosis, co-design, and co-implementation,” using a scale from 1 (low) to 5 (high). KIs gave HFA an average score of 4.4.³⁰ By level of care, average scores ranged from a low among provincial KIs (3.7) to a high among municipal/district KIs (5.0). Most above-site KIs who were familiar with HFA’s work appeared eager to praise HFA’s support (e.g., “*Whenever I ask for support, the project helps. It’s very present, impressive*”), even if they felt there was room for improvement in the collaboration approach.

When prompted to describe the collaboration approach, individual above-site KIs spontaneously described joint planning, joint supervision, and monthly meetings. On the other hand, among those who scored HFA’s technical approach below 4, one respondent felt (s)he should have been involved at the conception stage of the project, and was interested in greater collaboration through joint planning and implementation of activities. Clearly frustrated, another KI noted that the governor was sometimes more aware of HFA activities than the KI. This KI wanted sharing of work plans (e.g., 6-month work plan) and formal communication of FP activities (e.g., presentation or report). Above-site KIs who scored HFA’s technical approach above 4 also suggested increased joint planning and increased systematic communication about project activities—both verbal and written.

Supervision was a theme mentioned by KIs in both provinces. When asked for suggestions for improvement in how HFA works with them, KIs representing three health system levels in Huambo recommended joint supervision visits, and staff at three HFs in both provinces suggested more frequent supervision, including for replenishing contraceptives.

Service Delivery Approach: KIs with HF, municipal, and provincial GoA staff confirmed that the FP service delivery approach supported by HFA has been consistent with that described in the project’s FY 2018 work plan. On the service delivery side, the approach includes FP service from dedicated FP providers (one to two per HF), and from providers providing other services (including services to men), who are also trained to provide FP services in order to offer integrated services. The training strategy uses a ToT approach, which trains RH focal points and supervisors to train providers on FP counseling and on knowledge and skills associated with different contraceptive methods. On the FP demand side, HFA hired 30 *ativistas*,³¹ including 11 men, through a competitive process, and trained them to become IEC specialists on FP topics. Assigned to two or three HFs, the *ativistas* provide group and individual IEC sessions on FP and are expected to start providing IEC sessions in the community in PY3. They are supervised by a coordinator, who visits them on a rotating basis to check in, observe sessions, and provide feedback.

Implementation Plan: Interviews with GoA KIs were consistent with Result 4 activities described in the FY 2018 work plan, although it was not always possible to verify the numbers reached. Work plan activities that were not yet implemented included the finalization and approval of four national protocols (one was approved), support for District Health Information Software 2 (DHIS2) implementation, the broadcasting of 10 approved RH/FP radio episodes (using non-USAID funds), and training of FP focal points on the protocol for clinical management of survivors of gender-based violence.

³⁰ MASFAMU KIs who were available for interviews did not provide scores, as they were not very familiar with RMA’s work under HFA, although they were able to confirm some of the specific activities that corresponded to the work plan.

³¹ Referred to as “community health workers” in quarterly reports.

The evaluation team was not able to verify HFA activities implemented by RMA with MASFAMU, as the KIs interviewed were not very familiar with HFA activities and the key MASFAMU contact was not available.

Result 5: Capacity of municipal and provincial governments to plan, fund, monitor, and supervise health programs improved

Background: Due to the lack of approval by MOH authorities concerning the HFA proposal to implement activities related to annual planning, budgeting, and monitoring in Zaire and Lunda Sul provinces, USAID and PMI have agreed that HFA should focus on the following priorities:

- Under the Governance and Finance component:
 - Implement an iCCM costing study in community health on interventions regarding malaria, diarrhea, and pneumonia; and
 - Carry out a NMCP needs assessment to set up a capacity building plan to develop management capacities and performance improvement.
- Under the Health Information System Strengthening component, support the MOH to:
 - Develop/Improve DHIS2 as the national platform for health information, in coordination with other partner/stakeholders; and
 - Strengthen municipal-, provincial-, and central-level capacities in data insertion, data analysis, and data use in DHIS2 for decision-making.

Per USAID’s request, this evaluation focuses only on DHIS2 for malaria.

Outputs and Beneficiary Targets: Table 6 shows current HFA result and progress only for DHIS2 through September 2018. DHIS2 is installed and functioning in all the targeted HFA provinces, and the users have been trained at GPS and RMS level, following standardized procedures and methodology of the Office of Planning and Statistics/Office of Information Technology (*Gabinete de Estudos, Planeamento e Estatística–Gabinete de Tecnologia da Informação, or GEPE/GTI*).

Considering HFA’s goal for DHIS2, the current indicators do not allow proper monitoring of progress or outputs, assess the improvement of health information systems using DHIS2, or assess the performance of health technicians trained at national, provincial, and municipal levels.

Table 6: Progress under Result 5 – DHIS2 performance PY2

Result 5 Indicator	Baseline		FY 2017			FY 2018		
	Year	Value	Target	Result Achieved	Achievement (%)	Target	Result Achieved	Achievement (%)
# of DHIS2 users trained within MOH with USG assistance	N/A	N/A	N/A	N/A	N/A	278	282	101.4%
Percent of municipal HMIS reports submitted on time and complete (every quarter)	N/A	N/A	N/A	N/A	N/A	70%	70.6%	100.1%
Number of municipal authorities meeting quarterly to review HMIS data and incorporate feedback in reports	N/A	N/A	N/A	N/A	N/A	43	45	104.7%

Rapid DQA: For Result 5, USAID tasked the team to review one indicator: “# of municipal authorities meeting quarterly to review HMIS/DHIS2 data and incorporate feedback in reports.” This indicator was not assessed, as the activity had just started; it is not understood by municipal authorities and no meetings had been held. Thus, there is room for HFA to clarify the indicator with municipal authorities.

Box 4: Result 5 Data Flow, Collection, and Storage

Data Flow:

- Although implementation of this result just started, the data flow would be; meeting notes and presence lists recorded at municipal administration → HMIS/DHIS2 data analysis feedback incorporated in reports → Provincial and National health departments have the required DHIS2 information

Data Collection:

- Data Source – DHIS2 and meeting notes.

Data Storage:

- To be stored in statisticians’ office.

HFA Implementation Fidelity

Technical Approach: NMCP/GTI respondents (three out of three, or 100 percent), GPS (four out of five, or 80 percent), and RMS (three out of three, or 100 percent) mentioned that they were actively involved in all DHIS2 activities. At all levels (national, provincial, and municipal), communication and collaboration with PSI are very good. HFA’s technical approach (co-diagnose, co-design, and co-implement) was properly applied, and strong leadership and ownership of NMCP and GTI was noted.

Service Delivery (Operational Strategy): According to the Y2 Workplan and MOH (GEPE/GTI) DHIS2 established standards.

Implementation Plan: According to the plan of activities for DHIS2 (PY2).

According to national and provincial GoA interviews and the document review, PSI encountered a number of constraints in DHIS2 implementation, including lack of equipment, low partner synergies, and low MOH staff capacity, particularly at the beginning of DHIS2 activities. PSI allocated efforts to assure

capacity building at national (PNMC and GTI), provincial, and municipal levels, providing regular and qualified technical assistance and supervision visits, and purchasing 46 computers to cover the municipalities (DMS) and six provincial directorates of health, resulting in improved collaboration among all the DHIS2 partners and supporting MOH leadership.

EVALUATION QUESTION 2: IN EACH TECHNICAL SECTOR, WHAT ARE THE STRENGTHS AND CHALLENGES TO THE PROGRAM INPUTS, IMPLEMENTATION OF ACTIVITIES AND PROCESSES, AND THE QUALITY AND SUSTAINABILITY OF OUTPUTS?

For Evaluation Question 2, USAID/Angola asked the evaluation team to review HFA-generated tools or processes that support work under corresponding results. Accordingly, major findings are organized by the three major sectors—malaria, HIV/AIDS, and FP—and the corresponding HFA results. Specifically, findings summarize (1) the purpose, status, and HFA implementation fidelity of the tool/process; and (2) strengths and weaknesses.

Tools for Malaria (Results 1 and 2)

For the malaria component, USAID requested an assessment of four tools—the LLIN mass distribution campaign, the unified SBCC strategy, and the malaria supervision and health unit assessment tools. These were assessed using a checklist (Annex III) for technical review and users' interviews, and through direct observation of the tools' use in Zaire and Lunda Sul provinces.

LLINs Mass Distribution Campaign Toolkit

Purpose, Status, and HFA Implementation Fidelity: The tool's purpose is to guarantee effective and efficient planning, implementation, and monitoring of the LLIN campaign. The final draft of the toolkit is completed and with USAID for approval, but has not yet been tested and shared with NMCP.

Strengths and Weaknesses: The campaign toolkit is a comprehensive document that embraces the entire LLIN distribution cycle at all levels (national to distribution point). It aligns with Angola's National Malaria Control Strategy 2016–2020 and is based on lessons learned from previous campaigns conducted in Angola.

The weakness is the cost and time needed to prepare the training materials and implement the training (ToT, provincial, and municipal levels). Additionally, sustainability is challenged, given the shortage (quantity and quality) of proper personnel, particularly at provincial and municipal levels.

Unified SBCC Strategy

Purpose, Status, and HFA Implementation Fidelity: PSI developed this tool for SBCC campaigns. The document clearly describes the campaign approach, strategy, target audience, and key messages, and defines the communication channels to use. The document aligns with the *Plano Estratégico de Comunicação para Mudança Social e de Comportamento sobre a Malária 2017 – 2020*.

At USAID's request, PSI suspended the development and implementation of any new SBCC activities and materials. Since last August, the PSI communications team has been working on the SBCC action plan for FY 2019, according to USAID's new orientation.

Strengths and Weaknesses: N/A.

Malaria Supervision Tool (National, Provincial, and Municipal)

Purpose, Status, and HFA Implementation Fidelity: The purpose is to improve the supervision tool, since the NMCP tool being used was considered too long and unwieldy. PSI, in collaboration with

NMCP, developed three tools for the municipal, provincial, and national levels, disaggregating the former NMCP tool. The NMCP has approved the new tools, and they are being used in the targeted HFA provinces. The World Health Organization (WHO), NMCP, and HFA are revising the tool, based on the field application results. The three tools enable the collection of relevant information concerning HF general information, data recording/collecting, and flow, as well as service delivery and staff work performance.

Strengths and Weaknesses: The municipal-level tool is user-friendly, comprehensive, and appropriate for routine supervision. It enables easy assessment of the availability of key commodities (e.g., registers and medicines), recordkeeping, and reporting (register, inventory, monthly reports and submissions to the RMS) from HFs (health post, health center, outpatient, and ANC clinic).

The provincial- and national-level tools are appropriate for assessing the skills of trained health workers (malaria diagnosis, IPTp, and case management) at health center and hospital levels (outpatient and inpatient, pediatric ward, emergency room, and ANC). They are also useful for in-service training and mentoring, as well as follow-up supervisory visit after training sessions and gathering information about the availability of key commodities (e.g., registers, medicines) and collection and compilation of health services data (inventory, monthly HF monthly reports submitted to the RMS).

The main weaknesses detected are with the national and provincial tools: (1) lack of user-friendliness; (2) a questionnaire design that lacks supervision objectives and instructions on how to fill out the tool or collect information concerning training type; (3) lack of differentiation in content for provincial and national tools (the only difference is the number of pages); (4) lack of a scoring scale for the health personnel and health area supervised; and (5) that supervisory team profile/expertise, role, and responsibility have not been clearly established at all levels (national, provincial and municipal), nor have supervision procedures or frequency.

The main constraints for sustainability are (1) the shortage of qualified health personnel, particularly at the provincial level; and (2) MOH/DNSP ownership of the tools (interest in developing the same tools for all health programs and national guidelines/procedures for formative supervision).

Health Unit Assessment Tool and Results

Purpose, Status, and HFA Implementation Fidelity: The purpose is to assess health units for health worker information in order to plan for malaria training, supervision, and service delivery. The tool is final and was used for the assessment by PSI and GPS/RMS from October to December 2017. The document review and interviews did not provide relevant information on whether the HF assessment tool was approved/validated by NMCP/NPHD or whether it was intended only for HFA use.

Strengths and Weakness: The tool can be filled out quickly to update information on HF type, health worker category, lab information to identify health worker training needs in malaria diagnosis, treatment, and prevention (IPTp). The tool's weakness is its layout and organization; it provides insufficient information regarding HF lab and service availability, commodities, and other equipment. The tool does not provide information regarding health workers' age and employment status (government official or temporary employed). In addition, the tool can be used only for malaria. The HFA-developed tool is also not cost-effective, as the MOH (MOH/GEPE-NHRD) is updating its own procedures and tool for assessing HF and health worker information.

Approaches for HFA HIV (Result 3)

ICTT

Purpose and Status and HFA Implementation Fidelity: Piloted under SASH, the purpose of the ICTT program is to facilitate the HIV testing of contacts of the HIV-positive index case (IC), with the objectives of early identification of HIV-positive persons, referral, and linkage to care. Staff at former SASH pilot sites felt the HFA model was essentially the same as that of the SASH pilot. Program implementation, as described by HFA and HF staff, was consistent with the WHO/PEPFAR “5C” standards (*consensual, confidential, include counseling, correct test results, and connection to treatment or prevention services*).

The HFA ICTT approach is a combination of two models: (1) household testing in which everyone in the household of the index partner is given the opportunity to be tested; and (2) index testing, in which testing is focused on everyone with known HIV exposure with an IC (e.g., sex or needle partner or child of the IC). The process starts with a person who tests HIV-positive and consents to participate as an IC. The IC is first asked to bring his or her partner and children under 15 years of age to be tested.

If the IC is unable to disclose HIV status to the partner, the IC and community counselor agree on an alternative plan for testing the partner. Typically, the counselor conducts a disguised, “routine” community IEC home visit, in which family members are also offered HIV counseling and testing, with follow-up retesting conducted at the HF. HFA staff reported that community counselors not only visit the IC household, but also conduct IEC visits in neighboring households, in order to maintain the semblance of routine home visits and maintain the IC’s confidentiality. Disclosure of HIV status within the couple, if both opt to do so, can then be conducted as if both have been tested for the first time, facilitated by community counselors and sometimes aided by other site-level HFA staff. Counselors may extend support as the couple adjusts to living with HIV. The process is similar with former sexual contacts, although the IC has the option of anonymous disclosure.

Strengths and Opportunities for Improvement: HFA’s IC approach has a number of strengths. First, as originally designed, the IC testing and tracing program focuses on family members and sexual contacts of the IC, which is an appropriate strategy for a country with relatively lower HIV prevalence (2.0 percent). The testing yield of this strategy is also a program strength; estimated at 30 percent, it was reported to have at least twice the testing yield of other HF testing points.

Another significant strength of the HFA approach is facilitating disclosure, which harnesses HF staff’s creativity (and occasional deception, such as calling a visit a door-to-door visit or using creative theatrics to facilitate disclosure) to support those who are interested in disclosing their HIV status, but face barriers.

Overall, the IC program has been successful. No major weaknesses were identified for this evaluation. Opportunities for improvement include the current data analysis dependency on HFA staff and linkage to care of positive ICs and contacts (measured at 75 percent or less at three HFs in Quarter 3 of FY 2018). HF barriers mentioned by HF KIs included clients’ refusal to establish contact in the community after making an appointment for a home visit and the community counselor’s uniform, which allows easy identification in the community and could introduce stigma and discrimination.

Approach to Linking HIV-Positive Clients to Treatment

Purpose, Status, and HFA Implementation Fidelity: The purpose of the HFA approach to linking HIV-positive clients to treatment is to assure that HIV-positive clients identified at all HF testing points initiate ART within two weeks of diagnosis, or are monitored for follow-up if they do not agree to

initiate ART. To accomplish this, the approach explicitly stipulates that staff providing the HIV-positive diagnosis directly hand off the newly diagnosed patient to the PAF, who will follow up with the patient to reinforce adherence. Although HFA has, thus far, focused on linkage to care rather than linkage to treatment, program data indicate that nearly all patients who have opened a patient file have also initiated treatment. The HFA percentage of patients on treatment among those in care was 94 percent³² in Quarter 1 of FY 2017, a figure that has increased steadily each quarter. HFA's linkage-to-care strategy first emulated the SASH approach, and then added features to improve linkage from specific testing points, such as referrals from the Linkages project for key populations and from the TB clinic, in addition to adjustments derived from detailed analysis of linkage data, which enables comparison of indicator data across facilities.

Strengths and Weaknesses: One strength of the HFA approach to linkage to care has been continual efforts to increase system effectiveness to address known psychosocial and service delivery barriers, many of which are also barriers to retention in care. To this end, HFA has extended the definition of successful linkage to a period of 14 days after HIV testing, provided counseling training, sensitized providers on stigma, reorganized service delivery to reduce stigma, employed expert clients as PAFs, improved stock management, and implemented streamlined clinic visit schedules for stable patients (e.g., differentiated models of care). In addition, the HIV information system that HFA has developed, coupled with intensive analysis of linkage to care data, has been a strength for better understanding and response to linkage to care gaps.

Despite HFA's efforts, the estimated facility-level proportion of HIV-positive clients linked to care has remained stubbornly below 60 percent in the seven quarters since HFA started implementation. HFA analysis of linkage data provides some insight into the opportunities for improvement. Due in large part to the referral/counter-referral system, linking patients to care at the three national referral hospitals has been a challenge. HFA reported Quarter 3/FY 2018 linkage-to-care rates of 51 percent at Divina Providencia, 20 percent at Hospital Esperança, and 35 percent at Hospital Pediátrico. Adults at Hospital Pediátrico—mothers of HIV-positive children—faced dismally low rates of linkage to care, documented at 2 percent (73 percent for children) in the same quarter. Another patient population who have faced linkage-to-care challenges are TB/HIV co-infected patients. HFA's FY 2018 analysis of TB ART³³ indicated that only 54 percent of co-infected patients were on ART—far from the 90 percent target.

Identification of additional patient groups facing increased challenges in linking to care is dependent on data availability and analysis. For instance, since data analysis available in reports and presentations the evaluation team reviewed did not present key population linkage rates separately, it was not possible to assess the level of linkage success. Similarly, while the FY 2018/Quarter 3 linkage rate for children at Hospital Pediátrico was at 73 percent, the linkage-to-care rate of HIV-exposed infants that have not yet been tested for HIV and children testing HIV-positive at lower levels of care who are referred to Hospital Pediátrico do not appear to have been reported separately. Both groups have historically poor linkage and retention within programs for prevention of mother-to-child transmission of HIV. Analysis of linkage rates disaggregated by gender could also inform programming.

³² Not strictly a proportion, as this indicator is not based on longitudinal data.

³³ PEPFAR indicator “number of HIV-positive new and relapsed TB cases on ART during TB treatment,” which, when measured over the number of TB cases with documented HIV status, provides an estimate of the extent to which programs effectively link HIV-infected TB patients to ART.

Approach to Retain People on Treatment and Recover Defaulter Patients

Purpose, Status, and HFA Implementation Fidelity: The purpose of the HFA retention strategy is to monitor patients receiving treatment and actively trace patients who default on a clinic appointment. The process, which overlaps with the approach for linkage to treatment, hinges on the role of the PAF. The PAF accompanies patients from health unit testing points to the counseling and testing unit, and counsels those who agree to initiate ART, guided by a structured psychosocial and adherence assessment form. If a patient misses a clinic visit, a PAF calls the patient within 24 hours, calling three times on three consecutive days, at different times of the day. If the patient fails to return to the clinic in three weeks, the PAF attempts to locate the patient through a home visit. Patients are considered to have abandoned treatment if they do not return to the clinic within three months after a missed visit. If a patient does return, the PAF provides reinforced adherence counseling. Overall, facility-level KIs felt this PAF-led approach has been a continuation of the strategy that was successfully introduced through SASH, with no major modifications.

Strengths and Weaknesses: A strength of the active search strategy is the fact that it is an INLS strategy, implemented using national monitoring forms, such as the daily registers for follow-up of HIV-positive cases and for active search of patients. As such, HFA's efforts should help inform INLS on how to more effectively implement the strategy, adapting to facility-level particularities. HFA has supported a number of measures to reorganize care to reduce barriers to retention, many described in the Linkage to Treatment section. Despite these efforts, HFA's analysis for FY 2018 reported that only 48 percent of patients who initiated care were still in care 12 months later. Only one out of six HF health managers interviewed reported monitoring retention using data, and that health manager reported a 12-month retention level at more than 80 percent, which does not correspond to HFA reported data.

Although the implementation of VL testing, initiated in Quarter 3 of FY 2018, should provide a more direct measure of how patients are doing on ART, HFA has not reported on the proportion of patients who are receiving a VL test, among those who should have one. Without such context, it is possible that the reported 85 percent 12-month VL suppression rate (TX_PVLS) refers to only a small proportion of patients who receive a VL testing. Since there are known shortages of reagents for VL testing,³⁴ in addition to limited sites for VL testing, this is a possible scenario. Thus, VL data currently reported at HFA sites do not adequately inform on quality of care. Analysis of patients that do not receive VL testing would help targeting of corrective efforts, as well as supply chain management. Among children with VL data, viral suppression was reported at 29 percent in Quarter 2 of PY2.

Facility-level KIs cited a number of service delivery barriers to linkage to care and retention, many of which have been at least partially addressed. These include facility fees (e.g., laboratory fees); patients testing for HIV after normal service hours (weekends and evenings); laboratory and TB staff prejudice, resulting in reduced support for linkage to care; high patient-to-staff-ratio in the TB clinic; and delayed laboratory results. Patient-level barriers include provision of false contact information and lack of acceptance of test results or treatment. From the perspective of quality of care, areas for improvement mentioned by HF managers included clinical assessment, management of opportunistic infections, insufficient DPS/RMS supervision, and lack of standardization of case management and nutritional assessment of HIV-positive children.

³⁴ Supply of reagents is outside HFA's mandate.

Approaches for HFA FP (Result 4)

HNQIS Adapted for FP Supervision

Purpose, Status, and HFA Implementation Fidelity: The purpose of the HNQIS tool is to assess the quality of providers' performance in providing FP services. The tablet-based tool, which is adaptable to any content area, was designed to facilitate and standardize supervision of FP activities. When HFA FP staff were interviewed for this evaluation, the DNSP's RH Department had not yet approved the tool, although the tool had been favorably received in preliminary discussions and approval was expected.

While awaiting HNQIS approval, HFA staff reported that supervision was being conducted based on the tool's technical content. However, this was not confirmed by district and HF staff, suggesting that supervision by HFA staff is being conducted differently than supervision by MOH staff, although joint supervision was mentioned by staff at two Luanda sites.

Among the five sites visited, staff at two sites reported that there was no standard supervision tool, while staff at two other sites and one district reported the use of other supervision tools (SASH tool and MOH general supervision tool). Staff at the remaining site reported not having been supervised in the previous 12 months by HFA or GoA staff, even though HFA staff regularly visited the site several times a month. Although HFA quarterly reports have mentioned supportive supervision by HFA staff, a summary of supervision findings in the FY 2018/Quarter 3 report suggests that the focus of supportive supervision has been on contraceptive supply.

Strengths and Weaknesses: The HNQIS tool has several strengths. First, the content areas include counseling as well as manual skills for seven contraceptives, including insertion and removal of contraceptives. In addition, the software facilitates the supervision process by accommodating skip patterns and allowing relatively easy adjustment of technical checklist content. Use of the tablet should also facilitate uploading and analysis of supervision data, which should allow managers to provide quicker feedback and other actions based on quality gaps.

On the other hand, the tool does not always assess technical knowledge or skills related to specific contraceptives. For example, one of the checklist items is "*Establishes eligibility for oral contraceptives,*" without providing any guidance or memory aid for contraindications (e.g., high blood pressure, fully breastfeeding, heart disease). Since it is unclear whether supervisors have mastered the technical content (and there is evidence that they have not), the current implementation plan—in the absence of an adequate supply of job aids—does not assure the provision of correct and accurate information. In addition, the tool still needs to be approved. Since this process is likely to lead to content changes, the tool should be piloted for practicability.

Finally, the HNQIS tool cannot address issues with the supervision system. First, it was apparent that some HFA staff and HF KIs were not aware that they used different supervision tools, suggesting that the content of supervision visits was not being systematically discussed. In addition, the supervision monitoring system seems weak, as HFA does not appear to be monitoring whether health worker observations are conducted during supervision visits or whether different health workers are observed at the same HF.

HFA Approach to FP Counseling

Status and HFA Implementation Fidelity: The evaluation team assessed HFA's *approach* to assuring quality of FP counseling, focusing on the principles of voluntarism and informed choice. As a USAID-funded project providing training to FP service delivery, HFA must comply with the Tiaht requirements of voluntarism and informed choice. Compliance increases the likelihood that clients

continue with their chosen method. Informed choice depends on the client's receiving accurate information regarding the advantages and disadvantages of each method. In addition, the Tiarht provision requires comprehensible information about health benefits, risks, contraindications, and side effects of the selected method. Simply put, knowledge refers to understanding of facts and procedures; skill is the capacity to perform specific actions as a function of both knowledge and the particular strategies used to apply knowledge; and performance is the application of knowledge and skills at the workplace.^{35,36}

- *Provider Knowledge:* HFA FP training on counseling included the topics of voluntary and informed choice of FP methods. Staff who attended the Huambo training in August 2018 confirmed that the training emphasized that the health provider's job is to provide information about the "advantages and disadvantages" of each method and allow the client to choose the method in a voluntary manner, without pressure toward a particular method. On the other hand, the training post-test, used to assess knowledge gained from training, does not assess for voluntarism or informed choice. In fact, during the unstructured section of one KII, a health worker was unable to name the FP method that provides protection against HIV.
- *Provider Skills:* Having information on FP methods available in print is helpful, but not sufficient for assuring that FP counseling provides comprehensible information on FP methods. Information is comprehensible if it is understandable to the client, and thus the counseling process should be a dynamic two-way interaction, in which the provider confirms understanding and encourages questions. According to staff trained in the last year, HFA training included opportunities to practice counseling skills, although these skills were not assessed in the post-test.
- *Provider Performance:* Current HNQIS, DNSP, and SASH tools used by supervisors do not adequately assess for voluntarism or informed choice (e.g., content that includes benefits and risks of selected contraceptive, counseling that assesses client understanding). At the same time, there was evidence of gaps in these areas. An HFA CHW shared that peer CHWs have witnessed individual health workers with inadequate knowledge of long-acting reversible contraceptives, and one instance in which a health worker might have violated the principle of voluntarism.

Because of the need to master a body of knowledge to provide comprehensible information, USAID/Washington strongly recommends the use of job aids (e.g., wall charts, flip charts, counseling cards, or package inserts) at all service delivery points of contact to promote consistent information provision. Although the job aid *Album Seriado* was available at all sites visited, health workers at two sites noted that full coverage would require an additional copy, and GPS staff noted that not all FP sites have a copy. In Huambo province, *Album Seriado* distribution was conducted only recently, after the training in August.

Strengths and Weaknesses: Group IEC sessions on different FP methods, which are conducted by health workers and HFA-supported CHWs (i.e., *ativistas*), are definitely a strength of the counseling approach, as they provide an early opportunity to learn about the range of FP methods. Such IEC sessions have been integrated into waiting areas throughout the HF, not just at the FP clinic, including

³⁵ Kak, N, B Burkhalter, and M Cooper. 2001. Measuring the competence of healthcare providers. Operations Research Issue Paper 2(1). Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance (QA) Project.

³⁶ Marquez, L. 2001. Helping healthcare providers perform according to standards. Operations Research Issue Paper 2(3). Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project.

services that are more typically attended by men. Furthermore, among the 30 CHWs hired, 11 were men. Another strength lies in the content of HFA’s FP provider training, which covers the topics of voluntariness and informed choice. All HF KIs understood these concepts. In addition, all FP rooms at HFs visited were able to demonstrate a tray of contraceptives that were used to show and tell different methods during counseling sessions, a very practical approach.

On the other hand, the current HFA counseling approach does not provide adequate assurance that counseling adheres to the principles of voluntarism and informed choice. Specifically, the training pre-test and post-test assessment tools do not assess for voluntarism or informed choice. In addition, the supervision tool (HNQIS) does not assess for voluntarism and presumes the supervisor has accurate knowledge of the advantages and disadvantages of each FP method (i.e., the checklist prompts the supervisor to assess that the provider give this information without describing what the correct information is). Finally, at one evaluation site, repeated supervision visits were reported to have taken place without observation of health workers, including their counseling sessions. Due to limited time to conduct KIs, there were a few other KIs in which providers were interviewed separately from providers, so it is unclear to what extent supervision at other sites incorporate observation of health workers.

In short, the combination of available job aids, training, and supervision, as currently implemented, does not assure voluntarism in FP choice or adequate and comprehensible information on the benefits and risks of the selected FP method. In addition, although HFA and HF KIs described how the counseling approach for clients who have not preselected an FP method should involve the presentation of advantages and disadvantages of FP methods, it does not appear to facilitate the decision-making process. Finally, there appear to be gaps in the process of assuring systematic supervision coverage of health workers, which also potentially affects the quality of counseling.

EVALUATION QUESTION 3: WHAT SYSTEMS ARE IN PLACE TO IDENTIFY AND REMEDY CHALLENGES ON PROGRAM MANAGEMENT AND STRUCTURE (I.E., PLANNING, HUMAN RESOURCES, FINANCIAL, OPERATIONS, AND COMMUNICATIONS)?

HFA is a crucial investment for Angola. Following in the footsteps of its predecessor, *Força Saúde*, HFA emphasizes active partnerships at national, provincial, and municipal levels and aims to transfer ownership of efforts and results to local stakeholders. HFA is the largest USAID activity in the country, and the USAID/Angola Mission is committed to its success, as demonstrated by its allocations of funds (\$63 million over five years) and HR (specialized Mission staff assigned to three programmatic areas), steady GoA partnership support (MOH partners), and diligent monitoring and managing of implementation performance.

The HFA implementing team is composed of international and local organizations, whose roles and responsibilities are summarized in Table 7.

Table 7: HFA team roles and responsibilities

Team Member	Role	Responsibility	Total Budget	Cost Share
PSI	Prime, HFA administrator	Results 1, 2, 4, and 5	\$63 million (total award)	\$6,316,915
MSH	Subcontractor, HIV	Result 3	\$10,644,357	\$1,064,422
MENTOR	Subcontractor, malaria	Results 1 and 2	\$3,592,087	\$359,209
RMA (local)	Subcontractor, FP and malaria	Results 2 and 4	\$5,866,566	\$0

Team Member	Role	Responsibility	Total Budget	Cost Share
organization)				

PSI, MSH, and MENTOR each have strong parent organizations that guide and support their systems, operations, and service delivery. RMA, as the lone local organization, benefits from such strong organizations, which have decades of experience implementing USAID activities around the world.

During the OCA workshops, implementers agreed that there are generally good working relationships among IP members, space for each one to perform, and a willingness to collaborate, learn, and adapt (as in the CLA approach). Findings for Evaluation Question 3 are organized under three sub-sections: major factors affecting HFA implementation, OCA outcomes for HFA implementers, and OCA synthesis.

Major Factors Affecting HFA Implementation

Based on a review of project documents and USG interagency strategies, KIs, and the OCA workshops, this evaluation identifies key external and internal weaknesses limiting HFA’s full success. First, it is important to point out a number of overarching factors, as they influence or stem from gaps in organizational systems and structures the evaluation was tasked to assess. Although external factors are generally outside the control of HFA implementers,³⁷ internal factors are within their manageable interest.

Internal Factors

The evaluation team found six overarching internal weaknesses, all under the control of the HFA implementing team, that are constraining HFA’s service delivery, results achievement, and sustainability:

1. **HFA Team not Maximizing Collaboration:** This was echoed by all HFA implementing team OCA participants, who said the HFA team is missing important opportunities to leverage technical and operational efficiencies. To a large extent, the team is implementing as individual organizations, focused on achieving assigned results and specific geography. Although PSI diligently manages financial and administrative aspects of subcontracts, it is not facilitating the needed collaboration to maximize learning and adaptation across HFA implementation.
2. **Variable Fidelity of Touchstone Approach:** As described in its HFA proposal, PSI aims to engage the MOH, civil society, the private sector, and beneficiary partners via a three-pronged approach—co-diagnose, co-design, and co-implement. As discussed under Evaluation Question 1, the fidelity of this approach varies across results and is not strictly adhered to, as detailed in PSI’s proposal or cooperative agreement. For example, the inclusive approach is stronger under Result 5 (with GEPE/GTI) and weaker under Results 1 and 2 (with NMCP). The approach is also not used consistently among GoA provincial and municipal partners, or with civil society members or organizations. Lastly, although HFA has a private sector partnership with UNITEL that is yielding important in-kind contributions, the three-pronged approach does not appear to be rigorously followed.
3. **Insufficient HFA Performance Management System:** Based on the rapid DQA, stakeholder interviews, and the OCA, HFA’s performance

“How can I answer, when I have no concrete evidence?”
 —HFA partner, Luanda, when asked to rate HFA’s current performance on a scale from 1 (lowest) to 5 (highest)

³⁷ In USAID activities, “critical assumptions” are conditions that must hold true for results to be achieved, but for which USAID implementers have no control. An example is a government’s political will.

management system has numerous gaps: (a) no current monitoring, evaluation, and learning (MEL) plan;³⁸ (b) low data quality for malaria and FP indicators; (c) indicators whose definition and data collection methods are not fully described by Performance Indicator Reference Sheets³⁹; (d) no critical assumptions or context indicators; (e) incomplete data collection tools and standards; (f) inability of all IPs to collect, manage, and use high-quality data; and (g) poor external sharing of performance data.

4. **Incomplete Local Capacity Building:** The quality and quantity of HFA’s current capacity building efforts are seen as lacking. First, training is overemphasized as a key (and at times, unique) intervention. Second, most recent HFA quarterly reports indicate slow progress on capacity building efforts at the national level (e.g., NMCP malaria monitoring and management) and relatively little advancement at provincial and municipal levels. Third, the RMA capacity building approach, plan, and results are weak, including (a) over-reliance on job training and hiring; (b) insufficient focus on management, leadership development, board development, and technical capacity in FP and malaria; (c) incomplete capacity measurement system (i.e., indicators, collection methods, and periodicity); (d) no current specialist to manage and lead efforts; and (e) RMA’s lack of clarity about performance and why PSI has restrained HFA responsibilities.
5. **Phased Transition Plan not on Track:** As detailed in its proposal and cooperative agreement, PSI’s Phased Transition Plan is to transfer 30 percent of the annual budget to RMA in PY3 for FP, 30 percent of annual budget to a civil society organization (CSO) not yet subcontracted in PY3 for malaria, and 30 percent of the annual budget to a CSO not yet subcontracted in PY4 for HIV. The evaluation team was made aware of “local” health CSOs whose capacity had been strengthened by two USAID/Angola projects—Building Local Capacity (2011–2015) and Linkages (2015–2019).⁴⁰ Still, the evaluation questions the achievability of this transition strategy, given the time remaining for HFA and the current state of Angolan civil society.⁴¹ Likewise, and as discussed below, RMA is not yet considered ready to responsibly absorb and manage USAID funds at this juncture.
6. **Currently Low Technical and Financial Sustainability:** The OCA exercise revealed a strong reliance on implementers to resource and deliver interventions across the five HFA results. PSI and MSH respondents both cited external and internal challenges with delivery, measurement, and outcomes of local capacity building. At its current level of progress, the evaluation team feels it is unlikely that—absent continued USAID resources—services and benefits will continue once HFA ends. Given the contextual challenges identified under “External Factors,” full technical and financial sustainability may be too ambitious for HFA’s remaining time frame.

OCA Outcomes for HFA Implementors

The purpose of the OCA is to facilitate a comprehensive organizational self-assessment (see Annex IX for HFA IPs’ scores), followed by an evidence-based strengthening plan (see Annex X for HFA IPs’

³⁸ USAID ADS 201 states that Performance Management Plans (PMPs) are a Mission tool for its project portfolio. Activities, including HFA, use MEL Plans, not PMPs.

³⁹ See <https://implementer.usaid.gov/sites/default/files/documents/1868/201maf.pdf>

⁴⁰ CSOs (most focusing on HIV) include ADPP, Mwheno, Cuidado Infância, Associação de Solidariedade Cristã Ajuda Mútua, Acção Angolana para a Mulher, and Foja Sida.

⁴¹ USAID/Angola’s CDCS (2014–2019) cites the need to engage civil society to meet development needs. However, there has not yet been USAID investment in civil society strengthening projects that seek, for example, to remove regulations to establish CSOs, reform inhibiting policies, increase participation in government, or support a free and independent media.

plans). The OCA tool covers seven systems, or “OCA areas”: Governance and Legal Structure, Financial Management, Administration and Procurement, HR, Program Management, Performance Management, and Organizational Management and Sustainability. Under each OCA area are sub-areas that define it. Each sub-area is characterized via four levels of capacity, each associated with a score—low (1), basic (2), moderate (3), and strong (4). All sub-areas are assessed and scored. The sum of all sub-area scores establishes an average for each OCA area. The average area scores allow an overall organizational OCA score.

OCA findings for each HFA implementing organization are summarized into strengths and areas to strengthen.

PSI OCA – Self-Assessed OCA Average Score: 3.5/4

Strengths: PSI is a committed implementer and administrator that self-assessed its foundation systems of Financial Management and Administration and Procurement very highly. In particular, its financial management system was strongly self-assessed.⁴² PSI also has solid administrative and financial policies, manuals, and/or plans in place to appropriately guide staff and facilitate HFA operations.

Areas to Strengthen: PSI has both system- and structure-related weaknesses that are limiting optimal HFA management, operations, and results achievement. The following are gaps under five OCA areas:

- *OCA Area 1 – Governance and Legal Structure:* There are two major gaps. First, given HFA’s geographic and technical scope, PSI’s operational structure, staffing, decision-making, and processes are over-concentrated in Luanda. Second, the annual updating of the organizational chart is not allowing management utility, particularly as there is ongoing turnover and hiring.
- *OCA Area 4 – HR Systems:* Three sub-areas warrant strengthening. First, there are strong signs (e.g., gaps in service provision and supervision, ongoing recruiting needs, and deliverable quality issues) that PSI is understaffed for HFA—both in terms of employing full-time staff and in terms of identifying appropriate positions. Next, blurred lines of authority between the country representative and chief of party are limiting management effectiveness and efficiency. In addition, PSI’s safety and security focal point is not uniquely dedicated and IPs have no awareness or ownership of the security plan.
- *OCA Area 5 – Program Management:* Four sub-areas were identified as in need of strengthening: (1) subaward management, with emphasis on internal communication, technical collaboration (e.g., integrating HIV, FP, and malaria efforts), service delivery quality, sustainability and capacity building; (2) quarterly report format, data quality and visualization, delivery timing, and QC (i.e., edits and reviews); (3) stakeholder engagement frequency and effectiveness, which currently varies at national, provincial, and municipal levels; and (4) gaps in gender equality mechanisms, including a non-existent gender focal point and weak sex-disaggregation of indicator data, analysis, and use.

“HFA needs the structure to better manage LLIN distribution and support capacity building to health units. The structure must be adjusted to realities not only at the national level, but the provincial and municipal as well.”
—HFA Stakeholder, Luanda

⁴² The importance PSI places upon its financial management system is also being transferred to RMA in terms of its organizational structure, hiring of staff, and establishment of standards and protocols.

- *OCA Area 6 – Project Performance Management:* Two sub-areas warrant immediate attention. First is PSI's performance management system, which was self-assessed with numerous challenges—insufficient M&E staff in Luanda and the field, the M&E and program teams' inadequately coordinating to validate data, an incomplete MEL Plan, inadequate procedures and training, complex data flows, unrealistic targets, and insufficient use of data beyond reporting. Second are gaps in field supervision, including lack of supervisory efforts or staff, inadequately qualified or trained staff, not following established protocols (e.g., supervisor's guide or checklists), low supervision standards/requirements, insufficient communication, and inadequate capacity building and coaching for supervisors themselves.
- *OCA Area 7 – Organizational Management and Sustainability:* Two needs exist in Area 7. First, informants cited that PSI's awareness of, willingness to, and pace of change are slow. PSI also currently lacks an analytical framework, contingency plan, change metrics, and a designated change leader to facilitate and measure agile change. Second, the evaluation team is uncertain of the relevance and utility of the May 2018 Communication Plan as a general framework for coordinating internal actions. Related to this and external strategic communication efforts (e.g., SBCC plan), the evaluation questions why PSI HQ has not been more deeply involved.

MSH OCA – Self-Assessed OCA Average Score: 3.8/4

Strengths: MSH is a competent subcontractor for Result 3 and its ICCT model is well-received by health units. MSH self-assessed strongly across five of seven OCA areas—Governance and Legal Structure, Financial Management, Administration and Procurement, HR, and Performance Management. A limited technical scope and geographic proximity to its seven assigned health units allows close accompaniment of service delivery and data collection. Although the former assures higher levels of service delivery quality, the latter enables the collection of more reliable data.

Areas to Strengthen: MSH is centralized in Luanda with a small staff. It identified two gaps:

- *OCA Area 5 – Program Management:* MSH's gender equality efforts need particular strengthening, with respect to conducting gender analyses and integrating gender equality solutions into HIV service provision. There is also a gap in sex-disaggregated data collection, presentation, analysis, and use to refine strategies, approaches, or services.
- *OCA Area 7 – Organizational Management and Sustainability:* Two sub-area needs were identified. First, MSH does not yet have capacity in change planning, implementation, or measurement. There is also no contingency plan, dedicated personnel, or approaches to identify change needs or actions. Second, MSH cited that low technical and financial sustainability of the ICTT model for the Luanda and Huambo health units. Accordingly, a need was identified to better assess, build, and measure local capacity of health units and their personnel.

The MENTOR Initiative – Self-Assessed OCA Average Score: 3.3/4

Strengths: MENTOR's decentralized structure (HQ in Huambo, offices in Uige and Zaire) is ideal for its technical and geographic scope. The organization's long-time presence in these provinces provides opportunities to tap into management efficiencies such as leveraging existing infrastructure, relying on established processes or procuring from recognized vendors. It also affords MENTOR the chance to technically engage with known networks, partners, and stakeholders. Overall, MENTOR self-assessed highly across all OCA's seven areas, with the strongest in Area 5, Program Management.

Areas to Strengthen: Regardless of its self-scoring, a review of MENTOR's internal protocols, manuals, general ledgers, and staffing arrangements reveal that many of its systems are functional, but at basic levels. MENTOR identified sub-area vulnerabilities in nearly all of seven OCA areas, as follows:

- *OCA Area 2 – Financial Management and Internal Control Systems:* MENTOR cited a lack of accounting capacity building materials and efforts, as well as the need to train Zaire staff.
- *OCA Area 3 – Administration and Procurement Systems:* Two sub-area needs were identified. First, IT is non-functional due to lack of procedures, Portuguese materials, and adequately trained and dedicated staff. Second, PSI and MENTOR are not satisfactorily coordinating around procurement, which is negatively affecting training delivery.
- *OCA Area 4 – HR Systems:* There is an ongoing need to hire an operational coordinator (vacant for half a year) and there are challenges in hiring qualified personnel in Uige and Zaire.
- *OCA Area 5 – Program Management:* MENTOR expressed a need to better involve stakeholders at national (NMCP), provincial, and municipal levels around its malaria efforts.
- *OCA Area 6 – Project Performance Management:* First, although not self-identified, the evaluation team believes MENTOR must address gaps in monitoring and quality assurance (QA). Second, MENTOR cited the need to work with PSI to improve technical staff's field efforts and OPMs' effectiveness and capacity.
- *OCA Area 7 – Organizational Management and Sustainability:* Two sub-area needs were identified: (1) a more efficient annual work planning process among offices; and (2) improved change management with focus on capacity building at national, provincial, and municipal levels.

RMA – Self-Assessed OCA Average Score: 2.5/4

Strengths: RMA is a dynamic organization with a young, creative, and motivated staff. Since 2017, RMA has grown from 5 to 20 staff, and its organizational structure and systems are emerging. RMA self-scored at moderate levels in Governance and Legal Structure, Financial Management and Administration and Procurement. Like its mentor PSI, there is a significant emphasis on financial management.

Areas to Strengthen: Currently, and according to the OCA-NUPAS, RMA is not yet ready to directly receive and manage USAID funding without accompaniment. RMA identified the following areas to strengthen:

- *OCA Area 4 – HR Systems:* RMA cited three major needs. First are ongoing staffing issues, including no staffing plan, lack of a process or tool to calculate optimal staffing levels, understaffed technical and supervisory positions, and lack of clear roles and responsibilities. Second are recruitment and retention weaknesses; PSI not sufficiently involving RMA in the recruitment process, inability to offer market-competitive salaries, and lack of a perceived career track at RMA. Third is an ongoing issue with PSI's salary disbursement cycle, whereby RMA salaries are consistently arriving three to four weeks late.
- *OCA Area 5 – Program Management:* RMA noted internal gender equality shortcomings: lack of a gender integration plan, no organizational gender focal point, insufficient capacity to mainstream gender into RMA, and untapped RMA networks to promote gender in FP efforts.
- *OCA Area 6 – Program Management:* RMA identified three sub-areas to strengthen: (1) the performance management system, which lacks polices, processes, and tools; (2) organization,

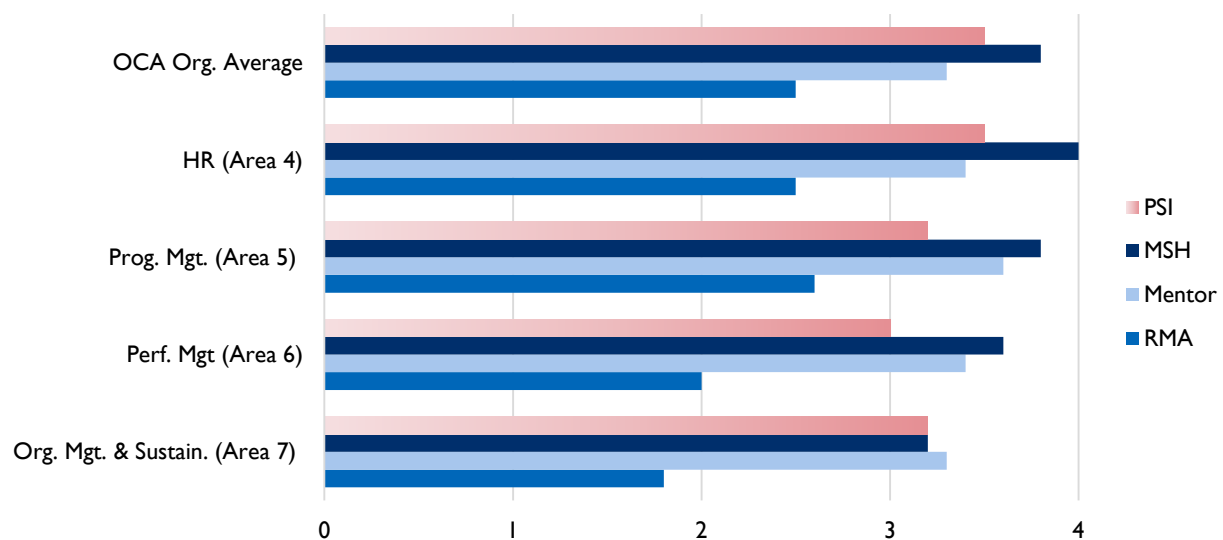
management, and use of internal or external evaluations; and (3) field support and oversight, whose gaps include insufficient operational approach to supervise and support FP field-efforts and activists, lack of high-level supervisory staff, and inadequate supervision capacity building.

- *OCA Area 7 – Organizational Management and Sustainability:* Three sub-areas were identified as in need of strengthening. First, RMA has no business plan that charts its way to securing new business and sustaining operations. Second, it does not have the staff, protocols/processes, or capacity to conduct effective change-management activities. Finally, RMA lacks techniques or plans to raise funds or generate new business.

OCA Synthesis

With respect to the overall OCA rating, as self-assessed by each IP, MSH rated its organizational structure and systems highest, followed by PSI, MENTOR, and RMA (Figure 3). Given the current levels of organizational responsibilities and maturity, the evaluation team concurs with this ranking hierarchy.

Figure 3: HFA implementing team OCA summary



Nonetheless, the OCA exercise revealed gaps in IPs’ structures and systems that must be strengthened to improve HFA implementation, results, and sustainability. With respect to structure, implementers (except MENTOR) are over-centralized in Luanda. For PSI, the current structure warrants immediate adjustments. For MSH and RMA, as long as target beneficiaries are geographically close, a Luanda-based structure can adequately serve operational needs.

With respect to systems, IPs cited gaps in the OCA tool’s more advanced systems of program management, performance management, and organizational management and sustainability (see Figure 3). Given this, the evaluation team sees three major management systems that all IPs must address: (1) performance management; (2) operations management (i.e., field supervision); and (3) organizational management and sustainability (capacity building, change management, and HFA IP coordination). Also, with the exception of MSH, IPs possess gaps in HR systems that include insufficient staffing levels, ability to determine optimal workforce headcounts, awareness of job descriptions and roles/responsibilities, recruiting, right-fitting personnel, and retention. Since PSI is prioritizing the strengthening of its HR system, it should look to transfer and scale improvements with its HFA implementing team, as detailed in the recommendations that follow.

V. CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations were presented and discussed in preliminary form to USAID and HFA, and then in a draft report. In each instance, feedback was solicited, received, and incorporated.

MALARIA

Result 1: LLIN access and use increased by at least 30 percent

Questions 1 and 2

HFA did not meet the planned target for LLINs distributed. About 64 percent of the target (2,483,612 LLINs) were distributed, and the distribution campaign was completed in only six of the eight selected provinces for PY2. However, the project has achieved positive results (90 percent) regarding the target for CHWs trained in counseling on ITN use.

Most evaluation informants (HFA IPs, NMCP, GoA IPs, and DPS/Zaire) cited that the short time frame represented the main barrier/constraint to efficiently and timely completion of the LLIN mass distribution campaign (preparation and distribution) and to guaranteeing NMCP leadership and Angolan ownership at national, provincial, and municipal levels. This limited time hampered the creation of the proper conditions to establish satisfactory collaboration between HFA and the new leadership of NPHD/NMCP, and with the new governmental authorities at provincial and municipal levels (provincial and municipal administrations, DPS, and DMS) following the 2017 legislative elections. It is likely that better adherence to HFA's stated technical approach to capacity building (co-diagnosis, co-design, and co-implementation) with local government could have reduced the poor level of government ownership.

Furthermore, HFA's proposed new strategies/tools for distribution (LLINs toolkit) and communication (SBCC) of the PY2 LLIN mass distribution campaign were not used, since the tools and documents developed by HFA are still awaiting USAID's evaluation/approval.

Only the LLIN Mass Distribution Campaign Toolkit has been assessed, since PSI suspended the development of new SBCC activities and materials, due to USAID's new orientation. The team found the following main strengths and weaknesses of the toolkit:

- It is a comprehensive document that embraces the entire LLIN distribution cycle at all levels (national to distribution point);
- It aligns with the current National Malaria Control Strategy (*Plano Estratégico Nacional de Controlo da Malária em Angola Ano 2016-2020/MINSA*) and WHO (universal coverage with LLINs) guidelines for distribution mechanisms and plan (Global Technical Strategy for Malaria 2016–2030); and
- It is based on lessons learned from previous campaigns conducted in Angola.

The weakness is the cost and time needed to set up the teaching materials and standardized procedures to establish training plans and implementation (ToT, training for provincial- and municipal-level/staff). Additionally, sustainability is challenged, given the shortage of proper personnel (quantity and quality), particularly at provincial and municipal levels.

RECOMMENDATIONS FOR RESULT 1

Based on this evaluation, the evaluation team recommends the following:

- **Promote NMCP leadership and GoA ownership at national, provincial, and municipal levels.** In the next actions concerning LLIN distribution, PMI/USAID and HFA representatives should organize regular meetings with the directors of NPHD and the NMCP, or their named official representatives, to analyze needs, gaps, and constraints and establish and agree on the activities to carry out, the beneficiaries, the geographical area of intervention (in provinces supported by PMI), and the resources to allocate. Once a joint intervention plan exists (MOH, PMI/USAID, and HFA), HFA should support the NMCP team (selected by the NPHD/NMCP directors) to sensitize the GoA (central, provincial, and municipal administrations) about LLIN distribution activities to assure commitment and support for implementation. Moreover, HFA could support the NMCP in revitalizing the national technical commission for the campaign to empower local governments in LLIN campaign planning, distribution, and follow-up. NMCP/NPHD should hold regular technical meetings with all stakeholders to monitor the LLIN interventions.
- **Develop a national LLIN plan and policy.** Since the LLIN distribution campaign will end in the coming months, HFA should provide technical assistance to the NMCP/NPHD to develop a single national LLIN plan and policy that includes both continuous and campaign distribution strategies. This plan should be based on an analysis of local opportunities and needs, as well as constraints and barriers encountered in the current and past campaigns.
- **Secure approval of the LLIN toolkits.** PMI/USAID should finalize the evaluation process to approve the LLIN Mass Distribution Campaign Toolkit developed by HFA. If the tool is approved and endorsed by the NPHD/NMCP, PMI/USAID should assure resources to support the NMCP in developing training materials and training the MOH technical team in 18 provinces.
- **Draw up a tool and strategy.** Once PMI/USAID approves the strategy and tools developed by HFA, the project—under the leadership of the NMCP/NPHD and key partners and through a Technical Working Group—should draw up standard implementation/monitoring tools (e.g., for calculation, logistics, plan, registration), training curricula/materials, and the SBCC strategy and tools (according to MOH Malaria Communication Strategic Plan 2017–2020 and revisions made per USAID/PMI advice).
- **Improve the NMCP M&E system.** HFA should support the NMCP to improve its own database at provincial and national levels to accurately track LLIN coverage and ascertain whether universal coverage has been achieved and maintained.
- **Improve HFA monitoring system.** Since the HFA intervention focuses on LLIN distribution (coverage and access), HFA should revise the outcome for Result 1.

Result 2: Malaria services throughout targeted municipalities improved

Questions 1 and 2

Regarding training, HFA achieved the following results against PY2 targets:

- For malaria case management at community level (iCCM), the target has been fully achieved (100 percent). A total of 120 ADECOs were trained and equipped in Zaire and Lunda Sul

provinces covering four municipalities (Soyo and Tomboco/Zaire, Cacolo and Dala/Lunda Sul), and the activities are ongoing at community level.

- The result for formative supervision (ACT use and malaria diagnostics) has exceeded the target. Despite this achievement, during the field visit in Zaire and Lunda provinces (KIs), the malaria provincial supervisors reported that supervision training had not been carried out, and although updated supervision tools (municipal and provincial level) were in place, they were not able to fill them properly. The document review (quarterly reports) showed that 51 percent of 407 HFs supported by HFA had received formative supervision during PY2 (all four quarters).
- HFA met targets on IPTp, malaria diagnostics (RDT and microscopy), and malaria case management with ACT at 70–77 percent of targets.
- The ACT (case management) training covered 19 (79 percent) of the 24 target municipalities, involving 699 health workers from 241 health units (59 percent). The IPTp training covered 14 municipalities (58 percent), involving 306 health workers from 156 health units (38 percent). The training in laboratory diagnostics covered five provinces (Lunda Norte, Lunda Sul, Malanje, Uige, and Zaire) and 23 municipalities, involving 104 laboratory technicians from 51 health units.
- The KIs at central (NMCP) level and at provincial and municipal levels (DPS and DMS) reported their active involvement, but only on training preparation and implementation, since the number of health workers to train was previously established by PSI/USAID. For iCCM, on the other hand, all GoA respondents at the national, provincial, and municipal levels reported their active involvement in all stages of HFA's technical approach and highlighted the excellent collaboration with HFA.
- Site visits to all six selected HFs (two provincial hospitals, maternal and child health [MCH] centers, one health post, and one municipal hospital) in Lunda Sul and Zaire showed that the 32 trained health workers interviewed in FGDs had good knowledge and skills in malaria case management, malaria diagnostics (microscopy and RDT), and IPTp. They reported constant and prolonged stockouts of clindamycin, whereas stockouts were not registered in the previous month for the other malaria commodities (RDT, medicines, and laboratory reagents). In 100 percent of the six HFs visited, the malaria job aid provided by HFA was available and used.

As requested by USAID, the team assessed the Malaria Supervision Tool (at national, provincial, and municipal levels) and the Health Unit Assessment Tool and Results.

Malaria Supervision Tool (national, provincial, and municipal levels): The three tools enable the collection of relevant information concerning general HF information, data recording/collecting, and flow, as well as service delivery and M&E of health workers' knowledge and practices, according to national guidelines on use of RDT, malaria case management, and IPTp protocols.

- The municipal-level tool is user-friendly, comprehensive, and appropriate for routine supervision. This tool easily assesses the availability of key commodities (e.g., registers and medicines), as well as recordkeeping and reporting (register, inventory, monthly reports, and submissions to the RMS) of the HFs (health post, health center, outpatient clinic, and ANC clinic). No weaknesses were detected.
- The tools for the provincial and national levels are appropriate for (1) assessing the skills of trained health workers for in-service training and mentoring, as well as follow-up supervisory

visits after the training sessions; and (2) gathering information about the availability of key commodities (e.g., registers and medicines) and collection and compilation of health services data (inventory, monthly HF monthly report submissions to the RMS). The main weakness detected at these levels were that (a) the tools are not user-friendly; (b) the questionnaire design, which lacks supervision objectives, has no instructions on how to fill it out or collect information concerning training type; (c) provincial and national tools lack differentiation in content, the only difference being the number of pages; and (d) there is a lack of scoring scale for the health personnel and health area supervised.

- Moreover, the supervisory team's profile/expertise, roles, responsibilities, as well as supervision procedures and frequency (monitoring and post-training) have not been clearly established at all levels (national, provincial, and municipal).

The Health Unit Assessment Tool, developed by HFA, is used for HF and health HR assessment in the 24 target municipalities. A strength is that the tool can be filled out quickly to update information on HF type, health worker category, and laboratory information to identify health workers' training needs in malaria diagnosis, treatment, and prevention (IPTp). Weaknesses include the tool's layout and organization: it provides insufficient information regarding HF laboratory and service availability, commodities, and other equipment; it does not provide relevant information regarding the health worker's age and employment status; and it can be used only for malaria service. It is also not cost-effective, as the MOH (MOH/GEPE–NHRD) is updating its own procedures and tool for gathering and updating data concerning HFs and health workers.

RECOMMENDATIONS FOR RESULT 2

Based on this evaluation, the evaluation team recommends the following:

- **Provide qualified and regular technical assistance to strengthen NMCP leadership and ownership of capacity building activities.** PMI/USAID and HFA should analyze the need for and feasibility of hiring a malaria specialist to provide qualified and regular technical assistance at the central NMCP level in order to strengthening the management and technical skills of key training staff.
 - HFA should support the NMCP and GPS to analyze training needs, determine the type of training to deliver; identify the professional categories of health workers to be trained; and define financial, logistical, and human resources for GPS/NMCP and HFA to allocate for facilitating the proposed training activities.
 - Based on the result of this analysis, each province should create its own training plan to submit to PMI–USAID and the MOH (NMCP/NPHD) for technical approval.
- **Set up joint annual training.** Under the leadership of NMCP, HFA, and international partners (WHO, the Global Fund, and the Elimination 8 Regional Initiative), HFA should draw up a joint annual training plan to avoid duplication and/or delays in implementation.
- **Build staff capacity to train and supervise activities.** The NMCP and GPS should use a cascade approach to assure the presence of skilled health personnel (trainers and supervisors) at all levels, but particularly at provincial and municipal levels.
- **Integrate training.** Under the leadership of the NMCP and National Department of Reproductive Health, HFA should support both programs to integrate malaria training (IPTp,

malaria in pregnancy, and malaria in children under 5 years) into MCH program training (e.g., integrated management of childhood illness). Drawing up a curriculum that covers this specific training for these two programs would heighten nurses' ability to approach service delivery through multitasking. Moreover, it would reduce costs and assure a multidisciplinary pool of trainers at all levels (central, provincial, and municipal).

- **Revitalize or Set Up the Provincial Training Body (*Núcleo de Formação Permanente Provincial*).** Under NPHD leadership, HFA should support collaboration between NMCP and the MOH/NHRD (Education Department) in order to revitalize or set up a provincial-level *Núcleo de Formação Permanente*. This would assure the quality of needs assessments, planning, implementation, and monitoring of training at GPS and RMS levels.
- **Support QA and Laboratory Training.** PMI/USAID, together with international partners WHO and the Global Fund, should support the National Institute of Health Investigation (*Instituto Nacional de Investigação em Saúde*) and the NMCP to develop guidelines/procedures for laboratory QA and QC and revise/update the current laboratory training curriculum. Under NMCP leadership, HFA should support refresher training for the certified national laboratory trainers.
- **Improve supervision.** HFA should improve provincial- and national-level tools, including purpose and objectives (i.e., used for in-service training/mentoring or for follow-up on health workers' skills and knowledge after the training sessions); establish a scoring scale to properly monitor health areas supervised and health staff skills; and establish the frequency for carrying out monitoring (supportive/formative) and post-training supervisory visits.
 - HFA should set up supervisory team profiles/expertise for carrying out the two types of supervision.
 - HFA should support the NMCP to develop training curriculum and material to train the malaria supervisor, as well as tools and training curriculum for laboratory supervisors.
 - Together with the NMCP and GPS, HFA should set up an annual supervision plan, based on the national guidelines from the NMCP/NPHD and accounting for the constraints encountered during PY2. Only 51 percent of the 407 HFA-supported HFs received formative supervision during PY2, but the number of annual supervisory visits realized for each HF is not specified.
- **Establish the number of HFs to cover.** HFA should share the health assessment findings with PMI/USAID in order to establish the correct number of HFs to be supported, given the discrepancy between the HF assessment result and number of HFs currently supported by HFA.
- **Support iCCM implementation and monitoring.** HFA should continue to provide technical support to the MOH and MAT at all levels (central, provincial, and municipal) to define complementary roles and responsibilities for assuring efficient implementation and monitoring of iCCM, as well as the quality of malaria diagnosis and treatment at community level.
- **Implement evaluation/coordination meetings.** Under NMCP leadership, HFA should hold regular meetings with all stakeholders (national and provincial levels) to coordinate and evaluate the implementation of malaria training activities being developed in the target provinces, to

detect constraints and needs and propose solutions/changes to assure the quality of the intervention.

Result 5: Capacity of municipal and provincial governments to plan, fund, monitor, and supervise health programs improved

HFA completed the planned DHIS2 activities and exceeded selected PY2 targets: (1) “number of MOH staff in DHIS2 (central, provincial and municipal levels) trained”; (2) “DHIS2 complete reporting rate”; and (3) “number of municipal authorities participating in HMIS data analyses.” DHIS2 is installed in 60 municipalities and six DPSs (targeted HFA provinces/municipalities), and 264 users have been trained at GPS and RMS levels, following the GEPE/GTI standardized procedures and methodology.

KIs from central, provincial, and municipal levels reported that they were actively involved in all DHIS2 activities/processes (co-diagnosis, co-planning, and co-implementation) and noted excellent collaboration with HFA IPs, as well as HFA’s strong commitment in providing qualified and regular technical assistance at all levels. DPS and DMS interviews carried out during the field visits (Zaire and Lunda Sul) highlighted the following problems about DHIS2 regular functioning: lack of electricity; difficult Internet access; and delays in HFs’ sending monthly reports, due to lack of transport and difficult access (remoteness and bad road conditions, particularly during the rainy season).

RECOMMENDATIONS FOR RESULT 5

HFA has achieved remarkable progress in setting up DHIS2 dashboard during PY2. Based on this evaluation, the evaluation team recommends the following:

- **Technical assistance.** HFA should continue to provide regular technical assistance at municipal, provincial, and national levels for DHIS2-related activities, and support NMCP/GTI and GPS in using the DHIS2 dashboard for data analysis and decision-making.
- **Supervision and training.** HFA, under MOH leadership (NMCP and DHIS2), should continue to assure regular supervision at provincial and municipal levels to monitor progresses and detect problems. Moreover, HFA should support the MOH (NMCP and GIT) to carry out refresher courses based on the detected gaps among DHIS2 users.
- **Implement evaluation/coordination meetings.** HFA should support the NMCP and GIT in organizing quarterly meetings with the selected provinces for data analysis and decision-making. With GoA international partners, PMI/USAID should support the MOH at the central level in organizing regular technical and coordination meetings to evaluate DHIS2 performance, discuss problems, and find appropriate solutions for improving DHIS2 implementation.
- **Support.** To focus on the issue of sustainability, PMI–USAID, together with GoA international partners, should support the GoA and MOH at the central level to establish their own mechanism/procedure to assure the needed financial and technical resources for regular DHIS2 functioning and use at all levels (central, provincial, and municipal). Moreover, PMI/USAID and GoA international partners should continue to support the MOH to advocate with local governments (provincial and municipal) to guarantee the regular operation of DHIS2.
- **DQA.** PMI–USAID/HFA, jointly with GTI/NMCP and GoA international partners, should develop a DQA system to guarantee the accuracy and completeness of data processed using DHIS2.

It was not the objective of this midterm evaluation to assess the Governance and Finance component of Result 5, concerning NMCP capacity at the central level to strengthen management capacities. PSI, jointly with international partners, has made efforts during PY2 to hold regular meetings with the NPHD/NMCP and the National Malaria Forum, and to encourage NMCP leadership. The evaluation team recommends that the MOH and GoA create mechanisms and procedures and define roles to facilitate HFA's intervention. Finally, the evaluation team recommends that HFA, in collaboration with international partners, continue to provide qualified and regular technical assistance to the NMCP to build capacity of key NMCP staff to:

- Set objectives and targets, ensure planning and implementation, and formulate malaria control policies;
- Design and support a national malaria control strategy;
- Formulate national malaria control plans, including setting targets;
- Set standards and conduct QA;
- Supervise, monitor, and evaluate malaria-related activities in Angola;
- Conduct and coordinate malaria surveillance and operational research;
- Build capacity and provide technical support (cascade approach and integration with other national programs); and
- Empower provincial and municipal stakeholders to manage highly reliable data and generate demand for national partners to manage and use DHIS2.

HFA is focused on providing technical assistance to NMCP and building the capacity of local partners. PMI–USAID should determine—taking into account the evaluation findings—the way forward for providing proper support to MOH (NMCP, GTI, GPS, and RMS) and local partners to increase their responsibility to meet project targets and guarantee sustainability, and to properly respond to malaria needs and GoA/MOH priorities.

HIV/AIDS

Result 3: Sustainable model for providing high-quality HIV/AIDS services established

Major HFA achievements for Result 3 include a very smooth transition from SASH project activities, including scale-up of the IC approach, robust analysis of patient-level service data to guide decision-making, and strong partnerships with HFs, enabling services to be responsive to evidence.

At the same time, indicator data show that gaps in quality of care persist, though there are also gaps with respect to the availability of quality-of-care indicator data (or guidance on which indicators to extract from SEGEP). There also appears to be a lack of emphasis on strengthening service delivery management and supervision by GoA staff at site and above-site levels, especially by municipal-level staff. Finally, the technical assistance strategy of embedding HFA staff at the facility level will require a longer-term transition/sustainability plan.

RECOMMENDATIONS FOR RESULT 5

Based on this evaluation, the evaluation team recommends the following. The audience for each recommendation is specified in brackets before each recommendation.

Above-site level:

- [USAID, HFA] *Develop and implement a communication plan that:*
 - Outlines new and existing fora for sharing of experiences among INLS, HFA, and ICAP. Ideally, the plan would include a timeline indicating the schedule for different modalities, including ad hoc exchange meetings (presentations, data reviews, focused discussions) and scheduled site visits, as well as selected routine HF meetings that could be open to participation by INLS observers;
 - Identifies key project documents to be systematically shared with INLS/GPS/RMS/RDS, such as work plans and schedules of key meeting and supervision site visits, and reports⁴³ to identify additional opportunities to meet mutual objectives and reduce barriers to GoA participation in said activities; and
 - Provides a roadmap to coordinate and transition site-level coaching and supervision between INLS (GPS/RMS/RDS), ICAP, and HFA supervisors.
- [USAID, HFA] *Facilitate a process for joint development of an HIV/AIDS service delivery sustainability plan.* Participation by key stakeholders (INLS, HFA, ICAP, GPS/Luanda, RMS, RDS, HFs) to guide the content will help to increase ownership, adherence, and effectiveness. This should include:
 - Identification of above-site and site-level GoA focal points to absorb project learning. Focal points would also lead the process of scaling up efforts to other MOH sites. Although existing GoA HIV *focal points* could be the logical individuals to adopt this role, many at the HFs are loaded with clinical work, so taking on this role would require a plan to reduce their clinical responsibilities (e.g., via task shifting);
 - A capacity building plan for RMS/RDS to direct, manage, and supervise service delivery and take ownership of results. A sustainable model for service delivery requires above-site supervision, and HFA has a mandate to build the capacity of local government. The PEPFAR directive that ICAP provide above-site technical assistance to INLS will require joint planning to accomplish coordinated systems strengthening; and
 - Jointly develop, with INLS, a strategy to transfer the HIV/AIDS service delivery model beyond the nine PEPFAR-supported sites. HFs are already transferring learning beyond HFA sites; lessons learned should be gathered to inform future efforts.
- [USAID, HFA] *Consider developing a hierarchy of HIV/AIDS service delivery quality-of-care dashboard indicators* that facility-level health managers can independently obtain to support health management decision-making.⁴⁴ Such a dashboard would be developed most effectively in collaboration with key GoA partners and over time, starting with key indicators based on the ART cascade using longitudinal data. Unlike progress-to-target indicators, ART cascade indicators provide health managers with a snapshot-intuitive understanding of high-level HF performance and the magnitude of key gaps in the continuum of care. The dashboard should

⁴³ The suggestion to share reports with INLS was spontaneously brought up by an IP KI when prompted for general recommendations.

⁴⁴ Decision-making can refer to actions stemming from site-level and above-site supervisors/managers, as well as the quality committee.

help managers make better use of limited resources by providing information to help prioritize which gaps to address, and indicator data should be available *on a monthly basis*⁴⁵ to enable assessment of whether actions in the previous month might have helped address gaps.

- [HFA] Consider conducting a gender assessment for Result 3 and integrate gender equality into ICTT approach.

Health facility level:

- [HFA] Consider providing guidance to QA committees as a strategy to strengthen HF staff management. In the last quarter of FY 2018, HFA launched HF-level QA committees, which are led by the case manager and include the HF director, HIV focal point, providers (HIV, RH, and TB), and laboratory technicians. Committees review quarterly indicator data⁴⁶ reported to PEPFAR, identify high-priority gaps and root causes, and test changes to address the gaps. HFA staff explained that HFA has taken a hands-off approach with the committee in order to build sustainability.
 - The evaluation team agrees that the QA committee is not only an excellent way to strengthen HF ownership and management capacity, but also could be a robust approach for finding ways to bridge gaps in linkage to care and retention, as root causes are specific to each HF and thus need to be analyzed at the HF level. However, rather than taking a hands-off approach, the evaluation team proposes that HFA be sufficiently involved with QA committees to increase the likelihood of success. As part of this process, the evaluation team suggests that:
 - Identification of gaps be based on proposed dashboard indicator data, which help prioritize gaps, rather than PEPFAR quarterly review data, which tend to focus on PEPFAR targets;
 - Committees be co-led by HIV focal points, with the objective of gradual transition of leadership;
 - Committee membership include patient representation;
 - After priority gaps are identified, the committee invite the participation of persons involved with the corresponding process (e.g., PAFs for retention in care); and
 - The QA committee create a mechanism for receiving feedback from patients. For example, one KI said she posted her phone number at the HF and regularly receives complaints and compliments on services.
- [HFA] To support linkage to care, the evaluation team also suggests that HFA refer to the *Linkages project* those patients who identify as members of a key population.

⁴⁵ Indicators that cannot be produced using the SEGEP database can be measured by hand; for instance, using a sample of medical records reviewed by the quality committee and/or site-level and/or above-site supervisors.

⁴⁶ From presentations prepared for quarterly PEPFAR meetings.

FAMILY PLANNING/REPRODUCTIVE HEALTH

Result 4: Strengthened, expanded, and integrated FP/RH services at provincial and municipal levels

HFA has made impressive strides in working with the GoA to strengthen FP service delivery efforts, especially given a relatively limited budget and a late start of project activities. Overall, government KIs with which HFA has worked have been satisfied with HFA's collaborative approach. On the other hand, current training and supervision systems do not sufficiently emphasize assessment and assurance of individual health workers' competence and performance, and the two systems do not appear to reinforce each other.

RECOMMENDATIONS FOR RESULT 4

At this juncture, the evaluation team recommends the following strategic actions [again, the audience for each recommendation is specified in brackets]:

- [HFA] **Improve coordination with the DNSP/GPS/RMS/RDS through increased joint planning.** One way to achieve this is through systematic sharing of key project documents, such as work plans and schedules of key meeting and supervision site visits, identifying additional opportunities to meet mutual objectives and reduce barriers to MOH staff participation in these activities.
- [HFA] **Continue to engage national- and provincial-level stakeholders who have not participated in current FP efforts.** At the end of FY 2018, HFA appeared to be working with one main partner at national and GPS levels. Broader buy-in, especially during the planning stage of new initiatives, would increase the efficiency, quality, and sustainability of FP assistance.
- [USAID, HFA] **Advocate for, implement, and coach on standardized supportive supervision guidance** for all FP supervisors, including HFA-, RMS-, RDS-, and HF-level supervisors. Do not wait until HNQIS is widely available to start the process of improving and standardizing the supervision system. Paper tools will always serve as a backup if tablets are not available or not functional, and tablets might not be sustainable in the long run.
 - Supervisors should be using the same tools and procedures during supervision visits to reinforce standards of care with staff providing FP services.
 - Supervision guidelines should outline procedures supervisors should follow at site visits, as well as tools. For instance, supervisors should conduct structured health worker observations and provide feedback. Huambo province was poised to initiate monthly GPS meetings, in which HF staff bring their stock management forms, which should allow supervisors more time to focus on supportive supervision of quality of care.
- [HFA] **Redesign and align training and supervision to assure voluntarism and informed choice.** KIs indicated that HFA training and supervision, as implemented, do not assure that FP clients receive comprehensible information on FP options to make an informed choice of FP method or that providers correctly apply the principle of voluntarism. These two principles must reinforce the same body of knowledge to promote learning and adherence. In short, training should include assessment of counseling skills (not just knowledge), training post-tests should assess for key knowledge of different methods and counseling skills, job aids providing comprehensible information on FP methods should be available at all HFs, and

supervision tools should assess health workers' performance in these two areas. Ideally, IEC materials outlining key counseling points for FP clients should also be available, as IEC sessions are not always available at different services at the hospital.

- **[USAID, HFA] Advocate for and develop an HR database (and relevant procedures)** to track FP health workers' competence, performance, and capacity building support received. KIs suggested that the current supervision information system (HFA, municipal, HF) does not appear to be designed to assure that FP health workers are actually observed during supervision visits or that supervision visits systematically assess each FP health worker (i.e., supervision coverage of all health workers). Anecdotally, one KI mentioned how the same participants seemed to be favored for attending different training deliveries, while others were not selected. Ideally, HFA and municipal- and HF-level RH supervisors should be coordinating to maintain the same database. If such a database existed, and if the procedures required to consistently collect and maintain relevant data were widely institutionalized, then this could be a major health system strengthening legacy for HFA.
- **[HFA] Monitor (and document) competence, performance, and training and supervision received.** If health workers' competence and performance were consistently assessed and documented (i.e., for each of the 200 to 400 FP focal points), such results could guide managers and supervisors to plan for future training and supportive supervision to maximize resources. Such documentation would also protect against the perception of favoritism in these activities and help managers keep supervisors accountable. In addition, projects such as HFA often state staff turnover as a common barrier to capacity building; documenting its magnitude and root causes is a first step to understanding and addressing it.
- **Define (and prioritize) what health workers are supposed to know and do.** Not all information in training is equally important. Only after defining priority health worker competencies and performance standards can one design training, knowledge and skills tests, and supervision tools that assure standards. *If everything is a priority, then nothing is a priority.*
- **[HFA] Use the GPS monthly meetings of RMS staff as an opportunity to strengthen management and leadership at the municipal level.** RMS supervisors and HFA staff should be jointly monitoring performance of all FP staff at FP HFs in their municipality, as well as HFA/RMS efforts to improve performance. The monthly meeting can serve many purposes. RMS staff can engage in problem-solving, share strategies around common barriers, and keep themselves accountable by reporting on their activities, performance, challenges, and plans. GPS/HFA can also promote friendly competition among RMS supervisors.
- **[HFA] Redesign the content of the HNQIS tool that makes explicit what health workers should do.** Some current checklist items presume that supervisors have already mastered a body of knowledge. For instance, a checklist item worded as “Establishes eligibility for oral contraceptives” should be reworded to include specific eligibility criteria that health workers should be assessing. If the supervision tool had good content and were user-friendly, it could be used for peer feedback, and health workers (or even QA committee members) could coach each other between supervision visits. Supervision tools should specify actions supervisors should take (e.g., observe health workers, provide written and verbal feedback), as well as the technical content.

- [HFA] **Develop and assess joint projects with partners.** There may be synergistic opportunities to collaborate with UNITEL and MASFAMU.⁴⁷
- [HFA] **In quarterly reporting, provide greater detail for indicator definitions and values for easy interpretation.** For instance, the indicator, “Percentage of health facilities whose providers reported a Quality of Care score \geq 80% for management of FP services,” it is unclear (1) whether providers in other services who also provide FP would be included in the indicator assessment; and (2) what the time frame is for being assessed. As another example, quarterly reports have not reported on denominator values for Result 4 data for indicators that are percentages.

CROSSCUTTING (MALARIA, HIV/AIDS, FP) PROGRAMMATIC RECOMMENDATIONS

- [HFA] **Align training and supervision into an integrated capacity building approach. HFA should design health worker training to better assess and address high-priority knowledge and skill areas.**
 - Training is rarely sufficient to build capacity or change health workers’ behavior. Learning requires reinforcement, and putting learning into practice requires understanding and addressing barriers in the work context. Thus, training post-tests should include health worker knowledge *and* skills. The same knowledge and skills should be reinforced during supervision and designed into supervision tools, such as checklists (observation and health worker knowledge).
 - Incorporate human-centered design and organizational development approaches to translate training into practice. This is a systems approach to change within health units, versus a focus on individual trainees.
- [HFA] **Jointly monitor health workers’ competence and performance with GoA supervisors.** For each health worker, data would include relevant training courses attended, supervision observations, and any competence (training assessment) or performance (supervision) scoring results. Such data would help guide in-service training and supervision efforts to assure coverage, prevent duplication, and track health workers’ competence and performance. Although such efforts do take place to some extent, KIIs indicated that sometimes, the same individuals are repeatedly selected for training, while others never receive the opportunity. Similarly, repeated supportive supervision visits may take place without the supervision of a particular health worker. Jointly maintained monitoring data supports coverage, coordination, and accountability.
- [USAID, HFA] **Work with GoA counterparts to develop an HFA sustainability plan,** highlighting major lines of action, across HFA results, that will increase the likelihood of technical and financial sustainability. Understanding how responsibilities will be transitioned helps clarify what needs to change in the next three years.
- [USAID, HFA] **Consider opportunities for integrating the CHW role across service areas** (i.e., community counselors and FP *ativistas*) for greater reach, where possible. For instance:

⁴⁷ The MASFAMU minister is president of the Maternal Mortality Commission, and the vice minister is technical coordinator. There are national, provincial, and municipal maternal mortality committees.

- Community counselors could be trained to assess the FP needs of all community members/patients they may work with (e.g., household testing), assess mosquito net ownership and use, and provide basic IEC information and referral;
- *Ativistas* could systematically provide IEC on HIV/AIDS testing and treatment messages and IPTp; and
- For pregnant women, CHWs could provide HIV and FP testing, and assess for TB and malnutrition, and provide integrated IEC.
- [USAID, HFA] **Consider the longer-term strategy of developing, with DNSP/INLS, a certification system for CHWs**, which could be used to guide future hiring decisions. There has been much discussion regarding the sustainability of PAFs, community counselors, and FP *ativistas*, with some KIs suggesting that ADECOs do not have the right background for providing IEC and/or counseling. In fact, although not everyone is well-suited for such positions, many can acquire the knowledge and skills. The key is to have a fair and robust system that uses the right tools for assessing health workers' competence (and possibly performance).
 - Requirements for certification could be based on an assessment of knowledge and skills, conducted as part of a series of in-service training courses or through a separate certification process, and could include a length-of-experience requirement (which could be based on volunteer experience) and/or performance scores assessed in supervision visits. The process would also result in a clear definition of the competencies needed for specific health worker roles.
 - If the MOH were interested in pursuing such a strategy, a roadmap could be developed jointly that would guide HFA's approach in the next three years. Such a strategy could also be considered for FP providers.
- [USAID, HFA] **Consider advocating with the MOH to:**
 - Increase health worker allocation at HFs. HF KIs reported that HIV/AIDS and FP services have experienced an increased demand for services at HFA-supported facilities, which is likely linked to the improvement in services;
 - Provide intermediate guidance to health workers for supervision guidelines and tools they should use until official approval takes place; and
 - Increase the numbers of supervising staff.
- [HFA] **Strengthen coordination and partnership with PSM** to reduce stockouts. For example, HFA could consider assigning a focal point at each facility who would, along with other HF focal points, identify ways to collaborate to reduce stockouts (e.g., coordination, advocacy with GoA).
- [HFA] **Expand and intensify participatory approaches** to diverse local stakeholders and beneficiaries in provinces and municipalities (e.g., women, youth, CSOs, companies).
- [HFA] **Consider the feasibility hiring for key positions to strengthen HFA support** HFA supervisors (i.e., equivalent of FP QA staff) and specialists in SBCC and organizational development/change management to work with HFA team to identify changing needs, get buy-in

from decision-makers, and implement change. Champions could also support field staff to improve and diversify approaches and attain higher-order results.

HFA STRUCTURE AND SYSTEMS (QUESTION 3)

HFA is a complex activity that operates under varied critical assumptions, many of which correspond to the Angolan context, the GoA and, to a lesser extent, the USG. These external conditions must be diligently equipped with solid organizational structures and systems that foment collaborating, learning, and adapting (CLA).

In the face of these challenges, the HFA implementing team is committed to achieving HFA results. PSI's emphasis on and attention to strong administrative and financial systems has had a contagious effect on each of its subcontractors, particularly RMA. Still, each IP has gaps and weaknesses in structure and systems that limit HFA implementation effectiveness, efficiency, and ability to achieve results. Thus, at this midpoint, there is ample opportunity for course correction. The recommendations that follow are developed for USAID and international partners. They are options to spur corrective action and enhance HFA results achievement.

HFA IP Team

The following recommendations seek to add value to the IPs' OCA action plans. As some recommendations have cost implications (i.e., structure, staffing, material resources), PSI and USAID can assess relevance and cost feasibility against available resources to prioritize actions in taking them.

PSI

Decentralize structure and reinforce field operations. Strategically decentralize operations by examining field arrangements, geography, and result areas. Specifically, PSI can:

- Establish and staff regional "hubs" to increase presence and better manage HFA across municipalities;
- Acquire infrastructure via any of the following actions: (1) secure permanent infrastructure (e.g., a house), similar to Result 1 operations; (2) expand within DPS offices, similar to Result 2 operations; or (3) co-locate with local (e.g., GoA), international (e.g., World Vision, United Nations), or other USAID IPs (e.g., Chemonics/PSM), or with HFA (e.g., MENTOR) partners;
- At the hubs, employ a core full-time staff: regional supervisor, results supervisor, M&E/quality coordinator; logistics and administrative coordinator; and regional HR/recruiting coordinator;
- Equip hubs with a car and printers that can print the volume of training materials required; and
- Craft a field operations strategy that contains organizational structure, staff responsibilities, lines of authority, and communication and reporting.

Strengthen the HFA performance management system:

- Assess the need for more M&E staff at HQ and in the field, and staff up as required;
- With USAID, review PMP indicators to assure all critical elements are being measured and routinely reported, including context indicators, and eliminate indicators that are not adding measurement, management or reporting value;
- Review and re-set targets as needed;

- Craft an Activity MEL Plan containing a performance monitoring plan, internal evaluation plan, learning plan, data quality and management plan, and an annex containing Performance Indicator Reference Sheets and Context Indicator Reference Sheets;⁴⁸
- Develop HFA data quality standards, process, training, templates, and tools;
- Improve data collection tools and processes, particularly for the evaluation's rapid DQA indicators;
- Standardize communication and coordination for MSH's Result 3 data management efforts, as two implementers leading data collection and management pose threats to data quality; and
- Establish a performance management committee (implementing team and USAID) that meets quarterly to assess results achievement, identify strengths/weaknesses, and prioritize improvements.

Intensify local capacity building with RMA:

- Hire a permanent local capacity building champion, responsible for building RMA's capacity and supporting and promoting capacity across HFA. The champion can be coached by an external, short-term capacity building specialist to guide planning, execution, and monitoring of efforts;
- Via the proposed capacity building team, strengthen the current RMA capacity building plan;
- Facilitate the design and approval of key RMA deliverables, such as the PY3 annual plan;
- Focus dually on RMA's HFA management systems (e.g., HR, administration, or financial management) and on efforts to promote organizational longevity (e.g., business planning and development, leadership development, and board development); and
- Diversify techniques beyond training—coaching, piloting of field efforts, embedding pro bono specialists, involving RMA in HR efforts, collaborating or co-locating with local/international partners, and co-locating (organizational mentoring) for longer periods with PSI, MSH or MENTOR.

Strengthen HR to support operations:

- Clarify roles/responsibilities and lines of authority and communication between the country director and chief of party. Based on this outcome, evaluate benefit of hiring an HFA deputy chief of party;
- Conduct a headcount analysis to determine staff adequacy at HQ and forecast field needs;
- Develop a HQ and field-based staffing plan, containing organizational charts and an incentive plan (e.g., bonuses, learning/professional opportunities, and career track advancements) to reduce turnover;
- Hire a full-time, HFA-dedicated recruiting lead who works across HFA implementing team;

⁴⁸ See: <https://usaidlearninglab.org/library/how-note-activity-monitoring%2C-evaluation%2C-and-learning-plan-template>

- Hire a full-time safety and security champion, with responsibilities across the HFA team; and
- Strengthen and orient subcontractors (particularly RMA) on the PSI security management plan.

Improve strategic management of the HFA implementing team:

- Proactively showcase good practices, transfer successes, adapt to challenges, and promote achievement (i.e., CLA);
- Improve internal communication processes and share information more regularly among all IPs;
- Elevate the HFA management committee's role, purpose, meeting frequency, and involvement;
- Hire a full-time editor and graphic designer (housed in the M&E area) to coordinate, review, and finalize all HFA deliverables and quarterly reports;
- Hire a full-time HFA gender champion to develop and implement a gender mainstreaming plan for HFA services, plans (e.g., sex disaggregation of indicators), and results;
- Refine and implement the HFA OCA Action Plan (for all partners). Focus on performance management, operations management (i.e., field supervision), and organizational management and sustainability (capacity building, change management, HFA IP coordination);
- Craft an HFA sustainability plan that highlights major lines of action across HFA results that will increase likelihood for technical and financial sustainability;
- Revisit PSI's touchstone approach (co-diagnose, co-design, and co-implement) and how it could/should be updated and integrated into the sustainability plan; and
- Facilitate flexibility in subcontractors' budgets. Be open to working with partners to reallocate resources, as long as total amounts remain unchanged. All subcontractors affirmed this need.

MSH, MENTOR, and RMA

Beyond carrying out the individual OCA plans, the evaluation team recommends that MSH, MENTOR, and RMA work with PSI to strengthen/develop:

- Internal change management processes and develop a contingency plan for each implementer;
- An HFA sustainability plan, with a section dedicated to MSH, MENTOR, and RMA;
- An HFA gender mainstreaming plan; conduct a gender assessment and integrate gender equality into service delivery;
- Performance management standards and efforts (e.g., MEL plan) and ability to collect, verify, store, share, and use HFA data;
- Strategic coordination and partnership with PSM to reduce stockouts across Results 3 and 4 (MSH and PSI);
- The search for an operational coordinator, as HFA responsibilities are falling on the country director, who manages six projects (MENTOR);

- The ability to absorb capacity building to best implement HFA (e.g., finance, HR, M&E, and technical service provision) and secure RMA's future (e.g., leadership and board development, and business planning and generation) (RMA); and
- Understanding whether there are sufficient staff for the HFA workload and generating future business (RMA).

ANNEX I. SCOPE OF WORK

Assignment #: 594 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro) Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: May 25, 2018

Last update: 8-29-2018

I. **TITLE:** Performance Evaluation of Angola's Health for All

II. **Requester / Client**

USAID/Washington

Office/Division: GH / OHA

USAID Country or Regional Mission (Funder & TDM Approval)

Mission/Division: Angola / _____

III. **Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)**

3.1.1 HIV

3.1.4 PIOET

3.1.7 FP/RH

3.1.2 TB

3.1.5 Other public health threats

3.1.8 WSSH

3.1.3 Malaria

3.1.6 MCH

3.1.9 Nutrition

3.2.0 Other (specify):

IV. **Cost Estimate** \$347,831

V. **Performance Period**

Expected Start Date (on or about): September 5, 2018

Anticipated End Date (on or about): February 28, 2019

VI. **Location(s) of Assignment: (Indicate where work will be performed)**

Washington, DC

Angola:

- Malaria: PSI (Lunda Sul) MENTOR (Zaire)
- HIV/AIDS: Luanda (MSH)
- Family Planning: Luanda and Huambo

VII. **Type of Analytic Activity (Check the box to indicate the type of analytic activity)**

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm

Endline

Other (specify):

Performance evaluations encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after

implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

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

Process Evaluation (Check timing of data collection)

Midterm Endline Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

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

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify): _____

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

Economic Evaluation (PEPFAR)

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

VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Project Title:	Health for All
Award/Contract Number:	AID-654-A-17-00003
Award/Contract Dates:	January 2017 – January 16, 2022
Project Funding:	\$63,000,000
Implementing Organization(s):	Population Services International (PSI)
Project AOR/COR:	Armando Cotrina

Background of project/program/intervention (*Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis*)

A. Description of the Problem

Malaria: Despite significant progress in the fight against malaria in the last decade in Angola, serious challenges remain to achieving the GRA's malaria goals. ITN ownership remains low, with 29% of households with at least one ITN in 2015 and 20% of population having access. Access to, and quality of, malaria services are also inadequate to meet the NMCP's targets for case management and malaria prevention and treatment during pregnancy. Only 45% of the population has access to a public health facility; stock outs of key supplies are common; infrastructure is weak; and healthcare workers have limited capacity to diagnose treat malaria and adhere to intermittent preventive treatment in pregnant women protocols. Consequently, coverage of these key services is low. Only 18% of pregnant women receive at least three doses of IPTp.15 Less than a quarter (24.5%) of children under five with a recent fever received any diagnostic test.

HIV: Findings from three recent population-based HIV sero-surveillance studies (DHS+2015, IBBS 2016, SABERS 2015) confirm that the HIV/AIDS epidemic in Angola is a low-level generalized, primarily heterosexually-driven epidemic. In 2015, PEPFAR Angola partnered with the GRA to conduct the first-ever nationwide Demographic and Health Survey (DHS+) which captured nationally-representative information on health behaviors and biomarkers, including HIV testing. DHS (2016) reported an overall HIV prevalence of 2.0% among adults aged 15 to 49 years in Angola. Prevalence among adult females age 15-49 years is higher than among adult males (2.6% vs 1.2%). HIV prevalence is not evenly distributed throughout the country; HIV prevalence is 1.9% in Luanda and is equal to or exceeds four percent in three provinces: Cunene (6.1%), Cuando Cubongo (5.5%) and Moxico (4.0%). These three provinces are sparsely populated, with a combined estimated population of 2.5 million; Luanda, the capital city, is home to 7.7 million or 27% of the nation.

FP/RH: Despite economic progress since the war ended in 2002, Angola's fertility rate is six children per woman, high even compared to other developing countries. More than three million Angolan women of reproductive age (WRA) lack FP/RH services and the contraceptive prevalence rate (CPR) remains low: 17.7% (all methods), 12.8% (modern methods).39, 40 Almost half of the population of Angola is under 15. One in every three girls aged 15-19 year-old already have a child. Angola has 2,366 health care units, however only 403 of those have staff trained and authorized to provide free FP services (>25% in Luanda). Globally, women living with HIV have eight times the risk of a pregnancy-related death compared to women without HIV. An estimated one in every four pregnancy-related deaths in sub-Saharan Africa are attributable to HIV.41

B. Program Goal, Strategy and Expected Results

The program goal is to transform USAID Angola partnerships to strengthen the effective use of Angola's resources to meet the country's development needs. Moving beyond "partnership as usual," Health for All will directly engage MOH, civil society, private sector, and beneficiary partners from day one to co-diagnose fundamental barriers, co-design approaches to strengthen health systems, and co-implement

proven interventions, thus building ownership and skills to transform Health for All interventions into measurable and sustainable outcomes beyond program end. These partnerships will lead to catalytic improvements in program design and implementation to ensure sustainable achievement of Program's Expected Results, contributing to three of the four USAID/Angola Country Development Cooperation Strategy Intermediate Results: build sustainable platforms, modernize public administration, and strengthen public financial management as well as Development Objectives of improved health status and well-being of the Angolan population and strengthened responsiveness to citizens' needs.

HFA's expected results relate to specific funding source and partner's participation.

Result 1: LLIN access and use increased by at least 30% (Malaria).

Result 2: Malaria services throughout targeted municipalities improved (Malaria).

Result 3: Sustainable model for providing high-quality HIV/AIDS services established (HIV).

Result 4: Strengthened, expanded and integrated FP/RH services at provincial, and municipal levels (FP).

Result 5: Capacity of municipal and provincial governments to plan, fund, monitor, and supervise health programs improved (Malaria).

C. Description of HFA Project in Angola

HFA is implemented by a consortium led by Population Services International (PSI/Angola). Consortium members include Rede Mulher Angola (Local Partner), Tropical Health LLP, Management Sciences for Health, and The MENTOR Initiative.

PSI serves as the program's administrative secretariat, leading responses to mission requests, overseeing partners and implementation of agreements, and serving as the primary contact for USAID. For Result 1, PSI leads workshops for national counterparts and partners on how to implement distribution, share tools, disseminate mass distribution strategy, etc. PSI lead LLIN distribution in 13 provinces with support from selected local partners. For Result 2, PSI develops Provider Behavior Change Communication methodology and tools for quality assurance as well as collection and management of aggregated service delivery data through information systems. PSI also leads the implementation of iCCM pilots and the strategy development for all SBCC under Results 1 and 2, and implementation in Lunda Sul, Lunda Norte, Cuanza, and Malanje. For Result 3, PSI manages activities related to community interventions in Luanda and two other provinces as jointly determined by INLS/USAID. For Result 4, PSI leads and implement all FP activities (including gender integration in FP programming), and for Result 5, PSI leads implementation of HMIS for data integration into the M&E and surveillance system for NMCP, as well as provide staff seconded to NMCP.

Rede Mulher Angola (RMA) supports LLIN distribution (Result 1) and implement iCCM in Lunda Sul in collaboration with PSI (Result 2). RMA will also implement SBCC activities in malaria, FP, and HIV in Results (Result 2, 3, and 4) through its network of 80+ local organizations in Luanda and other provinces as appropriate. RMA also leads capacity-building trainings for local organizations on topics including gender, organizational management, & budgeting. For Result 5, RMA leads advocacy for gender equity in allocation of resources.

Tropical Health LLP (TH) leads the strategy development for routine and mass distribution campaigns, the NMCP in net quantification exercises for mass and routine, and the post-distribution evaluation under Result 1.

Management Sciences for Health (MSH) leads all HIV-related facility-based activities (Result 3) in Luanda and the two provinces designated by USAID (including TA for policy change and supporting training materials, development of the COC model, institutionalization, and scaling up). For Result 5, MSH

develops costed municipal health plans in 24 selected municipalities.

The MENTOR Initiative leads the distribution of LLINs in Uíge and Zaire (Result 1). MENTOR leads laboratory strengthening and joint OTSS with MOH; the training of facility-based personnel in Uíge and Zaire; and the community interventions in Zaire, and Uíge. MENTOR has offices in Uíge and Zaire.

Moving beyond “partnership as usual,” the Team engages government, civil society, private-sector, and beneficiary partners directly from day one thereby building the ownership and skills necessary to transform Health for All interventions into measurable and sustainable outcomes beyond program end. To meet the program’s vision of a gradual transition of some program activities to the GRA and local partners by the end of Year 3, the Team will implement a phased transition plan. Phased transition will include a gradual increase of budget responsibilities will start at 10% for local partners, increase to 15% in Year 2. USAID will provide approval based on the readiness assessment for each partner to reach the required 30% in the final quarter of Year 3.

D. Summary of the Project/Activity Monitoring, Evaluation, and Learning (MEL) Plan

The project has a variety of data sources which includes:

Request for Application

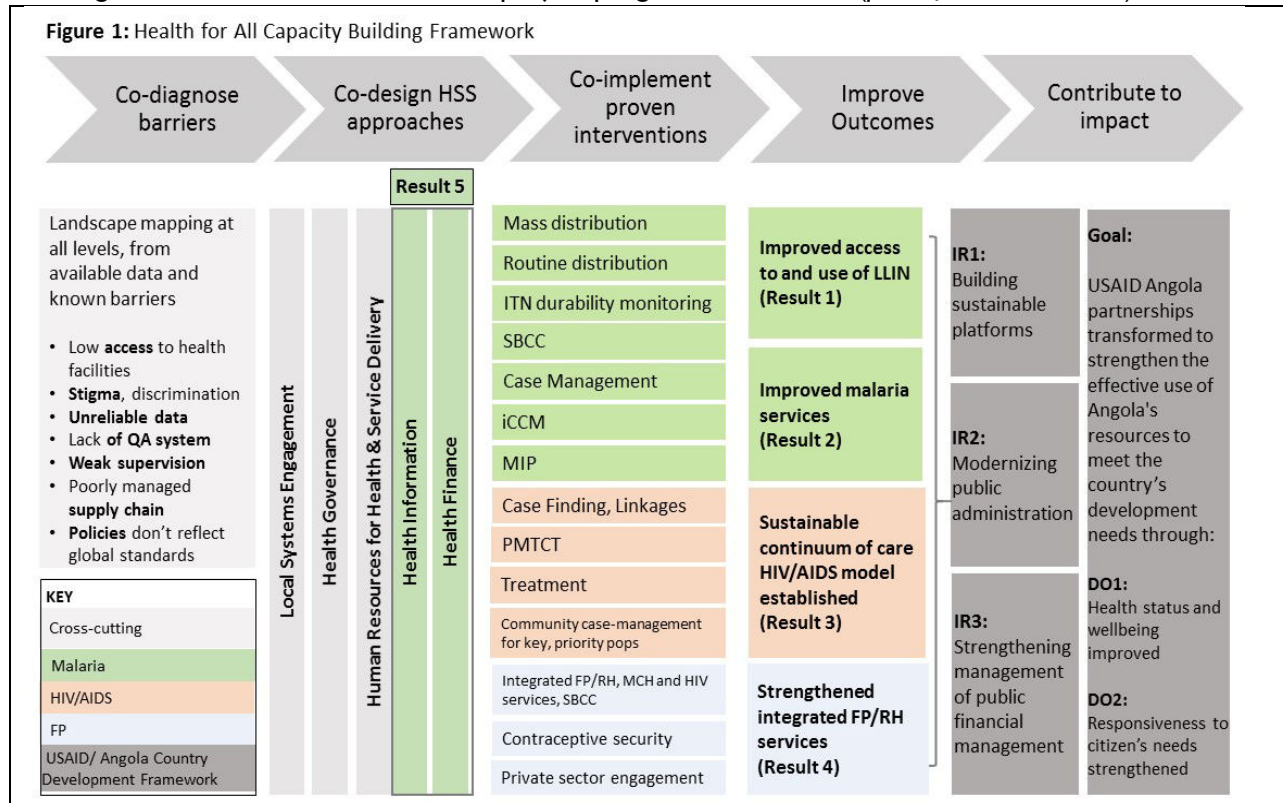
- a. Cooperative Agreement
- b. Annual and Quarterly Reports
- c. Project M&E Plan
- d. Result Framework/Technical Approach/Phased transition plan
- e. Annual work plans
- f. Activity deliverables (tools, training curricula)
- g. Financial data (to monitor phased transition plan)
- h. Program data (IP databases)
- i. Meeting minutes with GoA counterparts

In addition to the above-mentioned data sources, the evaluators should utilize surveillance and other data sources including DHS, IBBS, and SABERS to understand population level health status by health element.

Theory of change of target project/program/intervention

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



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

Malaria: PSI (4 municipalities in Lunda Sul) & MENTOR (4 municipalities in Zaire),
 HIV/AIDS: Luanda (MSH) (7 facilities)
 Family Planning: Luanda and Huambo

IX. Purpose, Audience & Application

A. **Purpose:** Why is this evaluation/assessment being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this mid-term performance evaluation of Health for All is to:

- Provide specific information about the gaps and opportunities for the project that can be acted upon by project staff and USAID management staff in the implementation of the remainder of the project
- Understand the effectiveness of the project in meeting the intended results
- To identify areas that need to be modified/improved to increase the likelihood of success

USAID Angola technical and management teams will utilize the findings from the evaluation to understand the gaps in implementation and to make decisions and take necessary actions accordingly.

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

USG and implementing partners. Major finding and recommendations (in Portuguese) will be shared to local government.

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

Improve the implementation of the project based on detailed finding and recommendations (USG specific). In addition, we will share recommendations with local government and other members of the cooperation community for transference of tools and methodologies.

X. Evaluation/Analytic Questions & Matrix:

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

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

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

	Evaluation Question	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
1	To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?	Program Description (PD) with goals and results, work plans, PMP, quarterly reports, key informant interviews, site level record reviews.	Key informant interviews, desk review	Pre- and post-baseline data and targets vs. achievements, progress to date and anticipated achievement of goals/milestones; descriptive statistics Qualitative analysis of key informant interviews
2	In each technical sector, what are the strengths and challenges to the program inputs, implementation of activities and processes, and the quality and sustainability of outputs?	Selection of three or more products, activities, and tools across health elements (FP, malaria, and HIV).	Content technical review of quality of product, compared to national and international standards. Direct observation of implementation of the tool or product under review and analysis of quality of use/application on the ground. Key informant interviews	Rating of tools using checklist against standards. (Checklist to be developed by Evaluation Team.) Rating of implementation of tool. (Rating instrument to be developed by Evaluation Team.)

	Evaluation Question	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
3	What systems are in place to identify and remedy challenges on program management and structure? (i.e., planning, human resources, financial, operations, and communications)	Project documents (organogram, management functions, financial records, HR records, process documents, meeting minutes and notes, etc.)	Desk reviews Key informant interviews (project and USAID staff in DC and Angola)	Content analysis Qualitative analysis of key informant interviews

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

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

General Comments related to Methods:

USAID/Angola would like the evaluation team to observe how HFA has integrated gender into program planning and implementation and should keep this in mind as a cross-cutting issue while answering the above questions. As required by USAID policy, all evaluations must be gender-sensitive meaning that all stages of the evaluation should reflect: 1) an awareness that the degree and meaning of program participation, program results, and potential sustainability are shaped by gender; 2) a recognition that explicit attention to gender issues must be integrated into the evaluation if gender equality objectives are to be addressed; and 3) a commitment to examining the extent to which gender equality was achieved as a result of the program or project that was implemented. Engendering the evaluation will allow us to examine if programming achieves positive results and improves quality of life for women as well as men, reduces gender inequities and gaps and empowers women and girls, and contributes to the high-level outcomes articulated in the Gender Equality/Female Empowerment Policy.

In addition to answering the above evaluation questions, USAID expects that the evaluation team develops specific recommendations for the remainder of the HFA project period of performance. Recommendations should be based on scientific evidence and pragmatic experiences from other development programs. If any specific HFA's methodology, approach, or tool is considered inappropriate, the evaluation team should be able to provide alternatives based on existing methodologies, approaches, or tools. In addition, while the primary purpose of this evaluation is to inform and course correct the current project, USAID would appreciate recommendations for future projects including technical and management recommendations that would inform any future procurements.

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

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

- 2017/2018 Malaria Operational Plan
- 2017/2018 HIV Country Operational Plan
- 2017/2018 FP USAID plan
- Angola Health Strategy Plan (Malaria, SBCC, HIV, FP)
- Surveillance reports (malaria, HIV)
- HFA/Angola workplans
- HFA/Angola quarterly and annual reports
- HFA/Angola M&E and annual indicator data
- Angola DHS 2015/6
- Angola MIS 2011
- Specific Plans/strategies: communication plan, SBCC plan
- USAID trip reports
- Monthly HIV reports
- Transition Plan within PD, with updates in annual reports and workplans

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

Data Source (existing dataset)	Description of data	Recommended analysis
Routine health data: GRA and HFA		Re-analysis of existing data to see how it can be better used (Note: USAID/Angola will obtain access to these datasets for the Evaluation Team.)
Operations research data		
Databases used for reports (GRA and HFA)		

■ **Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

The evaluation team will meet with implementing partners project staff in Washington DC (remotely) and Angola, as well as USAID staff in Angola and some technical backstops in USAID/W to gather input and feedback into the implementing partner performance.

Malaria: national and sub-national government counterparts; other international and local malaria partners (e.g., world vision, global fund, WHO); USG; HFA consortium members (expats and Angolans; using different questionnaires)

HIV: national and facility-based government counterparts; USG; HFA consortium members (expats and Angolans; using different questionnaires).

FP: national and sub-national government counterparts; other international and local FPI partners (e.g., UNFPA, WHO); USG.

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

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

Key informants may be interviewed in small groups of similar respondents, as long as all participants feel free to express their own opinions.

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

Malaria: municipal counterparts, community and facility health workers
HIV: Facility-based healthcare workers
FP: national level and municipal counterparts

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

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

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

Direct observations to be discussed and decided upon with USAID/Angola. This is HFA's result specific (training, patient-care, community services, LLIN-care). It'll depend on evaluation dates. GRA will be informed in advance.

Cost Analysis (list costing factors of interest, and type of costing assessment, if known)

■ Data Abstraction (list and describe files or documents that contain information of interest, and purpose of inquiry)

Facility records (registry books), patient-records (electronic database), ANC records

Malaria: 6 facilities in 2 municipalities in Lunda Sul & 6 facilities in 2 municipalities in Zaire.
HIV/AIDS: 7 HIV facilities in Luanda
Family Planning: 4 facilities in Luanda and 2 facilities in Huambo

Case Study (describe the case, and issue of interest to be explored)

Verbal Autopsy (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

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

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual”

Case	Counterfactual

HUMAN SUBJECTS PROTECTION

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

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

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XII. ANALYTIC PLAN

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

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

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

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

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

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

XIII. ACTIVITIES

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

Background reading – Several documents are available for review for this analytic activity. These include Health for All proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

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

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

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- **In-brief with Angola Authorities** to present the work to be done
- The Team Lead (TL) will brief the USAID/Angola and Southern Africa Regional Missions **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and USAID/Angola will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and

recommendations. Additionally, USAID/Southern Africa Regional Mission has requested a debrief. This will be discussed during the USAID in-brief and Team Planning Meeting. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (**Note:** *preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)

- **IP and Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID, including Angolan authorities. This will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

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

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. USAID will manage implementing partner(s)'s (IP) review of the report and compile and send their comments and edits to GH Pro. (Note: USAID will decide what draft they want the IP to review.)
5. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
6. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
7. Once the content of the Evaluation Report is approved, the Executive Summary will be translated into Portuguese
8. Once the Evaluation Report is approved, GH Pro will reformat and edit it for 508-compliance and post it to the DEC.

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

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

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

XIV. DELIVERABLES AND PRODUCTS

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

Deliverable / Product	Timelines & Deadlines (estimated)
<input checked="" type="checkbox"/> Launch briefing	September 18, 2018
<input checked="" type="checkbox"/> In-brief with USAID	October 1, 2018
<input checked="" type="checkbox"/> Workplan and methodology review briefing	October 5, 2018
<input checked="" type="checkbox"/> Workplan submitted (including methods, timeline and data collection tools)	October 6, 2018
<input checked="" type="checkbox"/> In-brief with IP	October 9, 2018
<input checked="" type="checkbox"/> Routine briefings	Weekly
<input checked="" type="checkbox"/> Debrief with USAID with Power Point presentation	November 6, 2018
<input checked="" type="checkbox"/> IP & stakeholders’ findings review workshop with Power Point presentation	November 7, 2018
<input checked="" type="checkbox"/> Draft report	Submit to GH Pro: November 26, 2018 GH Pro submits to USAID: December 3, 2018 USAID shares feedback on report: December 18, 2018
<input checked="" type="checkbox"/> Final report	Submit to GH Pro: December 26, 2018 GH Pro submits to USAID: January 3, 2019 USAID approves report: January 18, 2019
<input checked="" type="checkbox"/> Raw data (cleaned datasets in CSV or XML with codesheet)	December 27, 2018
<input checked="" type="checkbox"/> Report Posted to the DEC	February 22, 2019
<input type="checkbox"/> Other (specify):	
Holidays: September 3, 2018..... Labor Day US September 17, 2018..... National Hero Day Angola October 8, 2018..... Columbus Day US November 2, 2018..... All Souls’ Day Angola November 11, 2018..... Independence Day Angola November 22, 2018..... Thanksgiving Day..... US December 25, 2018..... Christmas Day January 1, 2019..... New Year’s Day January 21, 2019 MLK Day US February 4, 2019 Liberation Day Angola February 18, 2019 Presidents’ Day US	

Estimated USAID review time

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

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

Evaluation/Assessment team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/assessments must be an external expert with appropriate skills and experience.

- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that **all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI)**, or describing the conflict of interest if applicable.

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

- *List desired qualifications for the team as a whole*
- *List the key staff needed for this analytic activity and their roles.*
- *Sample position descriptions are posted on USAID/GH Pro webpage*
- *Edit as needed GH Pro provided position descriptions*

Overall Team requirements:

The evaluation team should include a team leader with 3 additional team members and an evaluation assistant/logistics coordinator. The positions include: **Team Leader/Evaluation & Technical Specialist (1), Malaria Specialist (1), Capacity and Organizational Development Specialist (1), Local Evaluator (1), and Evaluation Assistant/logistics (1)**. All key staff team members should have extensive experience conducting performance evaluations. All team members should have experience working in global public health (HIV/AIDS, malaria, and family planning/reproductive health). Among the key staff team members, the team will have expertise in HIV, malaria and FP/RH. It is critical that the evaluation team members have fluency in Portuguese or Spanish. Some gender expertise would be beneficial to the team and that at a minimum, one person on the team should be knowledgeable about gender concepts, the impact of gender norms, roles and other dynamics on health seeking behavior for women, men, youth and be familiar with the concept of gender integration. It would be beneficial if one person on the team also have experience in gender integration in performance evaluations.

Team Lead/Evaluation & Technical Specialist

Roles & Responsibilities: Serve as the Team Lead and as a member of the evaluation team, providing quality assurance on analytic issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. This person will also provide technical expertise in the areas of HIV and family planning (FP). The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/assessment team, and (5) leading briefings and presentations. As the Technical Specialist s/he will also provide expertise on HIV and FP.

Qualifications:

- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
 - At least 10 years of experience in USAID M&E procedures and implementation
 - At least 5 years managing M&E, including evaluations and/or assessments
 - Experience in design and implementation of evaluations and/or assessments

- Demonstrated experience leading health sector project/program evaluation/assessments, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Angola is desirable
- Familiarity with USAID
 - Strong knowledge, skills, and experience in qualitative and quantitative analytic tools
 - Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations and other evaluation and assessment methods that assure reliability and validity of the data.
 - Experience in data management
 - Able to analyze quantitative data, which will be primarily descriptive statistics and cross-tabulations
 - Able to analyze qualitative data
 - Experience using analytic software
 - Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
 - Experience conducting secondary analysis of existing quantitative datasets
 - Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
 - Strong data interpretation and presentation skills
- Familiarity with USAID policies and practices
 - Evaluation policy
 - Results frameworks
 - Performance monitoring plans

Key Staff 2 Title: Technical (HIV, Malaria and/or FP/RH) Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in HIV, malaria and/or FP/RH (at least 2 out of 3 of these areas). S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 8 years' experience with HIV, malaria and/or FP/RH (at least 2 out of 3 of these areas) projects; USAID project implementation experience preferred
- Expertise in supply and demand for HIV, malaria and/or FP/RH (at least 2 out of 3 of these areas) services at the community and clinical level
- Familiarity with HIV, malaria and/or FP/RH (at least 2 out of 3 of these areas) integration is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English and Portuguese (Spanish is acceptable)

- Good writing skills, including experience writing evaluation and/or assessment reports
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 3 Title: Capacity and Organizational Development (OD) Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate capacity and organizational strengthening activities. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing and will focus on the capacity strengthening, organizational structure, and transition planning components of the evaluation.

Qualifications:

- Background and at least 8 years' experience in organizational capacity development/strengthening.
- Knowledgeable in capacity building assessment (e.g., OCATs) and evaluation methodologies
- Master's degree in related field is mandatory;
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Familiar with PEPFAR Capacity Building and Strengthening Framework (<http://www.pepfar.gov/documents/organization/197182.pdf>)
- Professional proficiency in Portuguese/Spanish
- Experience working in the region and or Angola desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

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

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

Local Evaluator to assist the Evaluation Team with data collection, analysis and data interpretation. S/he will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluator will have a good command of English and Portuguese. S/he will also assist the Team and the Logistics Coordinator, as needed. S/he will report to the Team Lead.

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

- Full member of the Evaluation Team (including planning, data collection, analysis and report development) – If yes, specify who:
 Some Involvement anticipated – If yes, specify who:
 No

Staffing Level of Effort (LOE) Matrix:

This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

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

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

Activity / Deliverable		Evaluation/Analytic Team				
		Team Lead / Eval / HIV Specialist	Malaria Tech Specialist	OD Tech Specialist	Local Evaluator	Logistics/ Prog Assist
1	Launch Briefing	0.5				
2	HTSOS Training	1	1	1		
3	Desk review	5	5	5	2	
4	Preparation for Team convening in-country					2
5	Travel to country	2	1	2		
6	In-brief with Mission	0.5	0.5	0.5	0.5	0.5
7	Team Planning Meeting	4	4	4	4	4
8	Workplan and methodology briefing with USAID	0.5	0.5	0.5	0.5	0.5
9	Eval planning deliverables: 1) workplan with timeline, eval matrix, protocol (methods, sampling & analytic plan); 2) data collection tools					
10	In-brief with Angolan authorities	0.5	0.5	0.5	0.5	0.5
11	In-brief with project	0.5	0.5	0.5	0.5	0.5
12	Data Collection DQA Workshop (protocol orientation/training for all data collectors)	1.5	1.5	1.5	1.5	1
13	Prep / Logistics for Site Visits	1	0.5	0.5	0.5	2
14	Data collection / Site Visits (including travel to sites)	18	18	18	18	18
15	Data analysis	5	5	5	5	1
16	Debrief with Mission with prep	1	1	1	1	1
17	IP & Stakeholder debrief workshop with prep	1	1	1	1	1
18	Depart country	2	1	2		
19	Draft report(s)	8	7	7	4	1
20	GH Pro Report QC Review & Formatting					
21	Submission of draft report(s) to Mission					
22	USAID Report Review					
23	Revise report(s) per USAID comments	4	3	3		
24	Finalize and submit report to USAID					

Activity / Deliverable	Evaluation/Analytic Team				
	Team Lead / Eval / HIV Specialist	Malaria Tech Specialist	OD Tech Specialist	Local Evaluator	Logistics/ Prog Assist
25	USAID approves report				
26	Final copy editing and formatting				
27	508 Compliance editing				
28	Eval Report(s) to the DEC				
Total LOE per person		56	51	53	39

If overseas, is a 6-day workweek permitted Yes No

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

Angola:

- Malaria: PSI (4 municipalities in Lunda Sul) & MENTOR (4 municipalities in Zaire),
- HIV/AIDS: Luanda (MSH)
- Family Planning: Luanda and Huambo

XVI. LOGISTICS

Visa Requirements

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

Visa will be obtained in advance of travel to Angola

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

Name of Country	Type of Visa		
Angola	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input checked="" type="checkbox"/> No preference
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference

Clearances & Other Requirements

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

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

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week **Foreign Affairs Counter Threat (FACT)**

course offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

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

- USAID Facility Access (FA)
Specify who will require Facility Access: _____
- Electronic County Clearance (ECC) (International travelers only)
 - High Threat Security Overseas Seminar (HTSOS) (*required in most countries with ECC*)
 - Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)
- GH Pro workspace
Specify who will require workspace at GH Pro: _____
- Travel -other than posting (specify): Travel to sites for data collection
- Other (specify): Primarily cash economy. Problems accessing cash from ATMs. Credit cards use is limited (big hotels accept credit cards, except American Express)

Specify any country-specific **security concerns and/or requirements**

XVII. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/assessment team and provide quality assurance oversight, including:

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

XVIII. USAID ROLES AND RESPONSIBILITIES

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

USAID Roles and Responsibilities

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

Before Field Work

- SOW.
 - Develop SOW.
 - Peer Review SOW

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

During Field Work

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

After Field Work

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

XIX. ANALYTIC REPORT

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

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

- The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

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

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.

- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

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

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

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

- Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

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

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XX. OTHER REFERENCE MATERIALS

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

XXI. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)

ANNEX II. EVALUATION METHODS

This annex contains the list of evaluation sites, the detailed methodology and sampling by evaluation question, and the evaluation matrix.

EVALUATION SITES

Technical Area	Province	Municipality	Health facility
HIV/AIDS	Luanda	Viana	Ana Paula Health Center in Viana
HIV/AIDS	Luanda	Kilamba Kiaxi	Kilamba Kiaxi Maternal Hospital
HIV/AIDS	Luanda	Kilamba Kiaxi	Divina Providencia Hospital
HIV/AIDS	Luanda	Luanda-Rangel	Rangel Health Center
HIV/AIDS	Luanda	Luanda-Ingombota	Dispensario TB Hospital
HIV/AIDS	Luanda	Luanda-Ingombota	Bernardino Pediatric Hospital.
Family planning	Luanda	Luanda	Maternidade Lucrecia Paim
Family planning	Luanda	Cazenga	Hospital de Cajueiro
Family planning	Luanda	Cazenga	Centro de Saúde II de Novembro
Family planning	Huambo	Huambo	Hospital Mineira
Family planning	Huambo	Caala	Centro Materno Infantil de Caala
Malaria	Lunda Sul	Saurimo	Provincial Hospital De Saurimo
Malaria	Lunda Sul	Saurimo	Centro Saúde Materno Infantil
Malaria	Lunda Sul	Cacolo	Hospital Municipal Cacolo
Malaria	Lunda Sul	Cacolo	Posto de Saúde Tchizeca
Malaria	Zaire	Mbanza Congo	Hosp. Provincial de Mbanza Kongo
Malaria	Zaire	Mbanza Congo	Centro Saúde Materno Infantil

METHODOLOGY & SAMPLE SIZE BY EVALUATION QUESTION

Evaluation Question 1. To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

Result 1: Access to and use of insecticide treated nets (ITNs) increased by 30%

Sample Characteristics					
Informant Group	Organizations	Location	M	F	Total
IP	PSI MENTOR	Luanda Zaire Lunda Sul Lunda Norte Malanje Kwanza Norte Uige	9	2	11
GoA/MOH	MOH/GoA: National Provincial Municipal	Luanda Cuanza Norte Lunda Norte Lunda Sul Malanje Uige Zaire	21	4	25
International Donor and Partners	Global Fund Vector Work PSM E8	Luanda	1	3	4

1.1 Methodology & Sample Summary for Result 1 (Malaria): Primary data collection will be conducted at the national level (Luanda) as well as two target provinces and corresponding municipalities: Lunda Sul (Saurimo, Cacolo) and Zaire (Mbanza Congo). Under Result 1, information will be gleaned from three informant groups: Implementing Partners (IPs); Angola Government/MOH (GoA); International Donor and Partners. Within these three groups of stakeholders it is estimated that 40 people will be interviewed. Accordingly, the evaluation team will carry out the following data collection methods as linked to the following informant: SSIs for five group (IPs, MOH national, provincial, and municipal level of the two selected provinces and international partners) and email-surveys or telephone interviews will be conducted with GoA/DPS and partners in Lunda Norte, Uige, Malanje and Cuanza Norte.

Result 2: Malaria services throughout targeted municipalities improved

Sample Characteristics					
Informant Group	Organizations	Location	M	F	Total
IP	PSI MENTOR	Luanda Zaire Lunda Sul Lunda Norte Malanje Kwanza Norte Uige	10	1	11
GoA/MOH GoA/FAS	National Level: FAS NMCP MOH Provincial Level/DPS MOH at Municipal level/DMS Health Facilities Municipal Administration (FAS)	Luanda Zaire Lunda Sul Lunda Norte Malanje Kwanza Norte Uige	23	3	26
Beneficiary Health Service Providers	Saurimo: Provincial Hospital and Centro de Saúde Materno Infantil Cacolo: Hospital Municipal do Cacolo Posto de Saúde de Muachinongue ADECOs (Community)	Lunda Sul: Saurimo, Cacolo	9	6	15
	Mbanza Congo: Centro Materno Infantil 11 de Novembro Hosp. Provincial ADECOs (Community)	Zaire: Mbanza Congo Tomboco	13	8	21
International Donor and Partners	World Vision E8 WHO	Luanda	1	2	3

1.2 Methodology & Sample Summary for Result 2 (Malaria): Primary data collection will be conducted at the national level (Luanda) as well as two target provinces and corresponding municipalities: Lunda Sul (Saurimo, Cacolo) and Zaire (Mbanza Congo and Tomboco). Under Result 2, information will be gleaned from four informant groups: implementing partners (IPs); Angola Government (FAS and MOH); Beneficiary health service providers; and international donor and partners. Within these four groups of stakeholders it is estimated that 76 people will be interviewed. Accordingly, the evaluation team will carry out the following data collection methods as linked to each informant group: SSIs for 3 groups (IP, international partners, FAS and MOH/national, provincial, and municipal level); FGDs for 2 groups (health facility and ADECOs). Documents Review (Register,

Reports, etc.) at the 6 selected HFs and community level (iCCM), email-surveys or telephone interviews will be conducted with GoA/DPS and partners in Lunda Norte, Uige, Malanje and Cuanza Norte.

Result 5: Capacity of national, municipal and provincial governments to plan, fund and supervise health programs

Sample Characteristics					
Informant Group	Organizations	Location	M	F	Total
IP	PSI	Luanda Lunda Sul Lunda Norte Cuanza Norte Malanje Uige Zaire	7		7
GoA/MOH	MOH: National level (NMCP, GIT) DPS DMS	Luanda Lunda Sul Zaire Lunda Norte Cuanza Norte Malanje Uige	14	5	19
Donor and Malaria Partners	Global Fund	Luanda		1	1

I.3 Methodology & Sample Summary for Result 5 (Malaria): Primary data collection will be conducted at the national level (Luanda) as well as two target provinces and corresponding municipalities: Lunda Sul (Saurimo, Cacolo) and Zaire (Mbanza Congo). Under Result 5, information will be gleaned from five informant groups: implementing partners (IPs); Angola government (GoA)/MOH national, provincial, and municipal level; international donor and partners. Within these five groups of stakeholders it is estimated that 27 people will be interviewed. Accordingly, the evaluation team will carry out the following data collection methods as linked to the following informant: SSIs (IP, international partners, MOH/national, provincial and municipal level) and email-surveys or telephone interviews will be conducted with GoA/DPS and partners in Lunda Norte, Uige, Malanje, and Cuanza Norte.

Result 3: Sustainable models for providing high-quality HIV/AIDS services, through the prevention and care & treatment continuum, demonstrated and institutionalized by the Government of the Republic of Angola (GRA) and civil society organizations.

Sample Characteristics		
Informant Group	Organizations	Location
IP	PSI MSH Red Mulher	Luanda Huambo
GoA Partners (national, provincial, municipal)	INLS BFA MAT/FAS	
Beneficiary Health Service Providers	Esperanca Hospital	Luanda, Luanda Rangel
	Rangel Health Center	Luanda, Luanda Rangel
	Kilamba Kiaxi Maternal Hospital	Luanda, Kilamba Kiaxi
	Divina Providencia Hospital	Luanda, Kilamba Kiaxi
	Ana Paula Health Center	Luanda, Viana
	Dispensario TB Hospital	Luanda-Ingombota
	Bernardino Pediatric Hospital.	Luanda-Ingombota
International Donor and Partners	USAID Chemonics/PSM UNITEL	Luanda

I.3 Methodology & Sample Summary for Result 3 (HIV): Primary data collection will be conducted in Luanda, in the municipalities of Luanda, Kilamba Kiaxi, and Viana. In addition to staff associated with the seven facilities listed above, we will collect data from the following institutions: HFA implementing consortium partners, Ministry of Health, National AIDS Control Institute, Provincial Health Office of Luanda, Municipal Health Directorate, private sector partners and supply chain partner PSM. Data will be collected through group and individual semi-structured interviews.

Result 4: Strengthened, expanded and integrated FP/RH services at provincial and municipal levels.

Sample Characteristics			
Informant Group	Organizations	Location	Total
IP	PSI Red Mulher Angola	Luanda	4
GoA Partners (national, provincial, municipal)	MINFAMU MINSAs: CECOMA (?) DNSP/RH DNSP/Dept of Health Promotion DPS RMS		9-14
Beneficiary Health Service Providers	Maternidade Lucrecia Paim Hospital de Cajueiro Centro de Saude II de Novembro Centro de Saude de Catinton Hospital Mineira Centro Materno Infantil de Caala	Luanda Luanda, Cazenga Luanda Cazenga Luanda Huambo Huambo, Caala	~30
International Donor and Partners	UNFPA, UNICEF, WHO, EU, WB, private sector (Sagrada Esperanca and Multiperfil) and civil society partners PSM UNITEL Women's Health Project		4

1.4 Methodology & Sample Summary for Result 4 (FP): Primary data collection will be conducted in Luanda, and Huambo. In addition to staff associated with the seven facilities listed above, we will collect data from the following institutions: HFA implementing consortium partners, MOH's Reproductive Health Department, Health Promotion Department, Luanda and Huambo Provincial Health Offices, international organizations (UNFPA), private sector (Sagrada Esperanca and Multiperfil), civil society partners, PSM, UNITEL, Women's Health Project. Data will be collected through group and individual semi-structured interviews.

Evaluation Question 2. In each technical sector, what are the strengths and challenges to the program inputs, implementation of activities and processes, and the quality and sustainability of outputs?

The sample population and corresponding data collection methodology for evaluation question 2 will be organized via the activity's three major themes (Malaria, HIV or Family Planning) as they link to HFA's five key results. As requested by USAID will be assessed the following tools/processes:

1. Malaria: ITNs Mass distribution toolkits, Unified SBCC strategy Malaria, Supervision tool (National, Provincial, and Municipal) and Health Unit Assessment.
2. HIV
3. FP

The assessment of selected tool/process will be focused on: purpose, status, HFA implementation fidelity, strengths and weaknesses.

- I. Malaria tools:
 - a. ITNs Mass distribution toolkits
 - b. Unified SBCC strategy Malaria
 - c. Supervision tool (National, Provincial, and Municipal)
 - d. Health Unit Assessment

I.1 Background

Building on lessons learned and the evaluation results of past LLINs campaigns, PSI planned to work with NMCP to review the implementation approach as well as SBCC strategy and tools for the LLINs mass campaign of Y2. The tools campaign to assure an efficient plan, distribution and monitoring (campaign and post-campaign) of ITN's mass distribution have been developed by Tropical Health and currently under USAID evaluation/approval.

Since a universal campaign calls for a strong social mobilization and communication effort, PSI LLIN team and NMCP key staff planned to work together with the MOH Communication Committee to review the SBCC strategy and update communication tools and materials in order to reinforce behavior change at the community level. The final drafts of Unified SBCC strategy /Malaria have been drawn up and currently under USAID evaluation/approval.

PSI in collaboration with NMCP developed three tools for supervision (Municipal, Provincial and National) disaggregating the NMCP tool being used, since this tool was considered too long and unwieldy. The new three tools allow to collect relevant information concerning HU general information, data recording/collecting and flow, as well as service delivery and staff work performance.

The new tools have been approved by NMCP and currently used in the targeted HFA provinces.

PSI developed the Health Unit Assessment tool to identify needs for malaria training, supervision and services delivery in the selected 6 HFA provinces. The Tool is finalized and has been used by PSI and DPS/DMS for the assessment carried out in 2017 (from October to December).

Process & Sample Characteristics		
Tool or Process to be Assessed	Considerations or Key Questions	Best Practice, Standards or Model to be Measured Against
1. ITN Mass Distribution Campaign Toolkit	<ul style="list-style-type: none"> • Has HFA utilized its technical approach (co-diagnosis, co-design, co-implementation) for developing ITN Mass Distribution Campaign Toolkit? • How the developed toolkit assured efficiently plan, distribution and monitoring of ITN's mass distribution? 	<ul style="list-style-type: none"> • RBM "Action and Investment to defeat Malaria (AIM) 2016-2030": • WHO: Global Technical Strategy for Malaria "2016-2030." • Revised recommendations for achieving universal coverage with long-lasting insecticidal nets in malaria control, WHO (19 October 2017).
2. Unified SBCC strategy	<ul style="list-style-type: none"> • Has HFA utilized its technical approach (co-diagnosis, co-design, co-implementation) in developing Unified SBCC strategy? • Is this proposed strategy the best SBCC for achieving and maintaining LLIN's UC? • Is this proposed strategy the best SBCC to promote and guarantee the proper use of LLIN's? 	<ul style="list-style-type: none"> • Integrated SBCC Programs I-Kit (USAID) • MOH/DNSP: Plano estratégico de comunicação para mudança social e de comportamento (CMC) sobre a malária, 2017-20
3. Malaria Supervision tool (National, Provincial, and Municipal):	<ul style="list-style-type: none"> • Has HFA utilized its technical approach (co-diagnosis, co-design, co-implementation) in improving supervision tools? • Purpose of tool • What has been the supervision results/constraints in using the HFA revised tools? 	<ul style="list-style-type: none"> • Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria, WHO, UNAIDS, The Global Fund to Fight AIDS, Tuberculosis & Malaria, USAID, US Department of State, OGAC, CDC, UNICEF, MEASURE Evaluation and the World Bank (Second Edition 2006). • Plano Estratégico Nacional de Controlo da Malária em Angola Ano 2016-2020/MINSA. • Monitoring and Evaluation of Malaria Programs MS-16-110 –MEASURE (2016)
4. Health Unit Assessment tool	<ul style="list-style-type: none"> • Purpose of tool • Has HFA utilized its technical approach (co-diagnosis, co-design, co-implementation) in developing the HFA Health Units Assessment tools? • What has been the assessment results utilizing the HFA developed tools? 	<ul style="list-style-type: none"> • WHO (Regional Africa Office-2003): Tools for Assessing the Operationality of District Health Systems • MOH/GEPE – Health mapping tools • Profiles of Health Facility Assessment Methods/MEASURE.

1.2 Methodology & Sample Summary for Malaria Tools Review: The evaluation team will develop a check list to make the technical review of tool/process in order to define:

- Design Phase/Criteria:
 1. Standard International/National
 2. Best Practice
 3. Relevance

- Implementation phase:
 1. Usefulness
 2. Constrains
- Results/Effects

Data collection will be conducted at the national level (Luanda) as well as at two target provinces and corresponding municipalities: Lunda Sul (Saurimo, Cacolo) and Zaire (Mbanza Congo). The information will be gleaned from three informant groups: implementing partners (IPs); Angola government (GoA)/MOH; international donor and partners.

Accordingly, the evaluation team will carry out the following data collection methods as linked to the following informant: SSIs (IP, International partners, MOH/national, provincial and municipal level) and email-surveys or telephone interviews will be conducted with GoA/DPS and partners in Lunda Norte, Uige, Malanje and Cuanza Norte. Additionally, the evaluation team will be carried out an assessment of filled tools in the two selected provinces.

HFA HIV (Result 3)

Process & Sample Characteristics			
Tool or Process to be Assessed	Considerations or Key Questions	Best Practice, Standards or Model to be Measured Against	Key Informants
1. Index Case Testing and Tracing	<ul style="list-style-type: none"> – Describe the process of designing, testing, implementation, and uptake of the index case approach that HFA supports. – How is the level of success of the index case program? – What are the strengths and challenges to this approach (inputs, implementation, quality, sustainability)? – What is your plan for addressing the challenges? – How sustainable is this approach (financial, technical inputs)? 	Mozambique index case program	USAID PSM Linkages HFA (PSI/MSH) INLS GPS DMS Facility level leadership and HIV Providers Patient Assistant Facilitators
2. Approach to Linkage HIV+ to Treatment	<ul style="list-style-type: none"> – Describe the process of designing, testing, and implementing the HIV+ linkage to care that HFA supports. – How is the level of success of linkage to ART? – What are the strengths and challenges to this approach (inputs, implementation, quality, sustainability)? – What is your plan for addressing the challenges? – How sustainable is this approach (financial, technical inputs)? 	Literature search, including grey literature Experiences from other Sub-Saharan countries	Community Counselors Linkages Leadership Facility Staff Patient Assistant Facilitators, Community Counselors Patient Assistant Facilitators,
3. Approach to Retain People on Treatment + Recovery of Lost to Follow-Up	<ul style="list-style-type: none"> – Describe the process of designing, testing, implementation, and results of the ART retention approach that HFA supports. – How is the level of success of the ART retention approach? – What are the strengths and challenges to this approach (inputs, implementation, quality, sustainability)? – What is your plan for addressing the challenges? – How sustainable is this approach (financial, technical inputs)? 	Literature search, including grey literature Experiences from other Sub-Saharan countries	Community Counselors Facilitators,

2.2 Methodology & Sample Summary for HIV Tools Review: Primary data collection will be conducted in Luanda. In addition to staff associated with the seven facilities listed above, we will collect data from the following institutions: HFA implementing consortium partners, INLS, MAT/FAS, Luanda Provincial and Municipal Health Offices, international organizations (UNFPA), private sector (Banco de Fomento Angolano, UNITEL), civil society partners, PSM, Women’s Health Project. Other possible: Sagrada Esperanca and Multiperfil. Data will be collected through observation and semi-structured interviews (group and individual).

HFA FP (Result 4)

Process & Sample Characteristics			
Tool or Process to be Assessed	Considerations or Key Questions	Best Practice, Standards or Model to be Measured Against	Key Informants
HNQIS Supervision Tool	<p>Please describe the process of designing, testing, and implementing the supervision approach that HFA supports.</p> <p>How is the level of success of the supervision approach?</p> <p>What are the strengths and challenges to this approach (inputs, implementation, quality, sustainability)?</p> <p>What is your plan for addressing the challenges?</p> <p>How sustainable is this approach (financial, technical inputs)?</p>	WHO/USAID/JH Family Planning: A GLOBAL HANDBOOK FOR PROVIDERS	USAID PSI HQ and Huambo RMA MOH/Health Promotion MOH/RH DPS RMS UNFPA Health facility RH focal point Quality assurance officers
HFA approach on FP counseling to ensure that USG compliance FP/HIV requirements (i.e., voluntarism and informed choice) are taken into consideration	<p>Please describe the process of designing, testing, and implementing the FP counseling approach that HFA supports.</p> <p>How is the level of success of the FP counseling approach?</p> <p>What are the strengths and challenges to this approach (inputs, implementation, quality, sustainability)?</p> <p>What is your plan for addressing the challenges?</p> <p>How sustainable is this approach (financial, technical inputs)?</p>	Tiaht Requirements for Voluntary Family Planning Projects ⁴⁹	USAID MOH/Dept. Health Promotion MOH/RH DPS RMS Health Facility RF Focal Points Health Providers Ativistas

2.1 Methodology & Sample Summary for FP Tools Review: Primary data collection will be conducted in Luanda and Huambo. In addition to staff associated with the six facilities listed above, we will collect data from the following institutions: HFA implementing consortium partners, MOH/RH, MOH/Health Promotion, MAT/FAS, Luanda Provincial and Municipal Health Office, Ministry of Social Action, Family and Promotion of Women, international organizations (UNFPA), PSM and UNITEL. Data will be collected through observation and semi-structured interviews (group and individual).

⁴⁹ <https://www.usaid.gov/sites/default/files/documents/1864/tiahtqa.pdf>

3. What systems are in place to identify and remedy challenges on program management and structure (i.e., planning, human resources, financial, operations, and communications)?

For this question, responses will be organized by each IP organization (PSI, MSH, RMA, and MENTOR). Under each, findings will present: (1) a summary description of roles, responsibilities and geographic coverage of HFA; (2) major strengths and weaknesses in management and structure; and (3) developed action plans to strengthen the organization to best implement HFA. The sample population and corresponding data collection methods for evaluation question 3 is:

Sample Characteristics			
Informant Group	Organizations	Location	Total
IPs	PSI, MSH, MENTOR, RMA	Luanda	30
GoA Partners (national, provincial, municipal)	INLS NMCP Family Planning GEP/GTI FAS & IFAL	Luanda	10
International Donor and Partners	USAID *Global Fund *WHO * PSM *Linkages	Luanda	10

* Time permitting

3.1 Methodology & Sample Summary for Q3 (Systems & Structure): Primary data collection will occur in Luanda and center upon the HFA consortium partners (IPs), USAID and GoA partners. The total sample size is estimated at 50 informants. As recommended by the SOW and by key USAID personnel, secondary review will consider the HFA communication plan, quarterly reports, annual work plans, capacity building plans, HFA documents of systems, structures, financial records and partnerships. Primary data collection methods will primarily consist of, semi-structured interviews (SSIs) and organizational capacity assessment (OCA) workshops. SSIs will be conducted first to identify workshop participants, set performance targets and best tailor each OCA workshop. As well, an organizational capacity champion will be identified for each consortium member to guide, collaborate and make decisions across the evaluation. The champions will be oriented before roll-out of OCA workshops and participate in a Culminating Workshop, where they are to present finalized action plans. The Q3 team will conduct the SSI and OCA workshops across the four weeks (19 available business working days) available via fieldwork that will roll out under the following choreography:

Q3 Rollout

Week #	Key Informant	Approach	Choreography
Week 1 (Oct 15-19)	USAID GoA IP	1. SSIs for tailoring of OCA	Monday, 10/15/18: TBD w/ USAID Tuesday, 10/16/18 - PSI: 9 -12pm - RMA 1- 4pm Wednesday, 10/17/18: MSH 10-12pm Friday, 10/18/18: MENTOR 1-3pm GOA: TBD
		2. OCA Orientation Workshop for all IP Org. Strengthening Champions	Friday, 10/18/18 @ PSI, 10-1pm
Week 2 (Oct 22-26)	USAID GoA IP	1. Follow-up SSIs	Monday, 10/22/18: TBD w/ USAID and GoA Friday, 10/26/18: TBD w/ USAID and GoA
		2. OCA Workshop Delivery (2.5 – 3 days)	PSI OCA: 10/22-25/18, 9-3:30 pm @ PSI
Week 3 (Oct 29-Nov 2)	USAID GoA IP	1. Follow-up SSIs	Monday, 10/29/18: TBD w/ GoA and Int. Partners Friday, 11/2/18: TBD w/ GoA and International Partners
		2. OCA Workshop Delivery (2.5 – 3 days)	MSH OCA: 10/30 -11/1/18, 8-2pm (last day 8-12pm) @ MSH
Week 4 (Nov 5-9)	USAID GoA IP	1. OCA Workshop Delivery (2 days)	RMA OCA: 11/5-6/18, 9-5pm MENTOR OCA: 11/7-8/18, 9-5 pm
		2. OCA Culminating Workshop	Friday, 11/9/18: 9-1:30 @ PSI

Rapid DQA

Methodology for the Rapid DQA. The main focus of the DQA is to: (1) identify outstanding strengths and weaknesses of HFA data; and (2) determine to what extent the data can be trusted and is being used for management decisions. Given time and resource limitations, the team will emphasize secondary data collection and reviews of key HFA and GoA documents and country reports. Primary data collection will be integrated into research for each HFA area (i.e., malaria, HIV and FP) and utilize the DQA checklist that assesses data around five criteria: Validity, Integrity, Precision, Reliability and Timeliness. Each evaluation sub-team will use the checklist as an interview guide on specific and strategic M&E informants from IPs, GoA and health facility partners in Luanda, Huambo, Lunda Sul and Zaire.

Findings from the rapid DQA will be integrated into evaluation question I, under each result. Specific findings for USAID-selected indicators will discuss data issues, quality and use. The sample population and corresponding data collection methods and geographic coverage will be complementary to what occurs under question I. Currently, USAID/Angola has asked the team to review 18 of the total 44 indicators.

Given the requirements for this evaluation and the limited time, the team has asked for a reduction in the number of the indicators to be assessed. Thus, the team is strongly recommending the prioritization of the following 10 indicators:

Sample Characteristics

Result #	HFA PMP-Coded Indicator (s)	Key Secondary Sources	Location & Primary Source (Key Informant Group: IP, GOA, Health Providers USAID, Int. Partners)
1	A1.1 Number of insecticide-treated nets (ITNs) that were distributed in this reported fiscal year A1.2 Number of community HWs trained in counseling on ITN use	Cooperative Agreement, PMP (M&E Plan), Baseline Assessment, Annual Plan Y1 and Y2, Quarterly Reports, HFA database, information collection tools, provincial and municipal M&E information / reports / tools, municipal health report (annual),	IP: HFA M&E Coordinator GoA: NMCP M&E Officer, Municipal Malaria Focal Point, Malaria Provincial Supervisor Local LLIN Stakeholders: Soba, Activists Donor: USAID
2	A2.1 Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG Funds. A2.5 Number of health workers who received formative supervision in ACT use.		IP: HFA M&E Officer GoA: NMCP M&E Officer, Municipal Malaria Focal Point, HF representative
5	A5.4 Number of municipal authorities meeting quarterly to review HMIS/DHIS2 data and incorporate feedback in reports.		IP: HFA M&E Coordinator GoA: PNMC M&E Officer, Municipal DHIS2 Focal Point, GETE,
3	A3.1 Number of individuals who received HIV Testing Services (HTS) and received their test results (HTS_TST; including HTS_TST_POS). A3.3 Number of adults and children newly enrolled on antiretroviral therapy (TX_NEW).		IP: HFA M&E Coordinator, HIV Coordinator GoA: HIV national M&E Officer, Provincial HIV Focal Point, Provincial Supervisor Donor: USAID
4	A4.1 Percentage of USG-assisted service delivery points (SDPs) offering FP/RH counseling or services. A4.2. Percent of USG-assisted service delivery points that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide. A4.3 Couple years protection in USG supported programs.		IP: HFA M&E Coordinator GoA: National FP/RH M&E Officer, Municipal Point, FP/RH Provincial Supervisor Donor: USAID

After verifying the status of data collected for the below eight indicators with the FHA M&E lead, we have determined that very limited data exists. It is therefore recommended that the following eight indicators, originally part of the 18 identified by USAID, be removed from the DQA indicator list.

Result 2

- Number of CHW (ADECOs) supervised in malaria case management at community level

- Number of fever cases reported by CHW (ADECOS) at community level
- Number of fever cases tested with RDT by CHW (ADECOS) at community level
- Number of malaria cases confirmed reported by CHW (ADECOS) at community level
- Number of malaria confirmed cases treated with ACT reported by CHW (ADECOS)

Result 3

- Number and proportion of HIV+ linked to treatment (Not a MER indicator, please check attachment: HIV indicators.ppt)
- Number of ARV defaulters recovered (Not a MER indicator, please check attachment: HIV indicators.ppt)

Result 4

- Percentage of health facilities whose providers reported a Quality of Care score $\geq 80\%$ for management of FP services (+).

Of note, is that the team was purposeful in maintaining a balance of indicators distributed across the five HFA results, to be assessed the DQA.

EVALUATION MATRIX: GETTING TO ANSWERS

Using the foundation of the three evaluation questions, the following Getting to Answers Matrix clarifies methodological implications and options including envisioned data sources, data collection and analysis approaches, and sampling.

Key Evaluation Question	Type of Answer/ Evidence Needed		Methods for Data Collection		Sampling/Selection Approach (if needed)	Data Analysis Methods
			Data Source	Method		
1.1 To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program?		Yes/No	<ul style="list-style-type: none"> Initial approach: Workplan Year 1 & 2; M&E plan Current: quarterly and other reports, key informant interviews Efforts to mitigate barriers: quarterly and other reports, key informant interviews 	(1) Review of project documents and program data (2) Key informant interviews	Purposive sampling Convenience sampling for Result 1 (LLINs)	<ul style="list-style-type: none"> Pre- and post-baseline data and targets vs. achievements, progress to date and anticipated achievement of goals/milestones; descriptive statistics Qualitative analysis of key informant interviews
		Description				
	1.1	Comparison				
	1.2	Explanation				
2. In each technical sector, what are: (a) the strengths and challenges to the program inputs, implementation of activities and processes and (b) the quality and sustainability of outputs?	X	Yes/No	<ul style="list-style-type: none"> Selection of three or more products, activities, and tools across health elements (FP, malaria, and HIV). Malaria: Implementing Agencies Reports and Work Plans (Years 1 & 2) NMCP annual Reports GPS and DMS Monthly Reports HF's records and Reports MOH/DPS/RMA/facility Staff 	(1) Content technical review of quality of product, compared to national and international standards. (2) Direct observation of implementation of the tool or product under review and analysis of quality of use/application on the ground. (3) Key informant interview (4) FGD	Purposive sampling	<ul style="list-style-type: none"> Rating of tools using checklist against standards. (Checklist to be developed by Evaluation Team.) Rating of implementation of tool. (Rating instrument to be developed by Evaluation Team.)
		Description				
		Comparison				
		Explanation				
3. What systems are in		Yes/No	<ul style="list-style-type: none"> Leaders and key staff from 	(1) Semi Structured	Purposive; sample will	<ul style="list-style-type: none"> Comparative analysis of

Key Evaluation Question	Type of Answer/ Evidence Needed		Methods for Data Collection		Sampling/Selection Approach (if needed)	Data Analysis Methods
			Data Source	Method		
place to identify and remedy challenges on program management and structure (i.e., planning, human resources, financial, operations, and communications)?	x	Description	HFA Consortium, USAID, and GoA • Secondary information: (a) overview of roles and responsibilities; (b) Org chart; (c) Capacity Building Plan Red Mulher and others if available; (e) Partnership MOUs; (f) Quarterly and Annual Reports; (f) Annual Workplan; (g) Baseline data for Result 5; (h) Documents, protocols policies, systems from each consortium member.	Interviews (SSIs) (2) Organizational Capacity Assessment (OCA), using maturity model benchmarking (MMBA). (3) Culminating Workshop to share findings, develop action plans and prioritize solutions	consist of HFA consortium leaders; USAID/HQ & Angola; GoA staff at national, provincial and Municipal levels and key local partners.	MMBA data across organizations • Content analysis of synthesized SSIs and FGDs. • Synthesis of culminating workshop • Secondary analysis of HFA indicator data, reports and evaluations.
	x	Comparison				
	x	Explanation				

ANNEX III. DATA COLLECTION INSTRUMENTS

VERBAL CONSENT SCRIPT

Oral Consent Form

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

USAID/Angola has asked an evaluation team to collect information for its Health for All project Angola. This purpose of this study is to: (1) identify project gaps and opportunities that can be acted upon by project staff and USAID; (2) understand the effectiveness of the project in meeting intended results; and (3) identify areas that need to be modified/improved to increase the likelihood of HFA success in Angola.

You were recommended as a key person to inform our research effort and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time. Our interview will take 60 – 90 minutes.

Do I have your permission to begin?

Please know that anything you say during the interview will be kept confidential within the evaluation team, and that in our report we will not be attributing specific comments to any specific individual.

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

Evaluation Question I

Malaria

Result I: Access to and use of insecticide-treated nets (ITNs) increased by 30 percent

I. Telephone Interview & Email Survey

Provincial Implementers – PSI and MENTOR (Malanje, Cuanza Norte, Lunda Norte and Uige)

Note: PMOs, OPPM (GF) and DPS (Public Health Officer; PNMC Supervisor) will receive the below form via email

Introdução: Agradeço muito se o senhor (a) puder dispensar algum tempo para responder neste questionário.

A USAID/Angola solicitou a uma equipa de avaliação de recolher informação sobre o projeto Saúde para Todos em Angola. O objetivo desta avaliação é: (1) identificar as lacunas e oportunidades do projeto que podem ser trabalhadas pela equipa do projeto e pela USAID; (2) compreender a eficácia do projeto no cumprimento dos resultados estabelecidos; e (3) identificar as áreas que precisam de ser modificadas / melhoradas para aumentar a probabilidade de sucesso do projeto Saúde para Todos em Angola.

Você foi recomendado/selecionado como pessoa chave para nos fornecer informações sobre o projeto Saúde para Todos. Agradecemos conhecer, de acordo com a sua experiência/envolvimento no projeto, quais são as suas perspetivas, seus pontos de vista sobre o desempenho, desafios, barreiras e lições aprendidas. Quero garantir que todas as informações fornecidas neste questionário serão confidenciais.

Você também está livre de não participar. Se precisar de mais esclarecimentos sobre este questionário pode nos contactar (Ada Merolle: merollea@gmail.com ou Estevão Mango: e_mbambi@yahoo.com)

Only for PSI and MENTOR Staff

1. How has the HFA team involved the DPS staff on LLIN activities (i.e., plan, mass distribution, monitoring and training)?
2. How many LLIN's have been distributed in your province according to the established distribution plan?
3. Could you describe the strengths and weaknesses to implementing LLIN's mass distribution?
4. In your province, what measures have been taken in order to ensure an efficient and proper LLIN's distribution (target 1 LLIN x 2 person)?
5. How many activists have been trained (communication & registration and distribution) in your provinces according to the established plan?
6. Could you describe the strengths and weaknesses of training design and implementation?
7. Provide any recommendations for improvement of the LLINs mass distribution activities or training effort.

Only for DPS

1. Pode explicar qual foi o seu envolvimento e/ou papel nas actividades de distribuição massiva do MTILDs do projeto Saúde para todos?
2. Da sua opinião a população foi devidamente informada/sensibilizada sobre a distribuição massiva dos MTILD?
3. Quais são os resultados atingidos?
4. Descreva os principais problemas barreiras encontradas no planeamento, registo e na distribuição massiva dos MTILDs e como que a equipa do projeto Saúde para todos (HFA) está vos orientar e apoiar com estas actividades?
5. Em que medida o trabalho dos activistas/coordenador Provincial do projecto Saúde para todos (HFA) contribuiu na preparação e implementação da distribuição massiva dos MTILD?
6. Da sua experiencia quais recomendações que quer fornecer para melhorar a implementatação das actividades da distribuição massiva dos MTILDs do projeto de Saúde para todos (HFA).

2. Focus Group

DMS (Director, Malaria Supervisor, M&E Officer, Public Health Officer) and HF (In charge of HF and ILLN's staff/actors) in the four selected municipalities (Zaire and Lunda Sul)

Introdução: Agradeço muito a sua participação no **Grupo Focal de Discussão de hoje**.

O meu nome é (Ada Merolle ou Estevão Mango Mbambi) e faço parte da Equipa que está a avaliar o projeto Saúde para Todos denominado por HFA (sigla em Inglês) da USAID/Angola. A razão pela qual estamos a ter este GFD é para descobrir mais sobre o desempenho do projecto Saúde para Todos (HFA) no seu município. Em particular, estamos interessados em recolher informações sobre as atividades da malária, particularmente pela distribuição de MTILDs. Precisamos do seu parecer e queremos que partilha connosco o seu pensamento com honestidade. Todas as opiniões são importantes para nós, independentemente da sua diferença. O nosso propósito é ouvir todas as opiniões; não há resposta certa nem errada. Antes de começar, quero informar que qualquer informação ou exemplo que vou recolher durante o grupo focal de Discussão serão confidenciais, a menos que você me diga que gostaria de ter suas respostas citadas no relatório, ou atribuídas a si. Você também está livre de não participar ou interromper a entrevista em qualquer momento.

FGD Questions:

Key Question
Pode explicar qual foi o seu envolvimento e/ou papel nas actividades de distribuição massiva do MTILDs do projeto Saúde para todos?
Da sua opinião a população foi devidamente informada/sensibilizada sobre a distribuição e o lugar aonde receber o mosquitero?
Acha que a distribuição atingiu todas a população?
Descreva os principais problemas barreiras encontradas no planeamento, registo e na distribuição massiva dos MTILDs e como que a equipa do projeto Saúde para todos (HFA) está vos orientar e apoiar com estas atividades?
Podes descrever os pontos fortes e fracos da distribuição massiva do MTILDs?
Em que medida o trabalho dos activistas/coordenador Municipal contribui a implementar a distribuição massiva do MTILDa no município?
Da sua experiencia quais recomendações que quere fornecer para melhorar a implementatação das actividades da distribuição massiva dos MTILDs do projeto de Saúde para todos (HFA).

3. Semi-structured Interview Master Questions

Introduction Thank you for making the time to talk with me today.

USAID/Angola has asked an evaluation team to collect information for its Health for All project Angola. This purpose of this study is to: (1) identify project gaps and opportunities that can be acted upon by project staff and USAID; (2) understand the effectiveness of the project in meeting intended results; and (3) identify areas that need to be modified/improved to increase the likelihood of HFA success in Angola.

You were recommended as a key person to inform our research effort and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

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

Our interview will take 60 – 90 minutes.

Do I have your permission to begin?

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

[] Consent provided _____ [Interviewer/Recorder initials]

MOH Leaders and technical Staff (National): DNSP, NMCP,

1. Have you been actively involved in planning, monitoring and coordination of HFA's LLINs activities? From your experience how would you define your involvement, please explain?
2. How would you define the partnership and your engagement on HFA malaria activities, particularly LLIN's?
3. From your opinion/experience to what extent HFA shared positively your suggestion and advices concerning plan and implementation of LLIN's mass campaign activities?
4. To what extent has the HFA contributed in increasing the access and use of LLINs in Angola?
5. From your perspective, what have been the main issues or barriers to improving access to LLINs and how the HFA project has been addressing it?

MOH Leaders and Technical Staff (Provincial in two selected provinces): DPS, NMCP

1. Pode explicar qual foi o seu envolvimento e/ou papel nas actividades de distribuição massiva do MTILDs do projeto Saúde para todos?
2. Quais são os resultados atingidos?
3. Descreva os principais problemas barreiras encontradas no planeamento, registo e na distribuição massiva dos MTILDs e como que a equipa do projeto Saúde para todos (HFA) está vos orientar e apoiar com estas actividades?
4. Em que medida o trabalho dos activistas/coordenador Provincial do projecto Saúde para todos (HFA) contribuiu a implementar a distribuição massiva dos MTILD?
5. Da sua experiencia quais recomendações que quere fornecer para melhorar a implementataçãõ das actividades da distribuição massiva dos MTILDs do projeto de Saúde para todos (HFA).

IP (PSI and MENTOR)

1. How have you been in applying your key technical approach (co-diagnosis-co-plan and co-implementation) with: (1) consortium partners; (2) GoA; and (3) LLIN distribution stakeholders? Explain.
2. To what extent has the HFA contributed in increasing the access and use of LLINs in Angola/Province?
3. Could you describe the main constrains for implementing the activities according to the proposed Y2 work plan?
4. How rapidly has HFA been able to adapt and change to constraints and barriers concerning the mass LLINs distribution? What measures have been taken accordingly?
5. How responsive has the Angolan government been to supporting HFA on LLINs mass distribution?
6. What actions/strategy for the future do you recommend to USAID, GoA, and the HFA consortium to improve the effectiveness of LLINs mass distribution in Angola?

International Partners (Global Fund, WHO, PSM , E8)

1. From your perspective, what was the role of HFA in the LLIN mass distribution and how has HFA been in carrying out LLINs mass distribution?
2. Could you describe the main constrains for implementing LLINs mass distribution in Angola
3. How have you been involved with LLIN mass distribution (your role)? Has it been sufficient/effective? Explain?
4. What specific recommendations would you provide to HFA?

QI-Result 2: Malaria services throughout targeted municipalities improved

1. Telephone Interview & Email Survey

Provincial Implementers – PSI, MENTOR, World Vision (Malanje, Cuanza Norte, Lunda Norte and Uige)

Note: PMOs, OPPMs and MTOs (Malaria Training Officer) and DPS will receive the below form via email

Only MENTOR and PSI

1. How has the HFA team involved the DPS staff on malaria service activities (trainings, supportive supervision and iCCM)?
2. Could you describe the main constrain to designing and delivering training activities (malaria training, iCCM training and supportive supervision)?
3. In your province, what measures have been taken to ensure that HFA training activities achieve the HFA year 2, target?
4. How responsive has the DPS been to supporting HFA training activities?
5. Has HFA training methodology and content been appropriate to improve malaria skills and knowledge of HWs?

6. What are your recommendations to improve or strengthen HFA training activities?

Only DPS

1. De acordo com a sua experiencia, voce foi activamente envolvido na planificação, implementação e monitoria das actividades de formação do projecto saúde para todos (HFA)?
 - a) Não
 - b) Sim, explicar qual foi o seu papel nas diferentes fase (levantamento do pessoal e US, selecção do pessoal, planificação e organização das formações, supervisão)?
2. Em que medida o projecto Saúde para todos (HFA) contribuiu a melhoria da prestação de serviços da malária na sua Província?
3. Da sua opinião a melhoria da prestação de serviços da malária na sua Província/Municípios alvo abrange quais destas três componentes (Diagnostico, Tratamento, e TIP) e em quais tipo de US?
4. Voce tens conhecimento de quais técnicos de saúde (Prestadores, CPN, Diagnostico) e quais categorias (Médicos, Enfermeiros, Parteiras, Técnico de Laboratório) na sua Província/Municípios alvo foram treinados no serviço (supervisão formativa) e quantos na sessões de formação?
5. Descreva os principais problemas/e barreiras para planificar e implementar as formações/supervisões e como a equipa do projeto HFA está vos orientar e apoiar.
6. Pode nos explicar como está a ser implementado o iCCM (ADECOS) e os progressos na sua Província/Municípios alvo?
7. Do seu ponto de vista, quais foram os principais problemas ou barreiras para implementar as actividades de formação (Treinamento, Supervisão e iCCM) e como é que o projeto HFA tem resolvido estas?
8. Podes dar alguma recomendação/ções ao projecto (HFA) para melhorar as actividades de formação a fim de garantir a melhoria da dos serviços de malária nas US e comunidade?

2. Focus Group

HFA DMS & Health Facilities in the four selected municipalities

Introduction: Hello, and welcome to today's discussion. My name is (Ada Merolle or Mango Bambi) and I am part of the team that is evaluating USAID/Angola's HFA project. The reason we are having this FGD is to find out more about the HFA performance in your municipality. In particular, we are interested in learning about malaria activities, especially regarding training and service delivery. We need your input and want you to share your honest thoughts. All opinions are important to us regardless of their difference. Our purpose is to hear all opinions; there is no right or wrong answer. Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time. Each person please quickly state your full name, place of residence.

FGD Questions:

Key Question
Em que medida o projecto Saúde para todos (HFA) está a contribuir a melhoria da prestação de serviços da malária na sua US?
Da sua opinião a melhoria da prestação de serviços da malária na sua US abrange quais destas três componentes (Diagnostico, Tratamento, e TIP)?
Pode nos explicar como está a ser implementado o iCCM (ADECOS) na sua area?
Nesta US quais técnicos de saúde (Prestadores, CPN, Diagnostico) e quais categorias (Médicos, Enfermeiros, Parteiras, Técnico de Laboratório) da sua US foram treinados no serviço (supervisão formativa) e quantos na sessões de formação?
Podes descrever os pontos fortes e fracos das formações realizadas projeto HFA (iCCM, Treinamento e supervisão)?
Podes dar alguma recomendação/ções ao projecto (HFA) para melhorar as actividades de formação a fim de garantir a melhoria da dos serviços de malária nas US e comunidade?

3. Semi-structured Interview Master Questions

MOH Leaders and Technical Staff (National): DNSP. NMCP

1. Have you been actively involved in planning, monitoring and coordination of HFA's training activities ? From your experience how would you define your involvement, please explain?
2. How would you define the partnership and your engagement on HFA malaria activities, particularly for training design and implementation?
3. From your opinion/experience to what extent HFA shared positively your suggestion and advices concerning training activities (Health Staff and ADECOS)?
4. To what extent has the HFA contributed in strengthening health workers skills and knowledge of Malaria diagnosis and treatment?
5. From your perspective, what have been the main issues or barriers to implement training activities and how has the HFA project has been resolving it?
6. To what extent has the HFA contributed in implementing and monitor ADECOS project in Angola ?
7. What actions/strategy for the future do you recommend to HFA to assure equitable access to quality malaria services at HF and community level in Angola?

MOH Leaders and Technical Staff in two selected provinces

1. De acordo com a sua experiencia, voce foi activamente envolvido na planificação, implementação e monitoria das actividades de formação do projecto saúde para todos (HFA)?
 - a) Não
 - b) Sim, explicar qual foi o seu papel nas diferentes fase (levantamento do pessoal e US, selecção do pessoal, planificação e organização das formações, supervisão)?
2. Em que medida o projecto Saúde para todos (HFA) contribuiu a melhoria da prestação de serviços da malária na sua Província/Município?

3. Da sua opinião a melhoria da prestação de serviços da malária na sua Província/Município abrange quais destas três componentes (Diagnostico, Tratamento, e TIP) e em quais tipo de US?
4. Voce tens conhecimento de quais técnicos de saúde (Prestadores, CPN, Diagnostico) e quais categorias (Médicos, Enfermeiros, Parteiras, Técnico de Laboratório) na sua Província/Município foram treinados no serviço (supervisão formativa) e quantos na sessões de formação? Descreva os principais problemas/e barreiras para planificar e implementar as formações/supervisões e como a equipa do projeto HFA está vos orientar e apoiar.
5. Pode nos explicar como está a ser implementado o iCCM (ADECOS) e os progressos na sua Província/Município?
6. Do seu ponto de vista, quais foram os principais problemas ou barreiras para implementar as atividades de formação (Treinamento, Supervisão e iCCM) e como é que o projeto HFA tem resolvido estas?
7. Podes dar alguma recomendação/ções ao projecto (HFA) para melhorar as actividades de formação a fim de garantir a melhoria da dos serviços de malária nas US e comunidade?

IP (PSI, MENTOR and WV)

1. How successful have you been in applying your key technical approach (co-diagnosis-co-plan and co-implementation) with: (1) consortium partners; (2) GoA; and (3) stakeholders for improving malaria services and ICCM? Explain.
2. To what extent has the HFA contributed in increasing Health Workers skills and knowledge on Malaria diagnosis and treatment in the HFA targeted Province?
3. To what extent has the HFA supported the development of national iCCM implementation?
4. Could you describe the main constrains for implementing training activities (Supportive supervision a formal and iCCM training) proposed on Y2 work plan?
5. How responsive has the Angolan government been to supporting HFA malaria training activities ?
6. What actions/strategy for the future do you recommend to USAID, GoA, and the HFA consortium to improve training activities in order to assure quality of service at HF and community level?

International and GoA Partners

1. From your perspective, how successful has HFA been in implementing iCCM ?
2. According to your experience, could you describe the main constrains for implementing iCCM in Angola ?
3. How have you been involved in set up iCCM national strategy (your role)? Has it been sufficient/effective? Explain?
4. What are your recommendations to expand iCCM in Angola?
5. What specific recommendations would you provide to HFA?

QI-Result 5: Capacity of Municipal and Provincial Governments to Plan, Fund, Monitor, and Supervise Health Programs Improved.

1. Interview & Email Survey

Provincial Implementers – PSI and MENTOR (Malanje, Cuanza Norte, Lunda Norte and Uige)

Note: PMOs, OPPMs, DPS (M&E Officer, PNMC Supervisor) will receive the below form via email. The same form will be utilized in Lunda Sul and Zaire provinces.

Only DPS

1. Voce foi envolvido activamente nas atividades do DHIS2 (planificação, formação e monitoria)? Da sua experiencia, como podes definir o seu envolvimento, por favor explicar?
2. Em que medida o projeto Saúde para Todos (HFA) contribuiu na implementação do DHIS2 na sua província/Município?
3. Como que a equipa de M&A consegue manusear a DHIS2 ao nível municipal/provincial e quais são os actuais progressos?
4. Da sua perspectiva, quais foram os principais constrangimentos e barreiras para implementar o DHIS2 e como que a equipa do projeto Saúde para Todos (HFA) tem resolvido estes?
5. Que ações/estratégia para o futuro recomenda à ao projeto Saúde para Todos (HFA) para garantir o uso oportuno e pertinente da DHIS2 na sua Província/Município?

Only MENTOR and PSI

1. According to the technical approach (co-diagnosis-co-plan and co-implementation), how has the HFA team involved the DPS and DMS staff on DHIS2 activities?
2. Could you describe the main constrain to implementing DHIS2 component(data analysis and interpretation) at the provincial and municipal level(data entry, data registration and analysis)?
3. What measures have been taken to ensure a proper implementation of DHIS2 activities in your province?
4. How many municipalities are using DHIS2 for managing malaria data?
5. What is the current result concerning the malaria quarterly reports submitted (on time) in DHIS2 at (PNCM) national level ?
6. How responsive have the DPS and Local GoA been to supporting HFA training activities ?
7. What are your recommendations to improve or strengthen DHIS2 roll out in the province for managing and monitoring malaria data?

2. Semi-Structured Interview Master Questions

MOH Leaders and technical Staff (National GEPE,GTI and NMCP):

1. Have you been actively involved in planning, monitoring and coordinating DHS2 activities? From your experience how would you define your involvement, please explain?

2. How would you define the partnership and your engagement on HFA DHS2 activities?
3. To what extent has the HFA contributed in DHIS2 implementation in Angola?
4. How the trained M&E staff is managing DHIS2 ?
5. From your perspective, what have been the main issues or barriers to implement DHIS2 and how the HFA project has been addressing it?
6. What actions/strategy for the future do you recommend to HFA to roll out the DHIS2 for monitoring health routine data in Angola?

IP (PSI and MENTOR)

1. How have you been applied your key technical approach (co-diagnosis-co-plan and co-implementation) with: (1) consortium partners; (2) GoA; and (3) DHS2 stakeholders? Explain.
2. To what extent has the HFA contributed to rollout DHIS2 in Angola/Province?
3. Could you describe the main constrains for implementing DHIS2 activities according to the proposed Y2 work plan?
4. How rapidly has HFA been able to adapt and change to constraints and barriers in implementing DHS2 activities? What measures have been taken accordingly?
5. How responsive has the Angolan government been to supporting DHIS2 implementation?
6. What actions/strategy for the future do you recommend to USAID, GoA, and the HFA consortium to set up the DHIS2 for monitoring health routine data in Angola?

International Partners (Global Fund)

1. From your perspective, how HFA contributed in carrying out the DHIS2 activities in Angola?
2. Could you describe the main constrains for DHIS2 implementation in Angola ?
3. How have you been involved with DHIS2 activities (your role)? Has it been sufficient/effective? Explain?
4. What are your recommendations to support DHIS2 implementation?
5. What specific recommendations would you provide to HFA?

Evaluation Question I

HIV/AIDS

Technical and Service Delivery Approach and Implementation Plan Accomplishment	HIV/AIDS
MINSa/INLS - DPS/GPS - RMS/DMS – Hospital/Health Facility	Date: / /

EQ1.1 and EQ1.2: To what extent has the project adhered to the initial TECHNICAL AND SERVICE DELIVERY approach included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

HFA has described its technical approach for working with GoA at the national, provincial and health facility levels as “co-diagnosis, co-design, and co-implementation.” This approach is to work together with GoA leaders and technical staff to identify weaknesses in the HIV/AIDS service delivery system, identify a strategy and activities to address the gaps, and support implementation of these activities.

GPS/DMS/HF only

a) On a scale from 1-5, to what extent would you agree that, in the last 12 months, HFA’s has followed the technical approach of co-diagnosis, co-design and co-implementation?

(1) Strongly disagree (2) Disagree (3) Undecided (4) Agree (5) Strongly agree

b) How have they worked together with you? Write response

Co-diagnosis

Co-design

Co-implementation

c) How could they provide better support to INLS/GPS/DMS to support better quality and more sustainable HIV/AIDS services? Could you provide specific examples?

d) How have you most felt the impact of the support HFA has provided?

e) How could they improve, with respect to how they work together with you?

f) What recommendations do you have

EQ1.3 To what extent has the project adhered to the YEAR 2 WORKPLAN outputs and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

For verifying progress made on workplan, first interview HFA staff to determine if activity took place as planned. If activity took place, document who and what level of care was involved, and then verify activity with appropriate level of care.

Main Activities Planned for FY2:	Q	Q	Q	Q	HFA: activi accomplish ?	HF: Who was involved?	Indicate level of care N P D H	Verify activity with appropriate staff from appropriate level of care
	1	2	3	4				
Process 1: Counseling and Testing								
Peer Navigation in the HC								
Index Case at the Community	--	--	--	--				
<i>Index case:</i> HFA will expand index case interventions to the other four health facilities, holding monthly meetings to review compiled data and measure progress against targets					Yes No			
How has SPT facilitated use of mobile clinics for ART initiation and ARV refills? How?					Yes No			
Provide technical assistance to ensure availability of proper stock at the testing points and consistent application of the testing algorithm to improve testing service quality.					Yes No			
<i>Do you track this indicator:</i> percentage of (contacts) of PLHIV in ART clinic (TARV and pre-TARV) has been tested					Yes No			Co-diagnosis at facility level?
<i>Do you track this indicator:</i> percentage of patients get tested (evaluate monthly) in inpatient medical wards (PITC)—					Yes No			Co-diagnosis at facility level?
<i>Do you track this indicator:</i> percentage of persons tested for HIV that are positive by facility entry points					Yes No			Co-diagnosis at facility level?
Process 2: Linking to Pre-ART and ART								
Access to first consultancy								

Main Activities Planned for FY2:	Q	Q	Q	Q	HFA: activi accomplish ?	HF: Who was involved?	Indicate level of care N P D H	Verify activity with appropriate staff from appropriate level of care
	1	2	3	4				
Support development and improvement of SOPs to allow daily stock counts, retraining of testing staff, improving inventory management by inviting warehouse and laboratory personnel to the routine facility meetings and monthly analysis of how each facility improved their stock management.					Yes No			
HFA will also work towards having testing and tests availability information on a weekly basis. PSM and HFA formed a Committee to coordinate by weekly supervisions all the Testing Points in each HF's to provide permanent information of the stock level					Yes No			
Ensure that all clients are offered to join a support group, especially if the provider notes concern about retention					Yes No			
For KPs, have weekly case management meetings to follow up on individual clients to ensure linkages and retention in services.					Yes No			
Process 3: Retention and Adherence to ART								
Access to subsequent consultancy					Yes No			
Mutual Support Groups (<i>Grupos de Apoio Mútuo</i> – GAM)					Yes No			
HFA will also establish and pilot a Group of Mutual Support (GAM) in one selected health unit for adults PLHIV on TARV					Yes No			
Ensure that all clients are offered to join a support group, especially if the provider notes concern about retention					Yes No			
For KPs, have weekly case management meetings to follow up on individual clients to ensure linkages and retention in services.					Yes No			
Process 4: Viral Load Suppression								
Reinforced adherence for users with VL above the limit established by protocol and norms								
HFA will take over viral load TA responsibility in three of those facilities and scale up services in another four.					Yes No			

Main Activities Planned for FY2:	Q	Q	Q	Q	HFA: activi accomplish ?	HF: Who was involved?	Indicate level of care N P D H	Verify activity with appropriate staff from appropriate level of care
	1	2	3	4				
The project team will (a) train providers in the health units on VL testing and counseling, (b) adjust location of the GeneXpert machines into the seven Health Facilities to maximize use on Virus Load during the FY2,					Yes No			
(c) consider provision of permanent reagents for GeneXpert machines.					Yes No			
Process 5: Integration of TB/HIV Services and Co-Infection								
Reinforced adherence for co-infected HIV / TB Patients					Yes No			
HFA will collaborate with DNSP, INSP, INLS and PNCTB in order to ensure availability of a laboratory capable of conducting tests of resistance to antibiotics (GeneXpert), as well maintenance of equipment					Yes No			
Ensure that all patients suspected of TB and malnutrition testing on HIV/TB.					Yes No			
Process 6: Improve the Health HIV/AIDS Quality Services								
HFA will implement quality improvement interventions in 3 health centers					Yes No			
HFA will support the development and implementation of supervision guidelines.					Yes No			
Process 8: Patients Reference and Response System								
HFA will will implement a patient's reference and response system pilot.					Yes No			

EQ1 To what extent has the project adhered to the initial technical approach, service delivery approach, implementation plan, outputs and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

The Health For All project, implemented by a consortium including Population Services International (PSI), Rede Mulher Angola (Local Partner), Tropical Health LLP, Management Sciences for Health (MSH), and The MENTOR initiative, is a project focused on the reduction of malaria, sustainable, high quality HIV services, and expansion of family planning (FP) services.

PARTNERS ONLY

a) How does the work you do intersect with technical assistance support to the GoA that Health for All performs?

b) How have you interacted with and/or collaborated with the Health for All team?

c) Do you have suggestions on how the work you collaborate on could be better coordinated?

d) What suggestions or recommendations do you have of how this work could move forward in preparation for transitioning HFA's assistance to GoA and local partners?

e) What do you believe are HFA's strengths and areas for improvement and missed opportunities in its role supporting the GoA to deliver high quality HIV or FP services?

Strengths

Areas for improvement

Missed opportunities

USAID only

f) What specific concerns do you have regarding HFA?

Evaluation Question I

Family Planning

Technical and Service Delivery Approach and Implementation Plan Accomplishment	Family Planning
MINSA/INLS - DPS/GPS - RMS/DMS – Hospital/Health Facility	Date: / /

EQ1.1 and EQ1.2: To what extent has the project adhered to the initial **TECHNICAL AND SERVICE DELIVERY** approach included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

HFA has described its technical approach for working with GoA at the national, provincial and health facility levels as “co-diagnosis, co-design, and co-implementation.” This approach is to work together with GoA leaders and technical staff to identify weaknesses in the HIV/AIDS service delivery system, identify a strategy and activities to address the gaps, and support implementation of these activities.

a) On a scale from 1-5, to what extent would you agree that, in the last 12 months, HFA’s has followed the technical approach of co-diagnosis, co-design and co-implementation?

(1) Strongly disagree (2) Disagree (3) Undecided (4) Agree (5) Strongly agree

b) Can you explain how you have worked with HFA to co-diagnose weaknesses in the continuum of HIV/AIDS care? What did you find?

c) How could they improve, with respect to how they work together with you?

d) How could they provide better support to INLS/GPS/DMS to support better quality and more sustainable HIV/AIDS services? Could you provide specific examples?

e) How have you most felt the impact of the support HFA has provided?

EQ1.3 To what extent has the project adhered to the YEAR 2 WORKPLAN outputs and beneficiary targets included in the initial technical narrative? What efforts have been made to mitigate barriers or constraints limiting program implementation?

For verifying progress made on workplan, interview HFA staff to determine if activity took place as planned. If activity took place, document who and what level of care was involved, and verify activity with appropriate level of care.

RH and FP Activity Schedule	Q1	Q2	Q3	Q4	HFA		Level of care N P D H	Verify activity with appropriate staff from appropriate level of care
					Was this activity done?	Who was involved?		
1. Reinforcing the enabling environment for RH/FP								
1.1. Print and disseminate the 4 RH/FP pending protocols					Yes	No		
1.2. Refresher training on FP/RH counseling of 65% of USG-assisted service delivery points					Yes	No		
1.3. Co-organize with the UNFPA and RH/FP Department a monthly the terms of reference of the technical working group.					Yes	No		
1.4. Support RH/FP department in the implementation of the DHIS2 HMIS system in Luanda and Huambo.					Yes	No		
2. Promotion of Family Planning 2020								
2.1. Advocacy for the Angolan Government to incorporate FP 2020 indicators in the current SRH/FP national plan.					Yes	No		
2.2. Train 120 family planning providers in Strategy for Integral Health Care of Adolescents and Young People and Youth Friendly Health Services in Luanda and Huambo.					Yes	No		
2.3. Advocacy to secure funding for the procurement of contraceptive methods.					Yes	No		
2.4. Implementation of BCC campaigns in maternities and schools to increase youth and adolescent access to SRH/FP services by 10%.					Yes	No		

2.5. Support two participants from MOH to participate in the International Reproductive Health Conference.			x		Yes	No		
3. Informed Demand Activities					Yes	No		
3.1. Broadcast the approved 10 RH/FP radio episodes in local radios in Huambo province.		x	x	x	Yes	No		
3.2. Broadcast approved 10 RH/FP radio episodes online on PSI/A's Facebook page "Entre Nos."	x	x	x	x	Yes	No		
3.3. Reach 10.000 people (both women and men/boys and girls) during SRH/FP Behavior Change Communication (BCC) activities.	x	x	x	x	Yes	No		
3.4. Conduct 4 education campaign about gender based violence.	x	x	x	x	Yes	No		
3.5. Train 20 family planning focal points on integration on the protocol for the clinical management of survivors of gender based violence.		x			Yes	No		
3.6. Include 20 male healthcare providers on family planning training to provide resources and RH counseling and services to other man.		x			Yes	No		

RH and FP Activity Schedule	Q1	Q2	Q3	Q4	HFA		Level of care N P D H	Verify activity with appropriate staff from appropriate level of care
					Was this activity done?	Who was involved?		
4. Supervision and Quality Assurance in Public Health Facilities								
4.1. Monitor the quality of FP services on 207 USG-assisted service delivery points to ensure no stock out of contraceptives.					Yes	No		
4.2. Train 40 DPS and FP focal points in using DHIS2 dashboards for decision making.					Yes	No		
4.3. Support the refresher of 80 Training of Trainers (ToT) in LARCs (Long Acting Reversible Contraception) and other contraceptives in Luanda and Huambo.					Yes	No		
4.4. Organize an evaluation workshop of Y2 activities with DNSP and partners.					Yes	No		
4.5. Participate on contraceptive security monthly meetings.					Yes	No		
4.6. Support the development of a multi-year Contraceptive Security plan.					Yes	No		
5. Private sector engagement					Yes	No		
5.1. Advocacy for the inclusion of private sector in the Contraceptive Security Meetings					Yes	No		
5.2. Engage with International RH products manufacturer to work in Angola market.					Yes	No		

RH and FP Activity Schedule	Q1	Q2	Q3	Q4	HFA		HFA	Level of care N P D H	Verify activity with appropriate staff from appropriate level of care
					Was this activity done?	Who was involved?			
6. Reinforcing the enabling environment for RH/FP					Yes	No			
6.1. Print and disseminate the 4 RH/FP pending protocols					Yes	No			
6.2. Refresher training on FP/RH counseling of 65% of USG-assisted service delivery points					Yes	No			
6.3. Co-organize with the UNFPA and RH/FP Department a monthly the terms of reference of the technical working group.					Yes	No			
6.4. Support RH/FP department in the implementation of the DHIS2 HMIS system in Luanda and Huambo.					Yes	No			
7. Promotion of Family Planning 2020					Yes	No			
7.1. Advocacy for the Angolan Government to incorporate FP 2020 indicators in the current SRH/FP national plan.					Yes	No			
7.2. Train 120 family planning providers in Strategy for Integral Health Care of Adolescents and Young People and Youth Friendly Health Services in Luanda and Huambo.					Yes	No			
7.3. Advocacy to secure funding for the procurement of contraceptive methods.					Yes	No			
7.4. Implementation of BCC campaigns in maternities and schools to increase youth and adolescent access to SRH/FP services by 10%.					Yes	No			

Evaluation Question 2

Malaria

Part I – Technical Review

Tool or Process		<input checked="" type="checkbox"/> Malaria <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Family Planning
Name of tool or process		
1) Tool or Process?	a) <input checked="" type="checkbox"/> Tool : <input type="checkbox"/> LLINs Campaign Tool kit <input type="checkbox"/> Unified SBCC Strategy <input type="checkbox"/> Supervision Tool (National, Provincial, and Municipal) <input type="checkbox"/> Health Unit Assessment	
	b) <input type="checkbox"/> Process	
2) Why the tool: a-Development (new) b-Improvement c-Updating	a) <input type="checkbox"/> Requested by MINSA	
	b) <input type="checkbox"/> Developed or Inherited from USAID project	
	c) <input type="checkbox"/> Other:	
3) Was there a previous tool that served the same purpose (only for 2b and 2c)?	a) <input type="checkbox"/> Yes. <i>If yes, name:</i>	
	b) <input type="checkbox"/> No	
4) Background/ Status before HFA		
5) a- Purpose of tool		
6) Did HFA apply its technical approach?	a) <input type="checkbox"/> Co-diagnosis	
	b) <input type="checkbox"/> Co-design	
	c) <input type="checkbox"/> Co-Implementation	
7) Current status of tool	a) <input type="checkbox"/> Design	
	b) <input type="checkbox"/> Piloted/tested	
	c) <input type="checkbox"/> MOH review	
	d) <input type="checkbox"/> MOH approval	

Tool or Process		<input checked="" type="checkbox"/> Malaria <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Family Planning
	e) <input type="checkbox"/> Implementation/Adoption	
8) Best Practice (s) to be measured against the standard (International, National)		

Part 2. Gap Analysis (secondary review)

	Key Standards, BPs and Desired Outcomes	GAP	2.Current Status
1. Technical Review:			
2. Results			

Part 2. Provincial and Municipal level (to be analysed in addition to gap analysis)-	
Review	Key Question(s)
LLINs Toolkit a) Tool availability	A ferramenta usada para a campanha de distribuição de massa de MTILD está disponível em todos os municípios/DMS apoiados pelo projeto Saúde para Todos (HFA)? Sim Não
b) Tool being used? <i>What is the evidence?</i>	Se sim: Desde quando está a ser utilizada esta ferramenta nas sua provincia o município? Na sua opinião acha que melhorou a planificação, implementação e monitoria da distribuição dos MTLID? Não Se sim explica
c) Constraint/Suggestion	Pode nos explicar a maior barreira/constrangimento em utilizar esta ferramenta na sua provincia ou município? Qual e' a sua proposta /conselho para o projecto HFA para a melhoria e o uso pertinente desta ferramenta?
USBCC a) Tool availability	Està disponível na sua provincia/município o material de Comunicação para as campanhas de Mudança de Comportamento (CMC)/USBCC sobre a malária fornecido pelo projecto Saúde para todos?
b) Tool being used? <i>What is the evidence?</i>	Este material de USBCC está a ser regularmente utilizado na sua provincia/município de acordo com a metodologia estabelecida pelo Projecto HFA/PNMC? Se sim: Quais canais/mensagem estão utilizados? Pode explicar?
c) Constraint/Suggestion	Pode nos explicar a maior barreira/constrangimento no uso deste material/estratégia USBCC? O que aconselha para mitigar barreiras/constrangimentos?
d) Result	Da sua opinião o uso deste material/estratégia USBCC melhorou a implementação das actividades de comunicação? Não Sim, explica
Supervision a) Tool availability	A nova ferramenta de supervisão do nível provincial e municipal elaborada para HFA/PNMC está disponível na sua provincia/município?
b) Tool being used? <i>What is the evidence?</i>	Está a ser utilizada esta ferramenta nas sua provincia/município? Não Sim Se sim, na sua opinião acha que melhorou as actividades de supervisão? Pode explicar?
c) Constraint/Suggestion	Pode nos explicar a maior barreira/constrangimento em utilizar esta ferramenta na sua provincia e município? Qual e' a sua proposta/conselho para o projecto HFA para a melhoria e o uso pertinente destas ferramentas?

<p>d) Result</p>	<p>Da sua opinião o uso desta ferramenta permite a recolha adequada de informações e dados as US? Não Sim, explica</p>
<p>Health Assessment a) Tool being used? <i>What is the evidence?</i></p>	<p>Na sua provincia foi utilizada a ferramenta do projecto HFA/PNCM para o levantamento das US e pessoal para as formações sobre a malária? Sim Não</p>
<p>b) Suggestion</p>	<p>Da sua opinião pode nos explicar as vantagens/utilidade desta ferramenta? Algumas sugestões/conselho para HFA/PNCM para a melhoria da ferramenta?</p>
<p>c) Results</p>	<p>Da sua opinião o uso desta ferramenta permite de realizar de maneira mais oportuna e eficaz o levantamento das US funcionantes e recursos humanos (numero e categoria) na provincia? Não Sim, explica</p>

Evaluation Question 2

HIV/AIDS

EQ2 Content and process review guide

Index Case Testing and Tracing
HIV/AIDS

A) Interview with HFA staff

1	Describe index case programme		
2	Background/ Status before HFA involvement		
		<i>Diagnosis and Design Phase</i>	<i>Implementation Phase</i>
3	What was HFA's role?		
4	What activities has HFA supported?		
5	How did you apply your key technical approach (<i>co-diagnosis-co-plan and co-implementation</i>) in your technical support in this tool/process?		
6	What caused HFA's involvement with this tool/process?		
7	What do you consider HFA's key achievements in support to this tool/process? Why?		
8	Can you share data to illustrate your achievements?		
9	How do you monitor the level of effectiveness of the index case programme at the facility level? How often do you monitor it and who analyses it? Do you track the following: • Actual number of people receiving treatment at the facility VS the number of index cases. • Ratio of index cases: new-diagnosed/old on treatment.		

EQ2 Content and process review guide

Index Case Testing and Tracing
HIV/AIDS

10	Quais são as principais melhorias que você fez no ano passado?	
11	Estado atual	

B) Content Review

Index Case		
Client centered and focused		
Confidential		
• Physically Secure Environment: Partner services information and data should be maintained in a physically secure environment (e.g. locked filing cabinets).		
• Technically Secure Environment: Electronic partner services data should be held in a technically secure environment, with the number of data storage and persons permitted access kept to a minimum (e.g. password protected computers)		
• Individual Responsibility: Individual partner service staff authorized to access case specific information and data are responsible for protecting it (e.g. requiring staff to sign patient confidentiality agreements)		
Voluntary and non-coercive		
Free		
Non-judgmental		
Culturally and linguistically appropriate		
Accessible and available to all		
Comprehensive and integrative		

HIV positive adults and adolescents should be offered Index Partner testing for all sexual or injecting drug partners from the past year		
HIV positive adults and adolescents should be offered Family Testing for all biological children ((Mother is HIV positive OR Father is HIV positive AND reports the child's mother is HIV positive, deceased, or her status is unknown, OR Biological sibling is HIV positive		
Introduce basic partner/family testing services concepts and benefits at pre-test information or counseling OR at PMTCT or ART visits		
Partner elicitation and testing is NOT a one time event but should be offered continually: • Immediately after HIV diagnosis • At least annually as part of HIV treatment services • After a change in relationship status		
Family Testing is for biological children of index clients with an "unknown" status: • Offer HIV positive clients with an incomplete 'family tree' status documentation • Children without an ongoing or new HIV exposure do not need re-testing, if status is known.		
To improve access, partner(s) and child(ren) of index clients should be offered the option of coming to the health facility for an HIV test or having a counsellor/health worker test the partner(s) and children in the community (in their home or through mobile testing)		

B) Content Review

Linkage to care	HFA system—Indicate evidence
<i>Bolded entries have strongest evidence</i>	
Patient-level	
<ul style="list-style-type: none"> Educate on specific adherence tools: pillboxes, med-sets, phone alarms, daily triggers One-on-one ART education One-on-one adherence counseling Pre-ART counseling content: 	
Detailed discussion about willingness and readiness to initiate ART, the ARV regimen, dosage and scheduling, the likely benefits and possible adverse effects and the required follow-up and monitoring visits.	
Assess for mental health, substance use or other problems that are major barriers to adherence. If present, provide appropriate support	
Provide wide range of patient information materials as well as community and peer support can help the person's readiness and decision to start therapy.	
<ul style="list-style-type: none"> Instructions on how to take the medications exactly as prescribed. **Visual aid	
Provide advice that many adverse effects are temporary or may be treated, or that substitutions can often be made for problematic ARV drugs.	
Regular assessment about any other medications they take, including herbal remedies and nutritional supplements.	
Inform that while the ARV drugs reduce the risk of HIV transmission, they cannot be relied on to prevent other people from acquiring infection.	
They should be given advice on safer sex (including condom use) and avoidance of other high-risk activities, such as sharing of injecting equipment, to prevent transmitting HIV to other people.	

Assess readiness to initiate/continue ART at regular intervals.	
Facility level	
<ul style="list-style-type: none"> Community Health Workers. CHWs can improve linkage to care and retention. It is critical to identify CHWs who are familiar with the community in which they work. CHWs need regular pre-service and in-service training. CHWs can act as peer navigators, and have been shown to successfully link to care hard-to-reach populations, such as men. Recognizing the importance of clear evidence regarding the role of CHWs, the National Department of Health (NDoH) has commissioned a study regarding the impact of CHWs on the treatment cascade 	
Monitor success/failure of entry into care and have a follow-up plan for no-shows	
<ul style="list-style-type: none"> Enrolling PHAs into care at the earliest opportunity 	
Availability of ART initiation on same day as HIV test	
Assess for social service needs (housing, financial support, employment, food, mental health)	
Newly diagnosed PHAs were linked to integrated (one roof) and comprehensive services	
Strength based case management	
Patient navigator	
Seamless coordination of services from testing to care	
Visual tools to help patients navigate to treatment from various entry points	
Link newly diagnosed patients before receiving confirmatory test	
Linkage register	
Weekly or monthly defaulter tracking committees at facility-level	
Expert clients	

A) Interview with HFA staff

1	Describe HFA approach on FP counseling		
2	Background/ Status before HFA involvement		
		<i>Diagnosis and Design Phase</i>	<i>Implementation Phase</i>
3	What was HFA's role?		
4	What activities has HFA supported?		
5	How did you apply your key technical approach (<i>co-diagnosis-co-plan and co-implementation</i>) in your technical support in this tool/process?		
5	What caused HFA's involvement with this tool/process?		
6	What do you consider HFA's key achievements in support to this tool/process? Why?		
6a	Can you share data to illustrate your achievements?		
7	a) How do you monitor the level of effectiveness of the retention at the facility level? b) How often do you monitor it and who analyses, interprets and acts on the data?		
8	Current status:		

B) Content Review

Key "Tiaht" amendment requirements	Document review	FP provider semi-structured interview
1) Service providers or referral agents shall not implement or be subject to numerical targets or quotas of total number of births, number of family planning acceptors, or acceptors of a particular family planning method. Quantitative estimates or indicators used for budgeting or planning purposes are permissible.		I understand that family planning use is not so common in Angola. What types of things are you doing to increase the number of people who use family planning at your facility/municipality?
2) No incentives, bribes, gratuities, or financial reward for family planning program personnel for achieving targets or quotas, or for individuals in exchange for becoming a family planning acceptor.		Are there incentives or rewards for family planning providers to increase the number of people who use FP?
3) No denial of rights or benefits such as food or medical care to individuals who decide not to use family planning services.		Are there disincentives for patients if they decide not to use family planning methods?
4) Clients must be provided comprehensible information on the benefits of the family planning method chosen and the risks of the family planning method chosen, including conditions that might make the method chosen inadvisable and known adverse side.	Content review checklist • Benefits of the family planning method chosen • Risks of the family planning method chosen – conditions that might make the method chosen inadvisable – known adverse side.	How do patients learn about specific FP methods? What information do you provide patients during patient visits about a specific FP method they may be considering or they are using?
5) Experimental methods must be provided only within the context of a scientific study, and participants must be advised of all potential risks and benefit		Are there or have there been experimental family planning methods at this clinic/municipality/province?

A) Interview with HFA staff

1	Name of tool or process		
2	Background/ Status before HFA involvement		
		<i>Diagnosis and Design Phase</i>	<i>Implementation Phase</i>
3	What was HFA's role?		
4	What activities has HFA supported?		
5	How did you apply your key technical approach (<i>co-diagnosis-co-plan and co-implementation</i>) in your technical support in this tool/process?		
6	Has this tool be piloted? How?		
7	What caused HFA's involvement with this tool/process?		
8	What do you consider HFA's key achievements in support to this tool/process? Why?		
9	Can you share data to illustrate your achievements?		
10	Current status:	<i>Not yet reviewed by MINSA/approved</i>	

B) Content Review

Per Sprocket 2017 review,¹ there is no standardized or widely accepted tool to assess the quality of clinic-based family planning services in low- and middle-income countries. This review article presents a comparison of various tools, of which I identified the QIQ tools listed below. Another option would be to review the free, publicly available tools in the review to see if there is a better fit, and then conduct content review with that tool.

- 1) USAID/Measure Evaluation's Facility audit tool from Module 3 **Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning 2016**
- 2) USAID/Measure Evaluation's Provider-Client Observation tool from Module 3 **Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning 2016**

Evaluation Question 3

Implementing Partner	
N	Evaluation Question
1	On a scale from 1 (lowest) to 5 (highest), how would you rate HFA performance as: (i) a consortium; (ii) your organization? Explain your rating for each and any differences between the two?
2	How effective do you consider the HFA Consortium's systems and structures to generate quality and success?
3	Currently, what are the Consortium's (1) Strengths, (2) Weaknesses, and (3) Current Challenges?
4	Are you getting the necessary participation and support from (i) PSI, (ii) USAID, (iii) GoA? What needs to change to improve this?
5	What major organizational areas (e.g., management, finance, HR etc.) should be strengthened to improve the performance and interactions in HFA Consortium?
6	Given these, give me your top three Performance Targets for the coming year.
7	Please remind me: (1) the names of organizational strengthening champions you selected for OCA exercise? (2) Remind me the names of those who will participate in the OCA workshop?

USAID	
N°	Evaluation Question
1	On a scale from 1 (lowest) to 5 (highest), how would you rate HFA overall performance as: (i) a consortium; and (ii) individual organizations (PSI, MSH, RMA, MENTOR)? Explain your rating for each and any differences between the two?
2	How effective do you consider the HFA Consortium's systems and structures to generate success across the three areas (Malaria, HIV, FP)?
3	From your perspective, what are key organizational (1) Strengths, (2) Weaknesses, and (3) Challenges for: PSI, MSH, RMA, MENTOR?
4	Are you providing the needed guidance and support to the Consortium? Can anything be improved?
5	What areas should be looked at to improve the performance and interactions of HFA as: (1) a Consortium; (2) individual organizations: PSI, MSH, RMA, MENTOR?
6	Do you have specific strengthening recommendations to improve any organizational aspects of the Consortium or its IPs?

Government Partners

N°	Evaluation Question	INLS	NMCP	Family Planning	GEPE/GTI	FAZ & IFAL
1	Have you worked with HFA over the past? If so, how? If not, what do you know about the project and how can it better involve/work with you? (Go to question 6).					
2	On a scale from 1 (lowest) to 5 (highest), how would you rate the HFA's overall performance?					
3	From your perspective, what are the HFA Consortium's (1) Strengths, (2) Weaknesses, and (3) Challenges?					
4	Does the FHA Consortium make a strong effort to include the government of Angola in all aspects of the HFA project?					
5	As a key partner, do you believe you are providing the needed guidance, participation and support to facilitate FHA success? Can anything be improved?					
6	Are there any recommendations for the HFA consortium to improve its implementation of the project?					
7	Any final thoughts or observations you'd like to share before we close?					

International Partners

N°	Evaluation Question	Global Fund	WHO	PSM	Linkages
1	What is your relationship to HFA (if any) and your perspective of the project's effectiveness and quality thus far?				
2	Does HFA have the needed structures and systems to succeed? If yes, which? If no, what is needed?				
3	On a scale from 1 (lowest) to 5 (highest), how would you rate the HFA's overall performance?				
4	From your perspective, what are the HFA Consortium's (1) Strengths, (2) Weaknesses, and (3) Challenges?				
5	Do you have specific strengthening recommendations to improve any organizational aspects of the Consortium or its IPs?				
6	Any final thoughts or observations you'd like to share before we close?				

DQA INSTRUMENTS

SSI Questions to ask primary stakeholders about their data systems:

Overall Questions

1. Major strengths and weaknesses of your data collection system, with respect to:
 - Collection
 - Data flow to national level
 - Storage
 - Use
2. Do you see any issues with data linked to the HFA indicators? If yes, what?
3. Are any improvements needed for collecting, sharing and using data for HFA indicators? If so, what and why?

Note to Evaluators: Please be sure to collect relevant documents or reports or databases (examples) related to the indicators that correspond to your result (s) being evaluated (see above).

Indicator Checklist

HFA Indicator:				
		YES	NO	COMMENTS
VALIDITY – Data should clearly and adequately represent the intended result.				
1	Does the information collected measure what it is supposed to measure?			
2	Is there reasonable assurance that the data collection methods being used do not produce systematically biased data (e.g. consistently over- or under-counting)?			
3	Are sound research methods being used to collect the data?			
RELIABILITY – Data should reflect stable and consistent data collection processes and analysis methods over time.				
1	When the same data collection method is used to measure/observe the same thing multiple times, is the same result produced each time? (e.g., a ruler used over and over always indicates the same length for an inch.)			
2	Are data collection and analysis methods documented in writing and being used to ensure the same procedures are followed each time?			
TIMELINESS – Data should be available at a useful frequency, should be current, and should be timely enough to influence management decision-making.				
1	Are data available frequently enough to inform program management decisions?			
2	Are the data reported the most current practically available?			
3	Are the data reported as soon as possible after collection?			
PRECISION – Data have a sufficient level of detail to permit management decision-making; e.g. the margin of error is less than the anticipated change.				

HFA Indicator:				
		YES	NO	COMMENTS
1	Do your tools collect information that is adequately detailed (e.g., disaggregation by sex, age, location)?			
2	Is HFA collected data consistently error-free and able to be easily meet data needs and useful for management decisions?			
INTEGRITY – Data collected should have safeguards to minimize the risk of transcription error or data manipulation.				
1	Are procedures or safeguards in place to minimize data transcription errors?			
2	Is there independence in key data collection, management, and assessment procedures?			
3	Are mechanisms in place to prevent unauthorized changes to the data			

ANNEX IV. SOURCES OF INFORMATION

DOCUMENTS CONSULTED

Health for All (HFA) Population Services International (PSI) reports:

- PSI AID-654-A-17-00003 Program Description
- Performance Monitoring Plans Fiscal Year 2017 and 2018
- Quarterly Reports Fiscal Year 2017 and 2018
- Malaria Supervision Tools
- Report of Health Units and Health Human Resources Assessment in Six Provinces covered by PMI
- Unified SBCC Campaign Strategy/Malaria
- ILLNs Toolkits
- Monitoring and Evaluation Plan
- Work Plan for Fiscal Year 2018 (October 1, 2017 – September 30, 2018)
- Work Plan for Fiscal Year 2017 (January 2017 – September 30, 2017)

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Ministerio da Saude/Republica da Angola. Plano Nacional de Desenvolvimento Sanitário 2012-2025. Vol I.; 2014.

MINSÁ, DNSP- PNCM. Manual de Formação de Ponto Focais de Monitoria & Avaliação do Programa da Malária/(Versão Revisada 07.05.2009).

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KEY INFORMANTS

Key Informants – Malaria

Representatives from:

Centro Materno Infantil, Saurimo
DMS, Cacolo
DMS, Mbanza Congo
DMS, Saurimo
DPS, Saurimo
DPS, Zaire
Elimination 8, Luanda
FAS, Cacolo
Global Fund, Luanda
Health Post, Cacolo
iCCM staff, FAS, Tomboco
MCH Centre II de Novembro, Mbanza Kongo
MOH/GTI, Luanda
MOH/NMCP, Luanda
MOH/NMCP, Mbanza Congo
Municipal Hospital, Cacao
Provincial Hospital, Mbanza Kongo
Provincial Hospital, Saurimo
PSI, Luanda
PSI, Saurimo
PSM, Luanda
The MENTOR Initiative (HFA-IP), Mbanza Congo
USAID-Angola
Vector Work, Luanda
WHO, Luanda
World Vision, Luanda

Key Informants – HIV/AIDS

Representatives from:

Centro de Saúde Ana Paula Viana I
Dispensario Anti-TB
Divina Providencia
Gabinete Distrital de Rangel
Gabinete Provincial Luanda
Health For All
HKK
Hospital Pedriatico
Linkages
PSM
Rangel
Reparticao Municipal de Viana
UNITEL

USAID/Angola

Key Informants – Family Planning

Representatives from:

Centro de Saude 11 de Novembro
Centro Materno Infantil da Caala
Centro Materno Infantil da Mineira
Direcao Nacional de Saude Publica
DNSP/Promocao de Saude
DNSP/Saude Reprodutiva
Gabinete Provincial de Huambo
Gabinete Provincial de Saude Huambo
Gabinete Provincial Luanda
Health For All/Huambo
Health For All
Hospital Geral de Cajueiros
Lucrecia Paim
MASFUMU
Rede Mulher Angola
Reparticao de Saude do Distrito de Imgombota
Reparticao de Saude do Distrito de Maianga
Reparticao Municipal de Saude Huambo
RMS de Cazenga
UNFPA
USAID/Angola
USAID/Washington

Key Informants – Organizational Development

Representatives from:

GEP/GTE
Global Fund
INLS
Linkages/MSH
MENTOR
MENTOR, Huambo
MENTOR, Uige
MENTOR, Zaire
Ministry of Health
MSH/Angola
PNCM
PSI
PSM/Chemonics
RMA
USAID/Angola
USAID/South Africa

ANNEX V. HFA PROGRESS TOWARD FY 2018 TARGETS AT THE END OF QUARTER 3/FY 2018

Result 1 Indicator data progress at Quarter 3 of FY18

Indicator	Baseline		FY 17 Target	FY 17 Value	FY 17 Progress (%)	FY 18 Proposed Target	FY 18 New Target	FY 18 Value (Q1,Q3,Q4)	FY 18 Progress (%)
	Year	Value							
#of ITNs distributed in this reported fiscal year	2015	1,739,431	2,900,000	2,393,477	82.53	5,600,000	3,910,025	2,483,612	63.5
#of CHWs trained in counseling on ITN use	2015	399	4,000	4,764	119.10	5,4000	4,653	4,175	89.7
# HHs with at least one ITN for every two people	2015-16	106,864	1,000,632	920,193	91.96	-	1,530,009	851,332	55.6
#of CU5 years old covered with LLIN distribution	2015-16	187,944	892,086	672,181	75.35	1,400,000	1,363,973	719,076	52.7
#of pregnant women covered with LLIN distribution	2015-16	25,490	114,152	105,672	92.57	236,000	174,000	143,190	82

Result 2 Indicator data progress at Quarter 3 of FY18

Indicator	Baseline		FY 17 Target	FY 17 Value	FY 17 Progress %	FY 18 Target	FY 18 Value	FY 18 Progress %
	Year	Value						
Result 2								
#of HWs trained in IPTp with USG Funds	N/A	N/A	300	374	124.67	407	306	75.2
#of health workers trained in malaria diagnostics RDT(or microscopy) with USG funds in last year	2016	1,247	700	1,437	205.3	1,542	980	58.44
a) Number of health workers/lab technicians trained in malaria diagnostics (microscopy) with USG funds in last year	/	/	/	/	/	135	104	77
b) Number of health workers trained in malaria diagnostics (rapid diagnostic test (RDTs) with USG funds in last year	/	/	/	/	/	1,000	1,109*	72*
#of health workers trained in case management with ACTs with USG funds	2016	2,868	1,000	1,083	108.3	1,000	699	69.9
# of health workers who received formative supervision on malaria diagnostic in last year	/	/	124	0	0	320	335	105
#of health workers who received formative supervision in ACT use	/	/	124	0	0%	320	335	105
#of CHW (ADECOs) trained in malaria case management at community level	/	/	/	/	/	120	120	100%
#of CHW (ADECOs) supervised in malaria case management at community level	/	/	/	/	/	120	/	/
#of fever cases reported by CHW (ADECOs) at community level	/	/	/	/	/	TBA	/	/
#of fever cases tested with RDT by CHW (ADECOs) at community level	/	/	/	/	/	TBA	/	/
#of malaria cases confirmed reported by CHW (ADECOs) at community level	/	/	/	/	/	TBA	/	/
Number of malaria confirmed cases treated with ACT reported by CHW (ADECOs)	/	/	/	/	/	TBA	/	/
#of malaria confirmed cases referred to health	/	/	/	/	/	TBA	/	/

units by CHW (ADECOS)								
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Result 3 Indicator data progress at Quarter 3 of FY18

Indicator	Baseline		FY 17 Target	FY 17 Value	FY 17 Progress	FY 18 Target	FY 18 Value	FY 18 Progress
	Year	Value						
Result 3								
# of individuals who received HIV/AIDS Testing and Counseling services for HIV/AIDS and received their test results	2016	62,186	49,372	78,815	159.64%	43,845	54,034	123.24%
# of adults and children currently receiving antiretroviral therapy (ART)	2016	19,189	25,417	24,201	95.22%	22,003	20,640	93.81%
# of adults and children newly enrolled on ART	2016	3,390	5,818	4,276	73.50%	7,543	2,875	38.11%
# of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy	N/A	N/A	80.0%	46.3%	57.88%	80.0%	-	
% of ART patients with a viral load result documented in the medical record and/or LIS within the past 12 months with a suppressed viral load (<1000 copies/ml)	/	N/A	85.0%	71.4%	84.0%	85.0%	-	
# of ART patients who were started on TB treatment during the reporting period (numerator)	/	/	/	/	/	918	228	24.84%
# of ART patients who were screened for TB at least once during the reporting period (denominator)	/	/	/	/	/	18,615	7,225	38.81%
# of ART patients who completed a course of TB preventive therapy within the reporting period	/	/	/	/	/	1,954	711	36.39%
# of ART patients who were newly started on TB preventive therapy (including those who newly started on TB preventive therapy in this reporting period and those who started in the previous reporting period but had not been reported as they did not fulfill the minimum requirements for the previous reporting period)	/	/	/	/	/	2,836	1,410	49.72%
# of new and relapse TB cases with documented HIV status, during the reporting period	/	/	/	/	/	4,005	3,009	75.13%
Total # of new and relapsed TB cases, during the reporting period	/	/	/	/	/	4,682	3,394	72.49%
# of HIV-positive new and relapsed TB cases on ART during TB treatment	/	/	/	/	/	673	241	35.81%
TB_ART Den	/	/	/	/	/	750	438	58.40%

Result 4 Indicator data progress at Quarter 3 of FY18

Indicator	Baseline		FY 17 Target	FY 17 Value	FY 17 Progress	FY 18 Target	FY 18 Value	FY 18 Progress
	Year	Value						
Result 4								
% of USG-assisted SDPs offering FP/RH counseling or services (+) (^)	2016	59.5%	59.5%	58.6%	98.49%	59.5%	67.9%	114.12%
% of USG-assisted service delivery points that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide (+) (^)	2016	6.7%	6.7%	0%	0%	6.7%	2.1%	31.34%
Couple years protection in USG supported programs (^) (^)	2016	50,054	50,054	34,043	68.01%	59,054	57,190	96.84%
% of health facilities whose providers reported a Quality of Care score >= 80% for management of FP services (+)	/	/	/	/	/	40.0%	-	
# of health care workers who successfully completed an in/service training program	2016	192	26	42	161.54%	280	45	16.07%
# of protocols finalized and approved	2016	4	/	/	0%	4	1	25%
# of people trained with USG funds (u)	2016	307	60	59	98.33%	400	188	47.00%
# of USG-assisted CHWs providing FP information, referrals, and/or services during the year (+)	N/A	N/A	N/A	N/A		30	30	100%

Result 5 Indicator data progress at Quarter 3 of FY18

Indicator	Baseline		FY 17 Target	FY 17 Value	FY 17 Progress	FY 18 Target	FY 18 Value	FY 18 Progress
	Year	Value						
Result 5								
%of health units updated in DHIS2 organizational tree (new indicator in FY 2019)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
#of DHIS2 users trained within MOH with USG assistance	N/A	N/A	N/A	N/A	N/A	278	233	83.81%
%of quarterly reports submitted on time in DHIS2	N/A	N/A	N/A	N/A	N/A	70.0%	53.3%	76.14%
#of municipal authorities meeting quarterly to review HMIS/DHIS2 data and incorporate feedback in reports	N/A	N/A	N/A	N/A	N/A	43	30	69.77%
# of quarterly meetings in which NMCP officials lead DHIS2 analyses for decision making (new indicator)	N/A	N/A	N/A	N/A	N/A	4	3	75.00%

ANNEX VI. FINAL OCA SCORING FOR HFA ORGANIZATIONS

I. PSI OCA Score Sheet

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
1. Governance and legal structure	1.1 Vision and mission	4		
	1.2 Legal requirements and status	4		
	1.3 Organizational structure	3		
	1.4 Board composition and responsibility	N/A		
	1.5 Succession planning	3		
	Average section 1 score	3.5		
2. Financial management and internal control systems	2.1 Budgeting	4		
	2.2 Accounting system	4		
	2.3 Internal controls	3		
	2.4 Bank account management	4		
	2.5 Financial documentation	4		
	2.6 Financial statements and reporting	4		
	2.7 Audit experience	4		
	2.8 Cost sharing	4		
	Average section 2 score	3.9		
3. Administration and procurement systems	3.1 Operating policies, procedures, and systems	4		
	3.2 Information technology	4		
	3.3 Travel policies and procedures	3		
	3.4 Procurement	3		
	3.5 Fixed assets management	4		
	3.6 Branding and marking	4		
	Average section 3 score	3.7		

PSI's self-assessed OCA average score: 3.5/4. PSI is a committed implementer with adequate financial and administrative systems to manage HFA. Yet, there are system and structure-related weaknesses limiting optimal HFA management, operations, and achievement of results. PSI identified sub-area vulnerabilities under Human Resources, Program Management, Performance Management, and Organizational Management and Sustainability. One further sub-area gap exists under *Governance and Legal Structure*. All PSI gaps are connected to the six overarching weaknesses discussed in the report.

OCA Area I. Governance and Legal Structure (OCA average score, 3.5/4): This OCA area comprises five sub-areas, all highly self-assessed. Although not self-identified by PSI as a problem area, the evaluation finds two weaknesses under sub-area, *1.3 Organizational Structure*:

- *HFA Organizational Structure Over-Centralized in Luanda:* PSI has set up adequate facilities in Luanda. However, based on HFA's geographic and technical scope, the evaluation finds its operational structure, staffing, decision making and key processes to be over-concentrated in Luanda.

“HFA needs the structure to better manage LLIN distribution and support capacity building to health units. The structure must be adjusted to realities not only at the national level, but the provincial and municipal as well.”

—HFA Stakeholder, Luanda

Current set-up does not allow needed agility, flexibility, communications and quality control, particularly for results 1, 2, and 5. Lack of a more permanent and concentrated field presence is also the origin of other informant-identified gaps in: supervision, adaptability, logistics, tactics, achieving higher order results and generating local capacity and ownership. Finally, PSI does not have a documented operational structure or strategy for its field operations.

- *Organizational Chart not Allowing Management Utility:* PSI’s organizational chart is changing daily due to a combination of staff turnover and constant hiring. PSI updates the chart annually, which is not allowing a real-time reference point to facilitate optimal structure, staffing, workload distribution, reporting-lines or collaboration. Also, the current chart doesn’t sufficiently depict the administration-side (e.g., logistics, finance, HR) of PSI/Angola’s HFA efforts.

PSI OCA Score Sheet (p. 2)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
4. Human resources systems	4.1 Adequacy of staffing and job descriptions	3		
	4.2 Recruitment and retention	4		
	4.3 Personnel policies	4		
	4.4 Staff time management and payrolls	4		
	4.5 Staff and consultant history	4		
	4.6 Staff salaries and benefits	4		
	4.7 Staff and contractor supervision and work planning	2		
	4.8 Safety & Security (Tailored by Eval)	3		
	Average section 4 score	3.5		
5. Program management	5.1 Donor compliance requirements	4		
	5.2 Sub-award management	3		
	5.3 Technical reporting	3		
	5.4 Stakeholder involvement	3		
	5.5 Culture and gender issues	3		
	Average section 5 score	3.2		
6. Project performance management	6.1 Monitoring and quality assurance	3		
	6.2 Project and program evaluation	3		
	6.3 Service delivery standards	3		
	6.4 Field support, operations, and oversight	3		
	6.5 Project performance	3		
	Average section 6 score	3		

OCA Area 4. HR Systems (OCA average score, 3.5/4): This OCA area comprises eight sub-areas. The last sub-area, *Safety and Security*, was tailored at PSI’s request. PSI senior staff, including the HR Director, previously identified HR gaps. The OCA affirmed these and identified other sub-areas:

- *4.1 Adequacy of Staff and Job Descriptions (OCA score, 3/4):* PSI implements two other projects in Angola (CIDA and a private foundation). As of October 2018, PSI has 73 full-time, permanent staff. Of this, 20 are dedicated to HFA and 28 are common cost support staff (e.g., logistics, finance, administration). PSI also employs 170 HFA consultants and temporary staff (not counting LLIN). While not informed by a staffing analysis, there are strong signs PSI is

understaffed for HFA—in terms of employing full-time staff and identifying and right-fit-filling positions. These signs correspond to gaps in service provision, supervision, high-volume recruiting/low retention, and deliverables quality. PSI also does not have a staffing plan in place and lacks rigorous process or tools to conduct workforce, staff-load or headcount analyses to inform it.

- *4.7 Staff and Contractor Supervision (OCA score, 2/4):* PSI's HFA supervision includes the country representative (responsible for the entirety of PSI/Angola portfolio) and the chief of party. There are also HFA directors for technical areas, as well as M&E, finance, and communication. According to PSI, staff have strong understandings of roles, responsibilities, and reporting lines. The sub-area was scored low given current field supervision gaps, which is further discussed under sub-area 6.4. The evaluation did find that between the country representative and chief of party, there are blurred lines regarding HFA decision-making, roles and responsibilities, and internal and external communication. This is limiting the effectiveness and efficiency of HFA management.
- *4.8 Safety and Security (OCA score, 3/4):* PSI has a Security Management Plan in Portuguese that provides contact information, PSI focal points (PSI emergency committee) and SOPs. Yet, there are two gaps. First, PSI's Safety and Security Focal Point is not uniquely dedicated and cannot provide needed focus on Angola's challenging security environment. Second, implementing partners have no awareness or ownership in the plan.

OCA Area 5. Program Management (OCA average score, 3.2/4): This OCA area comprises five sub-areas, four of which PSI identified as in need of strengthening:

- *5.2 Sub-Award Management (OCA score, 3/4):* Strong relationships among the implementing team was noted. Still, PSI and its partners agreed on the need to improve HFA team management and fill gaps in communication; technical collaboration (e.g., integrating HIV, FP and malaria efforts); service delivery quality; sustainability; and moving beyond training. Also, and as discussed, the evaluation found weaknesses in the oversight and capacity building of RMA.
- *5.3 Technical Reports (OCA score, 3/4):* USAID cited quarterly reports, among other deliverables, as in need of improvement. PSI identified quarterly report strengthening priorities that include: format, data quality and visualization, delivery timing, and quality control (edits and reviews).
- *5.4 Stakeholder Involvement (OCA score, 3/4):* Stakeholder engagement is not at the level originally proposed by PSI in its RFA solicitation. Frequency, depth, and effectiveness vary at national, provincial, and municipal levels. Engagement of non-traditional partners such as CSOs or HFA beneficiaries is also considered to be low. Finally, KIs questioned why PSI HQ technical staff (e.g., communication experts) are not more consistently involved in HFA.
- *5.5 Culture and Gender (OCA score, 3/4):* PSI has a gender equality policy translated into Portuguese. PSI staff composition is relatively balanced between females and males at executive, director, and lower-level positions. Four key gaps, however, do exist: (a) lack of a plan to integrate or mainstream gender into HFA's processes and approaches; (b) non-existent gender focal point; (c) lack of commitment and clarity in MEL plan to disaggregate indicator data by sex; and (d) insufficient sex-disaggregated data analysis and presentation in quarterly reports.

OCA Area 6. Project Performance Management (OCA average score, 3/4): This OCA area comprises five sub-areas, two of which PSI identified as in need of strengthening:

- *6.1 Monitoring and Quality Assurance (OCA score, 3/4):* PSI’s performance monitoring is challenged by external factors and internal gaps. External factors include required standard indicators that, in some cases, are not direct measures of HFA results; relying upon GRA-generated (third-party) data that requires significant verification; and, obligatory use of GoA data collection tools (~70 percent of all tools), which are frequently inadequate and take time to gain approval for improvement changes. PSI also cited internal gaps: insufficient M&E staff in Luanda and field, M&E and program team inadequately coordinating to verify and validate data, incomplete MEL Plan, inadequate SOPs and training, a complex data flow involving numerous actors and levels, unrealistic targets, and insufficient use of HFA data.
- *6.4 Field Support, Operations & Oversight (OCA score, 3/4):* Field supervision consists of two efforts: (i) oversight of HFA efforts by LLIN coordinators, OPMs, and FP quality control officer; and (ii) transfer of training to good practices or techniques by technicians or trainers. In the former’s case, the objective is quality assurance; in the latter case it is behavior change. Yet in both, PSI cited significant weaknesses, including: gaps in needed supervisory efforts or staff, inadequately qualified or trained staff, not following HFA-established protocols (e.g., supervisor’s guide or checklists), low supervision standards/requirements, efforts that do not yield behavior change, insufficient communication, and inadequate supervisor capacity building or coaching.

PSI OCA Score Sheet (p. 3)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
7. Organizational management and sustainability	7.1 Strategic (business) planning	4		
	7.2 Annual workplans	4		
	7.3 Change management	3		
	7.4 Knowledge management and external linkages	3		
	7.5 Fundraising and new business development	4		
	7.6 Internal communications and decision making	3		
	7.7 External communications	3		
	7.8 Advocacy and influence	3		
	7.9 Local Capacity Building (Tailored by Eval)	2		
	Average section 7 score	3.2		
	Average OCA score (average of the seven section scores)	3.5		

OCA Area 7. Organizational Management and Sustainability (OCA average score, 3.2/4):

This area comprises nine sub-areas, two of which PSI identified as in need of strengthening:

- *7.3 Change Management (OCA score, 3/4):* PSI cited its change efforts in LLIN distribution as a success story. Still, informants stated that PSI’s change-awareness, willingness, and pace are slow. PSI also noted that its ability to change is influenced by external (e.g., ADECOs) and internal factors (e.g., HFA result areas). PSI does not have an analytical framework or a contingency plan in place to facilitate agile change. It also lacks performance metrics (e.g., critical assumptions, indicators) to identify constraints or measure success. There is also no designated person to lead change processes. The country representative and chief of party cannot fill such a role, given competing priorities.

- *7.7 External Communications (OCA score, 3/4):* In May 2018, PSI finalized its Communication Plan. While it provides a general framework to coordinate actions, the evaluation is uncertain of its utility and application for HFA external communication needs (e.g., SBCC). Also, HFA implementing team KIs expressed that they are not well-versed in the plan, have not received permission for use, and are not currently using strategic communication for HFA efforts. USAID also raised concerns about a lack of PSI HQ’s involvement, quality and utility of communication products, and the right fit of PSI/Angola staff leading or contributing to such efforts.

2. MSH OCA Score Sheet

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
1. Governance and legal structure	1.1 Vision and mission	4		
	1.2 Legal requirements and status	4		
	1.3 Organizational structure	4		
	1.4 Board composition and responsibility	4		
	1.5 Succession planning	4		
	Average section 1 score	4.0		
2. Financial management and internal control systems	2.1 Budgeting	3		
	2.2 Accounting system	4		
	2.3 Internal controls	4		
	2.4 Bank account management	4		
	2.5 Financial documentation	4		
	2.6 Financial statements and reporting	4		
	2.7 Audit experience	4		
	2.8 Cost sharing	3		
	Average section 2 score	3.9		
3. Administration and procurement systems	3.1 Operating policies, procedures, and systems	4		
	3.2 Information technology	4		
	3.3 Travel policies and procedures	4		
	3.4 Procurement	4		
	3.5 Fixed assets management	4		
	3.6 Branding and marking	3		
	Average section 3 score	3.8		

MSH self-assessed OCA average score: 3.8/4. MSH is a competent subcontractor for Result 3. The ICTT model is well-received by stakeholders. MSH is centralized in Luanda with a small staff. Limited scope and geographic proximity to its seven assigned health units allows close accompaniment of services and consistent data verification. MSH identified sub-area gaps in two OCA areas: *Program Management* and *Organizational Management and Sustainability*.

MSH OCA Score Sheet (p. 2)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
4. Human resources systems	4.1 Adequacy of staffing and job descriptions	4		
	4.2 Recruitment and retention	4		
	4.3 Personnel policies	4		
	4.4 Staff time management and payrolls	4		
	4.5 Staff and consultant history	4		
	4.6 Staff salaries and benefits	4		
	4.7 Staff and contractor supervision and work planning	4		
	4.8 Volunteers and interns	4		
	Average section 4 score	4		
5. Program management	5.1 Donor compliance requirements	4		
	5.2 Sub-award management	N/A		
	5.3 Technical reporting	4		
	5.4 Stakeholder involvement	4		
	5.5 Culture and gender issues	3		
	Average section 5 score	3.8		
6. Project performance management	6.1 Monitoring and quality assurance	4		
	6.2 Project and program evaluation	4		
	6.3 Service delivery standards	4		
	6.4 Field support, operations, and oversight	3		
	6.5 Project performance	3		
	Average section 6 score	3.6		

OCA Area 5. Program Management (OCA average score, 3.8/4): Under this OCA area, MSH identified one of five sub-areas as in need of strengthening:

- *5.5 Culture and Gender (OCA score, 3/4):* MSH/Angola also benefits from institutional gender policies and experience from HQ. MSH cited it has not sufficiently conducted gender analyses in its HIV work or integrated gender equality solutions into its service provision. Although MSH is collecting and presenting highly verified Result 3 data, there is a gap in sex-disaggregated data presentation in quarterly reports; therefore, the analysis of such data to refine strategy, approach or service provision is lacking.

MSH OCA Score Sheet (p. 3)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
7. Organizational management and sustainability	7.1 Strategic (business) planning	4		
	7.2 Annual workplans	4		
	7.3 Change management	2		
	7.4 Knowledge management and external linkages	4		
	7.5 Fundraising and new business development	N/A		
	7.6 Internal communications and decision making	4		
	7.7 External communications	2		
	7.8 Advocacy and influence	3		
	7.9 Local Capacity Building (Tailored by Eval)	3		
	Average section 7 score	3.2		
	Average OCA score (average of the seven section scores)	3.8		

OCA Area 7. Organizational Management and Sustainability (OCA average score, 3.2/4):

The technical and financial sustainability of the ICTT model for Luanda and Huambo health units is low. A significant contributor to this is that MSH is being directed by USAID to not interact with INLS, as that is ICAP's role. This area has nine sub-areas, two of which MSH identified as in need of strengthening:

- *7.3 Change Management (OCA score, 2/4):* MSH self-scored low as it does not have capacity in change planning, implementation or measurement. Like PSI, MSH does not have a contingency plan in place and no dedicated personnel or approaches to identify change needs or actions.
- *7.9 Local Capacity Building (OCA score, 3/4):* This sub-area was tailored by the evaluation at PSI and MSH's request. MSH is keenly aware of achievement gaps in sustainability and local capacity. It pointed to the need to better assess capacity of health unit personnel and measure any resulting higher-level result achievements (i.e., behavior change).

At the request of the OCA facilitator, MSH participants identified sub-areas for improved PSI management of the HFA implementing team, including *Change Management, Stakeholder Involvement, Culture and Gender, Internal and External Communication, and Monitoring and Quality Assurance.*

3. MENTOR OCA Score Sheet

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
1. Governance and legal structure	1.1 Vision and mission	4		
	1.2 Legal requirements and status	4		
	1.3 Organizational structure	3		
	1.4 Board composition and responsibility	3		
	1.5 Succession planning	2		
	Average section 1 score	3.2		
2. Financial management and internal control systems	2.1 Budgeting	3		
	2.2 Accounting system	3		
	2.3 Internal controls	3		
	2.4 Bank account management	3		
	2.5 Financial documentation	3		
	2.6 Financial statements and reporting	3		
	2.7 Audit experience	3		
	2.8 Cost sharing	4		
	Average section 2 score	3.1		
3. Administration and procurement systems	3.1 Operating policies, procedures, and systems	4		
	3.2 Information technology	2		
	3.3 Travel policies and procedures	3		
	3.4 Procurement	3		
	3.5 Fixed assets management	3		
	3.6 Branding and marking	4		
	Average section 3 score	3.2		

MENTOR's self-assessed OCA average score: 3.3/4: MENTOR's decentralized structure (HQ in Huambo, offices in Uige and Zaire) is ideal for their technical and geographic scope. While MENTOR self-scored highly under many OCA areas, organizational systems are seen to function at basic levels. MENTOR identified one or two sub-area vulnerabilities in nearly all OCA areas: Financial Management and Internal Control Systems, Administration and Procurement Systems, Human Resources, Program Management, Performance Management, and Organizational Management and Sustainability.

OCA Area 2. Financial Management and Internal Control Systems (OCA average score, 3.1/4): This OCA area comprises eight sub-areas, one of which MENTOR identified as in need of strengthening:

- *2.2 Accounting Systems (OCA score, 3/4):* Lack of accounting capacity building materials and efforts. Need to train Zaire staff to best enter, attribute, track and analyze financial transactions.

OCA Area 3. Administration and Procurement Systems (OCA average score, 3.2/4): This OCA area comprises six sub-areas, two of which MENTOR identified as in need of strengthening:

- *3.2 Information Technology (OCA score, 2/4):* The IT system is not functional due to lack of policies and procedures; Portuguese-translated materials; and adequately trained and dedicated IT staff.
- **3.4 Procurement (OCA score, 3/4):** Coordination and communication challenges for purchases and payments between PSI and MENTOR is negative affecting ability to deliver on-time trainings.

Mentor OCA Score Sheet (p. 2)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
4. Human resources systems	4.1 Adequacy of staffing and job descriptions	4		
	4.2 Recruitment and retention	3		
	4.3 Personnel policies	3		
	4.4 Staff time management and payrolls	4		
	4.5 Staff and consultant history	4		
	4.6 Staff salaries and benefits	3		
	4.7 Staff and contractor supervision and work planning	3		
	4.8 Volunteers and interns	3		
	Average section 4 score	3.4		
5. Program management	5.1 Donor compliance requirements	4		
	5.2 Sub-award management	4		
	5.3 Technical reporting	4		
	5.4 Stakeholder involvement	2		
	5.5 Culture and gender issues	4		
	Average section 5 score	3.6		
6. Project performance management	6.1 Monitoring and quality assurance	3		
	6.2 Project and program evaluation	4		
	6.3 Service delivery standards	3		
	6.4 Field support, operations, and oversight	4		
	6.5 Project performance	3		
	Average section 6 score	3.4		

OCA Area 4. Human Resource Systems (OCA average score, 3.4/4): This OCA area comprises eight sub-areas, one of which MENTOR identified as in need of strengthening:

- *4.7 Staff and Contractor Supervision (OCA score, 3/4):* Need to hire an operational coordinator; this position has been vacant for close to a half-year. The evaluation team also found that MENTOR has challenges in finding and securing qualified personnel in Uige and Zaire.

OCA Area 5. Program Management (OCA average score, 3.6/4): This OCA area comprises five sub-areas, one of which MENTOR identified as in need of strengthening:

- *5.4 Stakeholder Involvement (OCA score, 2/4):* MENTOR expressed a need to better involve stakeholders at national (NMCP), provincial, and municipal levels around its malaria efforts.

OCA Area 6. Project Performance Management (OCA average score, 3.4/4): This OCA area comprises five sub-areas, one of which MENTOR identified as in need of strengthening:

- *6.1 Monitoring & Quality Assurance (OCA score, 3/4):* While not self-identified, the evaluation believes that MENTOR must strengthen the way it conducts monitoring and quality assurance. Perceived weaknesses in MENTOR's current system include: no M&E leader at HQ responsible for verifying, analyzing, and managing data; information from 10 different projects being managed simultaneously; country coordinator providing final verification of HFA data as well as all other

projects; and, questions on M&E field staff capacity to collect, verify and manage high-quality data.

- *6.4 Field Support, Operations & Oversight (OCA score, 4/4):* The evaluation team does not concur with MENTOR’s self-score for this sub-area. In addition to improving technical staff’s field efforts, MENTOR cited the need to work with PSI to improve the OPMs’ effectiveness and capacity.

Mentor OCA Score Sheet (p. 3)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
7. Organizational management and sustainability	7.1 Strategic (business) planning	4		
	7.2 Annual workplans	4		
	7.3 Change management	3		
	7.4 Knowledge management and external linkages	3		
	7.5 Fundraising and new business development	3		
	7.6 Internal communications and decision making	3		
	7.7 External communications	3		
	7.8 Advocacy and influence	3		
	Average section 7 score	3.3		
	Average OCA score (average of the seven section scores)	3.3		

OCA Area 7. Organizational Management and Sustainability (OCA average score, 3.3/4):

This OCA area comprises eight sub-areas, two of which MENTOR identified as in need of strengthening:

- *7.2 Annual Workplans (OCA score, 4/4):* As MENTOR has identified this as a sub-area for improvement, the evaluation team questions its self-score of 4. It noted the need for a more efficient and effective annual planning process among offices; improved sharing of HFA Result 1 and 2 activities and progress and improved ability to plan more achievable activities.
- *7.3 Change Management (OCA score, 3/4):* MENTOR emphasized the need to heighten technical sustainability and the adoption of HFA’s key technical efforts by beneficiaries. In particular, it mentioned the need to better work with the GoA at national, provincial, and municipal levels.

At the request of the OCA facilitator, MENTOR participants identified sub-areas for improved PSI management of the HFA Implementing Team, including *Safety and Security, Culture and Gender, and Monitoring and Quality Assurance.*

4. RMA OCA Score Sheet

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
1. Governance and legal structure	1.1 Vision and mission	3		
	1.2 Legal requirements and status	3		
	1.3 Organizational structure	3		
	1.4 Board composition and responsibility	3		
	1.5 Succession planning	3		
	Average section 1 score	3		
2. Financial management and internal control systems	2.1 Budgeting	3		
	2.2 Accounting system	3		
	2.3 Internal controls	3		
	2.4 Bank account management	4		
	2.5 Financial documentation	4		
	2.6 Financial statements and reporting	3		
	2.7 Audit experience	3		
	2.8 Cost sharing	2		
	Average section 2 score	3.1		
3. Administration and procurement systems	3.1 Operating policies, procedures, and systems	3		
	3.2 Information technology	2		
	3.3 Travel policies and procedures	2		
	3.4 Procurement	3		
	3.5 Fixed assets management	3		
	3.6 Branding and marking	4		
	Average section 3 score	2.8		

RMA's self-assessed OCA average score: 2.5/4. RMA is a dynamic organization, with a young, creative, and motivated staff. Since 2017, RMA has grown from 5 to 20 staff. Its organizational structure and systems are emerging. Yet, the evaluation team has concerns about PSI's capacity building emphasis, approach, intensity and management. Similarly, concerns exist about RMA's absorption and progress thus far. Currently, and according to the OCA-NUPAS exercise, RMA is not considered ready to directly receive and absorb USAID funding or implement HFA areas unaccompanied. RMA identified numerous sub-area vulnerabilities across the following OCA areas: Human Resources, Program Management, Performance Management, and Organizational Management and Sustainability.

OCA Area 4. HR Systems (OCA average score, 2.5/4): This OCA area comprises eight sub-areas, three of which RMA identified as in need of strengthening:

- *4.1 Adequacy of Staff & Job Descriptions (OCA score, 2/4):* RMA mentioned a number of ongoing issues: (i) no staffing plan in place, (ii) lack of a process or tool to calculate optimal staffing levels, (iii) short-staffed for technical and supervisory staff, and (iv) lack of clarity around roles and responsibilities. It is worth noting that PSI, as RMA's organizational mentor, suffers from similar issues.
- *4.2 Recruitment and Retention (OCA score, 2/4):* A major challenge, according to RMA, is that PSI is leading recruiting efforts and not involving RMA's key staff in the development of job postings,

interviewing, and selection. RMA also noted it is having staff retention problems that stem from three issues: (i) not able to offer market-competitive salaries, (ii) lack of a perceived career track in RMA, and (iii) receiving late salary payments (at times three to four weeks behind) from PSI (see 4.6).

4.6 Salaries and Benefits (OCA score, 2/4): RMA stated that there is a serious and ongoing issue with PSI’s salary disbursement cycle, whereby staff salaries are consistently arriving three to four weeks late. As MENTOR and MSH did not identify payroll disruptions, this is a problem between RMA and PSI. From RMA’s side, there are challenges with fulfilling PSI’s time-bound and quality-oriented requisites for salary disbursement approval and processing. On PSI’s side, there is inadequate feedback, guidance, and/or capacity building to resolve issues and ensure they do not recur. The evaluation team questions why this has persisted across multiple salary disbursement cycles. Numerous RMA staff noted that PSI does not have time to build RMA’s capacity or resolve such issues.

RMA OCA Score Sheet (p. 2)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
4. Human resources systems	4.1 Adequacy of staffing and job descriptions	2		
	4.2 Recruitment and retention	2		
	4.3 Personnel policies	4		
	4.4 Staff time management and payrolls	3		
	4.5 Staff and consultant history	3		
	4.6 Staff salaries and benefits	2		
	4.7 Staff and contractor supervision and work planning	3		
	4.8 Volunteers and interns	2		
	Average section 4 score	2.5		
5. Program management	5.1 Donor compliance requirements	2		
	5.2 Sub-award management	2		
	5.3 Technical reporting	3		
	5.4 Stakeholder involvement	3		
	5.5 Culture and gender issues	3		
	Average section 5 score	2.6		
6. Project performance management	6.1 Monitoring and quality assurance	2		
	6.2 Project and program evaluation	1		
	6.3 Service delivery standards	3		
	6.4 Field support, operations, and oversight	2		
	6.5 Project performance	2		
	Average section 6 score	2.0		

OCA Area 5. Program Management (OCA average score, 2.6/4): This OCA area comprises five sub-areas, one of which RMA identified as in need of strengthening:

- *5.5 Culture and Gender (OCA score, 3/4):* A key reason RMA was part of PSI’s team was its focus on promoting gender equality through extensive women-focused networks. RMA noted a number of internal shortcomings, including: lack of a gender integration plan, no organizational gender focal point, insufficient staff capacity to mainstream gender into FP efforts, and thus far untapped RMA networks to promote gender equality in FP efforts.

OCA Area 6. Program Management (OCA average score, 3.4/4): This OCA area comprises five sub-areas, three of which RMA identified as in need of strengthening:

- *6.1 Monitoring and Quality Assurance (OCA score, 2/4):* RMA has a dedicated M&E staff person and the organization is conscious of the importance of performance monitoring to learn and grow. However, RMA has a rudimentary system that lacks polices, processes, and tools to conduct solid performance monitoring and ensure quality. Similar to the entire HFA implementing team, RMA is not using specific performance data to grow and improve.
- *6.2 Project and Program Evaluation (OCA score, 1/4):* RMA identified a need to strengthen its ability to conduct internal evaluations and/or organize, manage, and utilize external evaluations. RMA lacks policies, processes or experience in evaluations.

6.4 Field Support, Operations and Oversight (OCA score, 2/4): RMA’s gaps include insufficient operational approach to supervise and support FP field-efforts and activists, lack of high-level supervisory staff (see 4.2), and inadequate internal capacity building for supervision.

RMA OCA Score Sheet (p. 3)

Section	Sub-Section	Scores: OCA #1*	Scores: OCA #2	Scores: OCA #3
7. Organizational management and sustainability	7.1 Strategic (business) planning	1		
	7.2 Annual workplans	2		
	7.3 Change management	1		
	7.4 Knowledge management and external linkages	2		
	7.5 Fundraising and new business development	1		
	7.6 Internal communications and decision making	3		
	7.7 External communications	2		
	7.8 Advocacy and influence	2		
Average section 7 score		1.8		
Average OCA score (average of the seven section scores)		2.5		

OCA Area 7. Organizational Management & Sustainability (OCA average score, 1.8/4): This OCA area comprises eight sub-areas, three of which RMA identified as in need of strengthening:

- **7.1 Strategic Business Planning** (OCA score, 1/4): RMA has no business plan that solidifies its mission, vision, and strategic objectives; highlights its distinguishing approaches; or charts its way to securing new business and sustaining operations. The evaluation team finds it concerning that, at this stage, RMA does not have such a plan and believes this should be a priority moving forward.
- **7.3 Change Management** (OCA score, 1/4): RMA does not have the staff, protocols/processes or capacity to conduct effective change-management activities. RMA notes that this concept is foreign to them and will need outside support to build such capacity.

7.5 Fundraising & New Business Development (OCA score, 1/4): This is a priority as it is linked to RMA's long-term viability and should be part of RMA's Strategic Business Planning (7.1).

ANNEX VII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

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

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

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

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

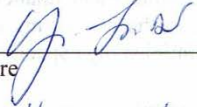
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature		Date	11 JULY 2018
Name	Yashwanth	Title	CONSULTANT

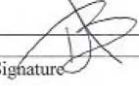
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.


Signature _____ Date 8/24/18
Name R. Balesimo Title Independent Consultant

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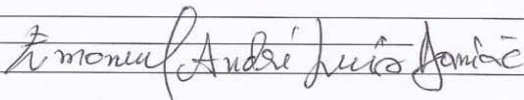
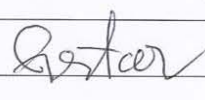
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature  _____ Date 08/08/18

Name  _____ Title 

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 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

<hr/>	
<i>Ada Merolle</i>	
Signature	Date 15 August 2018
<hr/>	
Ada Merolle	
Name	Title Consultant

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

01/08/18

Name

Estevao Mangos Mbambi

Title

Local Evaluator Consultant

ANNEX VIII. SUMMARY BIOS OF EVALUATION TEAM

Yashin Lin, Team Lead, HIV/AIDS and family planning specialist, is a program evaluation specialist with 18 years of global health experience with a focus on HIV/AIDS, maternal, reproductive and child health, and health systems. She has experience in various methods to measure, evaluate, and improve programs, including monitoring and evaluation, quality improvement, program evaluation, operations research, and implementation science. Ms. Lin has carried out performance evaluations from the perspective of the donor, the implementer, and the external evaluator. She has evaluated HIV/AIDS programs in Zambia and Vietnam, as well as a program to strengthen health systems, HIV/AIDS, and family planning in Angola (USAID Essential Health Services). Ms. Lin also led an impact assessment of a program to reduce early marriage in Tajikistan, and supported impact assessments in Zimbabwe, Lesotho and Uganda, focusing on strategies to increase retention of women in antiretroviral treatment. She has nearly 10 years of experience with quality assurance methods applied to health systems in low resource countries. She holds an MPH in epidemiology from the University of Washington. She speaks English, Portuguese, Spanish, French, and Mandarin.

Ramon Balestino, Organizational Development Specialist, has decades of experience facilitating customer-driven transformations to maximize impact in the public and private sectors. He has been highly effective in using collaborative, results-based approaches to build capacity, enabling change in challenging environments, and managing large projects. Mr. Balestino's competencies include research and analysis of mixed methods, organizational assessment, and action planning; strategic planning and communication; results-based project management; performance improvement; monitoring and evaluation and learning; executive education; and training and facilitation. These skills have enabled high-level contributions in a wide range of international development sectors, including global health, economic growth, youth and education, gender and social inclusion, democracy and governance, rule of law and agriculture. In addition, Mr. Balestino has been successful in supporting a wide range of development partners, including governments of many countries, USAID, World Bank, the World Health Organization, the Inter-American Development Bank, the International Labour Organization, the Millennium Challenge Corporation, the United Nations, and various U.S. government and private agencies. He is fluent in Spanish and Portuguese, holds a master's degree in economic development from California State University; is a Certified Technologist of Performance (CPT); and is certified in Myers-Briggs Type Indicator.

Emanuel Andre Luis Damião, Local Logistics Coordinator, is the logistics consultant for the Angolan program. He currently holds the position of administrator of the company *MANAZANGUI Servicos e Consultoria*. He worked as logistics consultant for the Angola Eye Kutoloka Evaluation, and was administrator for Chemonics International Inc. in the implementation of the USAID Essential Health Services Project in Angola. He was also an administrator for Save the Children USA in Angola. Mr. Damião holds a bachelor's degree in business administration from the Brazilian Faculty AIEC, and has 18 years of experience working in administration with a main focus on logistics. He speaks Portuguese, English, and Spanish.

Ada Merolle, Malaria Specialist, is a tropical medicine specialist with 29 years of work experience, including 18 years in planning, implementing, monitoring, and evaluating health projects in Sub-Saharan Africa. Dr. Merolle has worked for various consulting firms, international nongovernmental organizations, and research institutions. In PASS II, she provided technical assistance to the Angolan

Ministry of Health (MOH) to strengthen and improve the ministry's capacities at the provincial level to plan, budget, organize, and manage integrated health services in accordance with the decentralization policy. As laboratory advisor for CDC/FELTP-Angola, she improved the curriculum of the MECL Laboratory course, and provided technical support to INLS and DNSP/MOH for the detection and response to outbreaks. As national director of MENTOR in Angola, in collaboration with the PNCM, CDC, and USAID, she implemented and monitored a PMI-funded malaria project, in the provinces of Huambo and Zaire. Dr. Merolle provided technical assistance to PNCM and MENTOR teams in improving and monitoring standard protocols for malaria diagnosis and treatment, training laboratory technicians, developing a tool and methodology for quality control of laboratory diagnosis, and by the laboratory. She has also provided technical assistance to the MOH at the national, provincial, and municipal levels to develop health worker training curricula, and to conduct clinical/operational research in Angola, the Democratic Republic of Congo, Kenya, Sierra Leone, Somalia, and South Sudan.

Estevão Mango Mbambi, Local Evaluator, is a monitoring and evaluation specialist. He recently held the position of monitoring and evaluation specialist with World Vision and monitoring and evaluation manager with Abt Associates. Mr. Mbambi also served as monitoring and evaluation officer with the International Potato Center and as technical supervisor of the International Organization for Migration in Angola. He holds an MBA from the University of Bradford, a degree in business administration from the University of Wales, and a diploma in education from the University of Zambia. He speaks six Angolan languages beside Portuguese and English.

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