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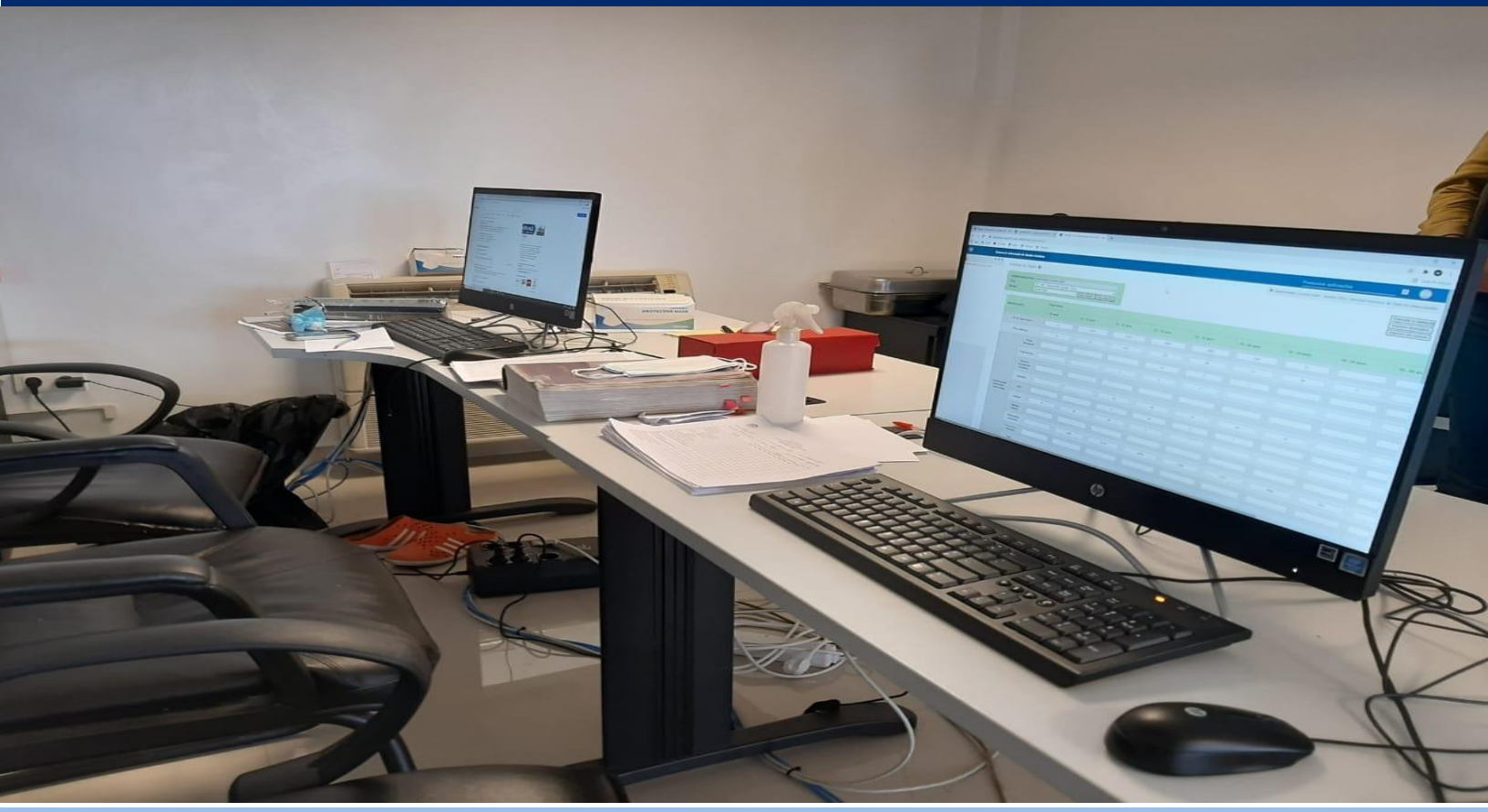

# ASSESSMENT OF THE HEALTH FOR ALL PROJECT

**October 2021**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by ME&A, Inc., its subcontractor Dexis Consulting Group, and the assessment team comprised of Dr. Elvira Beracochea, Dr. Xiomara Brown, Miguel da Cruz, Anna Pena, and Dr. Zephirin Mpambu.

# ASSESSMENT OF THE HEALTH FOR ALL PROJECT

## October 2021

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**Cover Photo**: DHIS2 room, Lucrecia Paim Maternity, Luanda. Credit: Zephirin Meya Mpambu, Miquel da Cruz and Anna Parellada Pena

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# ABSTRACT

The assessment of the Health for All (HFA) project in Angola was conducted by an independent assessment team contracted by the Global Health Evaluation and Learning Support (GH EvaLS) activity between December 2020 and August 2021. The purpose of the assessment was to review HFA's project design and its implementation and assess how it is supporting the project's goals.

The assessment was inductive, participatory, and cyclical in nature, and its goal was not to evaluate the project's performance, which was done in the 2018 HFA mid-term evaluation (MTE). The assessment focused on assessing how effective the project's design and implementation have been to date and made recommendations for the two-year extension. The methodology included a thorough desk review of relevant project and background documents and secondary data, key informant interviews (KIIs), an online survey of those key informants that could not be interviewed virtually or in-person, and an assessment of a sample of top- and low-performing HFA-supported health facilities. Representatives from the Angola Ministry of Health (MOH) and USAID/Angola accompanied the assessment team in the health facility visits. For each health facility, the assessment team completed a KII with the officer in charge and filled out a checklist based on the Service Availability and Readiness Assessment (SARA) Tool developed by USAID and the World Health Organization. Data collection was done in either English or Portuguese.

The findings indicate that the HFA project is performing in accordance with its design and has implemented the 2018 MTE recommendations. However, a number of design assumptions have not been fulfilled, which limited its impact. Malaria case management has improved but this is not consistent yet, and causal pathways do not permit a clear line of sight between project activities and outcomes. The HFA project has increased long lasting insecticidal net (LLIN) coverage through its participation in the last distribution campaign. The coverage of prevention of malaria in pregnancy (MiP), is about 30 percent, far from the desired 80 percent target. According to the MOH policy, MiP and routine LLIN distribution is limited to antenatal care (ANC) clinics, the immunization program, and maternity hospitals, and only an estimated 28 percent of HFA-supported facilities provide ANC. Notably, HFA's Scope of Work (SOW) did not require the project to cause a change in the above-mentioned policy. Family planning coverage is stagnant in the 42 facilities supported by the project. District Health Information Software2 (DHIS2) rollout is reported to be the most important achievement of the HFA project. The project is now focused on addressing data quality and use challenges. The HFA project has invested about 70 percent of its resources and effort in training, but handing over of this component to the MOH and the sustainability of this investment is uncertain at this time. Online training is reported to have increased access to affordable and possibly sustainable in-service capacity at the MOH; the platform has yet to be transferred to the MOH.

The assessment team presents a number of recommendations for the HFA project to sustain its impact in the two-year extension period and an overview of lessons learned.

# ACKNOWLEDGEMENTS

This assessment was conducted during the COVID-19 pandemic, which prevented members of our team from traveling to Angola and working closely with the HFA team, USAID/Angola, and the Angola MOH colleagues. We are truly grateful to Joana do Rosario, Arciolanda Gravata, and Sarah Labuda of the PMI/Angola team, without whose constant support this assessment would not have been possible. We acknowledge their continuous support to arrange online interviews and data collection in the provinces, and for their continuous feedback and involvement. We also thank the HFA team who generously provided valuable information, helped us ensure the findings were interpreted in the right setting, and responded to the local priorities during this challenging time.

We are very grateful and humbled by the participation of the MOH and National Malaria Control Program (NMCP) colleagues who took time out of their very busy schedules to meet online and inform this assessment. We especially want to thank the NMCP team and the NMCP Coordinator, Dr. José Franco Martins. His leadership, knowledge and experience have been essential to identify opportunities and propose viable options for continuing to improve health services and malaria outcomes in Angola.

The assessment team wants to particularly acknowledge and express our gratitude for the participation of the healthcare providers and local authorities in the 20 facilities and five provinces visited. They generously gave their time and energy during this uniquely challenging time to share their views and experience. We are truly indebted to them all.

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# ACRONYMS

| Acronym | Description |
|---|---|
| ACT | Artemisinin-based Combination Therapy |
| ADECOS | Agentes de Desenvolvimento Comunitário e Sanitário (Community Health Workers) |
| ADHS | Angola Demographic and Health Survey |
| ANC | Antenatal Care |
| AQ | Assessment Questions |
| CDC | Centers for Disease Control and Prevention |
| CDCS | Country Development Cooperation Strategy |
| CM | Case Management |
| CHW | Community Health Worker |
| COVID-19 | Coronavirus Disease 2019 |
| CSO | Civil Society Organization |
| DHIS2 | District Health Information Software2 |
| DHS | Demographic and Health Survey |
| DQA | Data Quality Assessment |
| eLMIS | electronic Logistics Management Information System |
| EPI | Expanded Program on Immunization |
| FCR | Findings, Conclusions, and Recommendations |
| FGD | Focus Group Discussion |
| FP | Family Planning |
| FY | Fiscal Year |
| GF | The Global Fund to Fight AIDS, Tuberculosis, and Malaria |
| GH EvaLS | Global Health Evaluation and Learning Support Activity |
| GH | Global Health |
| GHSC-PSM | Global Health Supply Chain Program-Procurement and Supply Management |
| GoA | Government of Angola |
| HF | Health Facility |
| HFA | Health for All |
| HIS | Health Information System |
| HNQIS | Health Network Quality Information System |
| HRH | Human Resources for Health |
| HSS | Health System Strengthening |
| HW | Health Worker |
| iCCM | Integrated Community Case Management |
| IMCI | Integrated Management of Childhood Illness |
| IP | Implementing Partner |
| IPT | Intermittent Preventive Treatment |
| IPTp | intermittent preventive treatment in pregnancy |
| IR | Intermediate Result |
| IRS | Indoor Residual Spraying |
| ITN | Insecticide Treated Net |
| JIRO | Juventude Informada, Responsavel e Organizada (Informed, Responsible and Organized Youth: a youth non-governmental organization) |
| KI | Key Informant |
| KII | Key Informant Interview |
| LLIN | Long Lasting Insecticidal Net |

| Acronym | Description |
|---|---|
| LOE | Level of Effort |
| LOP | Life of the Project |
| M&E | Monitoring and Evaluation |
| MASFAMU | Ministry of Social Action, Family and Women's Promotion |
| MAT | Ministry of Territorial Administration |
| MCM | Malaria Case Management |
| ME&A | formerly Mendez England & Associates |
| MEL | Monitoring, Evaluation, and Learning |
| MiP | Malaria in Pregnancy |
| MIS | Management Information System |
| MOH | Ministry of Health |
| MTE | Mid-term Evaluation |
| NMCP | National Malaria Control Program |
| PBO | Piperonyl Butoxide |
| PEPFAR | The President's Emergency Plan for AIDS Relief |
| PHC | Primary Health Care |
| PMI | President's Malaria Initiative |
| PNDS | Plano Nacional de Desenvolvimento Sanitariá (The National Plan for Health Development) |
| PSI | Population Services International |
| RDCS | Regional Development and Cooperation Strategy |
| RDT | Rapid diagnostic test |
| RF | Results Framework |
| RH | Reproductive Health |
| RMA | Rede Mulher Angola |
| SADC | Southern African Development Community |
| SARA | Service Availability and Readiness Assessment Tool |
| SOP | Standard Operating Procedure |
| SOW | Scope of Work |
| SP | Sulfadoxine + Pyrimethamine |
| TB | Tuberculosis |
| TDM | Technical Directive Memo |
| TL | Team Leader |
| TOC | Theory of Change |
| US | United States |
| USAID | United States Agency for International Development |
| USG | United States Government |
| WB | World Bank |
| WHO | World Health Organization |

# EXECUTIVE SUMMARY

## INTRODUCTION

The assessment of the Health for All (HFA) project in Angola was conducted by an independent assessment team contracted by the Global Health Evaluation and Learning Support Activity (GH EvaLS) between December 2020 and August 2021. This assessment took place during the COVID-19 pandemic and although it did not assess the impact of COVID-19, it took into consideration its effect on the project's implementation and on Angola.

## PROJECT BACKGROUND

Moving beyond "partnerships as usual", HFA was designed to **directly engage** the Ministry of Health (MOH), civil society, private sector, and beneficiary partners from day one to **co-diagnose** fundamental barriers, **co-design** approaches to strengthen the country's health system, and **co-implement** proven interventions. Thus, it was envisioned that HFA would **build ownership and skills** to transform its interventions into **measurable and sustainable outcomes beyond the program's end**. These partnerships were to lead **catalytic improvements** in program design and implementation to ensure sustainable achievement of the following 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 4**. Strengthened, expanded, and integrated reproductive health and family planning (FP/RH) services at provincial and municipal levels
- **Result 5**. Capacity built in District Health Information Software 2 (DHIS2) in 60 municipalities, in Zaire, Uíge, Cuanza Norte, Malanje, Lunda Norte, and Lunda Sul

## ASSESSMENT PURPOSE, QUESTIONS AND METHODS

The purpose of the assessment was to review HFA's project design and its implementation and assess how it is supporting the project's goals. It was designed to answer four main assessment questions (AQs), as shown in the box below.

**DESIGN**

**AQ1. To what extent has the HFA project <u>design</u> been *effective in achieving the desired results*?**

AQ1.a To what extent are the underlying assumptions still valid?

i. MOH timely approves HFA activities: How has HFA mitigated delays, and facilitated and empowered the MOH to coordinate and manage its activities?
ii. Medicines and contraceptives are available: How has the supply chain worked over the LOP?
iii. Health facilities have required personnel and supplies: What percentage of the project-supported facilities meet the required standards of personnel?

AQ1.b Are the current causal pathways producing the required outcomes? (Causal pathways were assessed by each of the results listed above: R1, R2, R4 and R5)

**IMPLEMENTATION**

**AQ2. To what extent is the project's implementation plan effective in achieving the desired results?**

AQ2.a To what extent is the HFA project managed effectively (internally and externally; nationally and provincially)?

AQ2.b What are the enabling factors critical to success and the barriers that impede implementation?

AQ2.c What are the key strategic, programmatic, technical, and managerial features of the project that should be taken into account when designing and implementing the next project in Angola?

**OPPORTUNITIES**

**AQ3. What are the current opportunities faced by the project?**

**SUSTAINABILITY**

**AQ4. What mechanisms are in place by USAID and/or IPs to ensure the sustainability of the project's achievements?**

AQ4.a What has HFA done to ensure the sustainability of its interventions and achievements?

AQ4.b What have other IPs done that can be sustained?

AQ4.c How much has the Angolan health information, LLIN, and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services?

AQ4.d How and how much has capacity building been institutionalized at national and provincial levels?

The assessment team implemented a participatory and cyclical methodology, working closely with the HFA team, USAID/Angola, the MOH, and other partners. Each cycle informed the next phase of the inductive process. The assessment team **first** conducted a thorough desk review of relevant project and background documents; **secondly,** completed key informant interviews (KIIs) with representatives from a number of stakeholders, including USAID/Angola, senior members of the HFA team, and MOH authorities; and reviewed secondary data; and **thirdly,** conducted an online survey of those key informants that could not be interviewed virtually or in-person, and assessed a sample of top- and low-performing HFA-supported health facilities[1].

The assessment took place during the COVID-19 pandemic and travel restrictions prevented the Team Lead and the Senior Malaria Advisor from travelling to Angola and participating in the field visits. Despite this limitation, thanks to the support of USAID/Angola and the contribution of the local assessment team members, the team gathered all the relevant information to respond to the AQs.

[1] For each visited health facility, the assessment team completed an in-depth interview with the officer in charge and filled out a checklist based on the Service Availability and Readiness Assessment (SARA) Tool developed by USAID and the World Health Organization.

## FINDINGS

**AQ1. To what extent has the HFA project design been effective in achieving the desired results?** The design of the HFA project was effective in improving LLIN distribution and increasing access to malaria diagnosis and treatment. It was also highly effective in the DHIS2 rollout. The HFA project design was not as effective in improving prevention of malaria in pregnancy (MiP), mostly due to the limited availability of antenatal service delivery points in the country. The FP/RH component was designed to include FP but not RH services, and to be implemented in only 22 facilities in Luanda and 20 in Huambo provinces. The design did not include expansion of integrated FP/RH services. A number of design assumptions with respect to the involvement of the MOH and availability of human resources and commodities were reported to not have been fulfilled and may have limited the project's impact. The design did not include the creation of mechanisms for enabling co-diagnosing, co-creating and co-implementing, and the project was reported to not have engaged partnerships in this manner.

**AQ2. To what extent is the project's plan of implementation effective in achieving the desired results?** HFA is being implemented in accordance with the plans approved by USAID/Angola and the recommendations from the mid-term evaluation (MTE) completed in 2018. The number of partnerships created by HFA was limited and mainly included the consortium partners and other development partners such as the Global Fund (GF) grantee and the telecommunications company, Unitel. HFA is implemented in collaboration with the MOH at the national, provincial, municipal, and facility levels with various degrees of involvement, through the National Malaria Coordination Program (NMCP). Coordination with the NMCP was reported to have improved after the MTE.

HFA has increased LLIN coverage **(Result 1)** in all the PMI provinces through its participation on the last distribution campaign. Malaria case management **(Result 2)** has improved, but performance indicators are not consistent across all the HFA-supported facilities. The causal pathways include in person and online training and supervision and management support. Online training just started during the COVID-19 pandemic, and it is well-accepted and likely to get expanded. The coverage of prevention of MiP is about 30 percent, far from the desired 80 percent target. According to the MOH policy, MiP and routine LLIN distribution is limited to antenatal care (ANC) clinics, the immunization program, and maternity hospitals, and only an estimated 28 percent of HFA-supported facilities provide ANC. Reportedly, HFA's SOW did not require the project to cause a change in the above-mentioned policy.

FP/RH coverage **(Result 4)** is stagnant in the 42 facilities supported by the project. The HFA-supported facilities constitute a small number of all facilities in the country and are insufficient to achieve the FP objectives of increasing the contraceptive prevalence rate and expanding the program.

The DHIS2 rollout **(Result 5)** is reported to be the most important achievement of the HFA project. HFA is now focused on addressing DHIS2 data quality and data use challenges. Improving data quality is important because many facilities still report treating more than 100 percent of diagnosed patients.

**AQ3. What are the current opportunities faced by the project?** The assessment team identified a number of opportunities, the main three are shown below:

- **Strengthening MOH ownership and sustainability by assisting to add malaria and FP service guidelines to the national integrated Primary Health Care (PHC) service delivery model.** The MOH has created an integrated PHC Division and is moving towards an integrated PHC service delivery approach. By assisting the MOH to integrate malaria and FP services, HFA will ensure the sustainability of the USAID's malaria investments.
- **Improving PHC facility organization and management in low-performing municipalities.** HFA has strengthened a number of facilities, but there are still low- performing facilities that need to be improved. Top-performing facilities are important assets to serve as models for the low-performing ones; HFA can achieve this by twining top- and low-performing facilities, so that the former can help the latter.

- **Improving timely malaria service delivery through community-based services.** During this assessment, USAID/Angola reported that HFA will receive a cost-extension until July 2023 and will manage a number of the *Agentes de Desenvolvimento Comunitário* e *Sanitário* (ADECOS; Community Health Workers) in PMI-focus provinces**.** This represents an opportunity for PMI to strategically strengthen malaria services at "the last mile" and expand community health to reach vulnerable populations in hard-to-reach communities.

**AQ4. What mechanisms are in place by USAID and/or implementing partners (IPs) to ensure the sustainability of the project's achievements?** The HFA project has developed a number of mechanisms that need to be sustained. The three main ones are highlighted below:

- **DHIS2 Mechanism**. The DHIS2 is the main HFA intervention that will ensure sustainability of other interventions because it empowers managers to make informed decisions. The MOH at the national level has demonstrated that it can manage DHIS2 and data use to address priority problems. During the two-year extension, HFA should strengthen the data usage and quality improvement components of the MOH at the provincial and municipal levels.
- **Training Mechanism.** The HFA-trained trainers, the training tools, manuals and Kasai, and the online platform are all important assets to be transferred to the MOH. These assets will allow the MOH to sustain in-service training and the country's academic institutions to update their malaria and FP/RH pre-service curricula. Although institutionalization of in-service training was not part of the HFA project design, it can help sustain the important investment made in training by the project.
- **Supervision Mechanism**. HFA has successfully implemented supportive supervision. The achievements in supportive supervision along with those in online and in-person training need to be sustained. HFA should hand over the open source options of these tools to the MOH to ensure sustainability.

## CONCLUSIONS

The assessment team concluded the HFA project has been implemented in accordance with the MTE recommendations. However, there are a number of design and systemic weaknesses. For example, the design did not include sustainability activities from the start. The project developed a sustainability table only in its last year, and still does not have a detailed sustainability plan. In addition, there are a number of design assumptions that were not fulfilled and could not be mitigated, mostly due to the impact of COVID-19 in the health sector and the country's financial crisis due to the drop in oil prices and revenue. There are reports of medicines stockouts, staff shortages, high mortality among frontline workers due to the lack of protective equipment, and a large number of unfilled vacancies due to the lack of funding for recruitment. These vacancies have limited the capacity of the HFA-supported facilities to expand coverage.

## RECOMMENDATIONS FOR THE HFA PROJECT OR FUTURE PROJECTS

The assessment team has designed the following recommendations for the HFA project or future projects to successfully complete the two-year extension (by July 2023):

1. HFA should consider assisting and strengthening the capacity of the NMCP to coordinate, implement and monitor the next LLIN campaign.
2. Future projects should consider working with provincial and municipal authorities to ensure that ADECOS assist in promoting the proper use of the LLINs distributed in the campaign along with scaling up the work that they are currently doing.
3. Future projects should consider the possibility of assisting the MOH to develop a DHIS2 digital expansion plan to include health facilities supported by PMI.
4. HFA should consider sharing and transferring its training experience and tools to a number of local academic institutions and create an in-service training team of trainers in the MOH.
5. HFA should consider transferring ownership of the Kasai online training platform, training toolkits and tools to the MOH in-service training team. They will oversee the capacity development of Angolan

health workforce with the help of local academic institutions and a critical mass of Angolan HFA-trained malaria experts.

6. HFA should consider transferring the new online FP training program to the new PHC division and discuss with stakeholders the possibility of supporting the Menstrual Hygiene Program to increase demand for FP services in its 42 supported facilities. HFA should also assist to select Angola's FP2030 targets.
7. HFA should transfer the HNQIS supervision tool to the national, provincial, and municipal MOH teams to monitor the performance of each facility.

# 1. INTRODUCTION

The assessment of the Health for All (HFA) project in Angola was conducted by an independent assessment team recruited by the Global Health Evaluation and Learning Support Activity (GH EvaLS) between December 2020 and August 2021. These assessment findings, conclusions and recommendations will be used by the HFA team, the Ministry of Health (MOH), and USAID/Angola.

The goal of this assessment was not to evaluate the project's performance, which was done in the 2018 HFA mid-term evaluation (MTE). The assessment focused on assessing the effectiveness of HFA's design and implementation and the degree of sustainability it has achieved and it is likely to achieve in the Life of the Project (LOP), and on identifying opportunities for improving the HFA project[2].

## 1.1 ASSESSMENT PURPOSE

The purpose of the assessment was twofold:

1. To have an external review of the project design and its implementation to see how it supports the project's goals.
2. To identify and recommend adaptation measures that can be used to enhance the design, management, implementation, applicability, sustainability, and accountability of the HFA project.

The US President's Malaria Initiative (PMI) provides the bulk of the funding for HFA. Therefore, the assessment team gathered evidence and prepared recommendations for USAID/Angola and the PMI team, for improving the malaria program in Angola.

During the HFA's LOP, USAID/Angola became part of the Southern Africa Regional Office and joined a combined regional strategy designed to help countries advance their journey towards a successful exit strategy, and thus, the eventual end of the need for foreign assistance. Therefore, the assessment team looked at how the HFA project is working as a building block in the journey towards sustainable malaria and FP services.

The COVID-19 pandemic has had health and economic impacts on the Angolan population. Therefore, the assessment gave important considerations to mitigating this impact and sustaining the gains achieved by the HFA project.

## 1.2 ASSESSMENT QUESTIONS

The assessment was expected to answer a number of assessment questions (AQs) and sub-questions (sub-AQs) (see Box 1). These AQs and sub-AQs guided the assessment methodology and the design of the data collection tools.

[2] See Scope of Work (SOW) in Annex 1.

**Box 1. Assessment Questions and Sub-Questions**

**DESIGN**

**AQ1. To what extent has the HFA project design been *effective in achieving the desired results*?**

AQ1.a To what extent are the underlying assumptions still valid?

i. MOH timely approves HFA activities: How has HFA mitigated delays, and facilitated and empowered the MOH to coordinate and manage its activities?
ii. Medicines and contraceptives are available: How has the supply chain worked over the LOP?
iii. Health facilities have required personnel and supplies: What percentage of the project-supported facilities meet the required standards of personnel?

AQ1.b Are the current causal pathways producing the required outcomes? (Causal pathways were assessed by each of the results listed above: R1, R2, R4 and R5)

**IMPLEMENTATION**

**AQ2. To what extent is the project's implementation plan effective in achieving the desired results?**

AQ2.a To what extent is the HFA project managed effectively (internally and externally; nationally and provincially)?

AQ2.b What are the enabling factors critical to success and the barriers that impede implementation?

AQ2.c What are the key strategic, programmatic, technical, and managerial features of the project that should be taken into account when designing and implementing the next project in Angola?

**OPPORTUNITIES**

**AQ3. What are the current opportunities faced by the project?**

**SUSTAINABILITY**

**AQ4. What mechanisms are in place by USAID and/or IPs to ensure the sustainability of the project's achievements?**

AQ4.a What has HFA done to ensure the sustainability of its interventions and achievements?

AQ4.b What have other IPs done that can be sustained?

AQ4.c How much has the Angolan health information, LLIN, and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services?

AQ4.d How and how much has capacity building been institutionalized at national and provincial levels?

# 2. BACKGROUND

The HFA project started in January 2017 and was to end in January 2022. It has recently been extended through July 2023. The HFA project was designed to move beyond "partnership as usual" and to directly engage the 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. This approach was designed to help build ownership and skills to transform HFA interventions into measurable and sustainable outcomes beyond the program's end. These partnerships were to lead **catalytic improvements** in the program design and implementation in order to ensure sustainable achievement of the project's expected results, contributing to three of the four USAID/Angola Country Development Cooperation Strategy (CDCS) Intermediate Results (IRs):

- Build sustainable platforms
- Modernize public administration
- Strengthen public financial management

The above catalytic improvements were to improve the health status and well-being of the Angolan population and strengthen responsiveness to citizens' needs. HFA's expected results[3] relate to specific funding sources and partner's participation:

**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 4**: Strengthened, expanded, and integrated reproductive health (RH)/family planning (FP) services at provincial, and municipal levels

**Result 5**: Capacity building in 60 District Health Information Software 2 (DHIS2) municipalities, located in Zaire, Uíge, Cuanza Norte, Malanje, Lunda Norte, and Lunda Sul

The SOW for this assessment (see Annex 1) listed a number of challenges that the HFA project was to address from the start for the assessment team to consider:

- The 2015-16 Angola Demographic and Health Survey (ADHS) reported that only 29 percent of households had at least one insecticide treated net (ITN) and 20 percent of the population had access to one.
- The National Plan for Health Development (*Plano Nacional de Desenvolvimento Sanitariá*; PNDS) 2012-2015 reported that only 45 percent of the population had access to a public health facility (HF).
- The 2015-16 ADHS reported that only 19 percent of pregnant women had received three doses of intermittent preventive treatment in pregnancy (IPTp).
- The total fertility rate in Angola is six children per woman, and the contraceptive prevalence rate is 17.7 percent for all methods and 12.8 percent for modern methods, according to 2015-16 ADHS.

HFA is a consortium led by Population Services International (PSI), an international leader that is "helping to build sustainable solutions for the world's most serious health issues" and "creating a healthcare experience that treats beneficiaries like consumers—starting with putting more care and control directly

[3] Result 3 related to HIV/AIDS was deleted after the MTE and was not part of this assessment.

in consumers' hands."[4] PSI's expertise is particularly recognized in the FP/RH area. The other consortium members include Rede Mulher Angola (a local civil society organization), the MENTOR Initiative (improving malaria case management), and APPY (a private sector technology company in charge of developing the project's e-learning platform).

It is important to consider that Angola has been severely affected by the COVID-19 pandemic. The drop in oil prices reduced government's revenue and created a financial crisis that forced the GoA to borrow from the World Bank to cover its national budget and procure required medicines and medical supplies. The impact of the pandemic is likely to be felt for years to come.

[4] www.psi.org

# 3. ASSESSMENT METHODS AND LIMITATIONS

## 3.1 ASSESSMENT METHODOLOGY

The assessment team was composed of five members: a Team Lead (TL) (Dr. Elvira Beracochea), Senior Malaria Specialist (Dr. Xiomara Brown), Local Malaria Specialist (Dr. Zepherin Mpambu), a Local FP/RH Specialist (Anna Parellada Pena), and a Local Evaluation Specialist (Miguel da Cruz). The team used a multi-method design, **inductive and cyclical in nature** to assess the HFA project's design, implementation and degree of sustainability achieved so far. The project's performance was not assessed because it had already been evaluated in the HFA's MTE conducted in 2018. The assessment methodology was designed to look for lessons learned and how to best sustain the project's achievements to date and expand coverage and sustainability of the malaria and FP/RH programs, and the health information system (HIS).

The inductive approach used a "bottom-up" methodology to identify the current enabling factors, barriers, and opportunities starting at the community, health facility, and municipality levels moving up to the provincial and national levels. This allowed the assessment team to identify what works from the perspective of participants at each level, as well as understand factors that would help achieve sustainable results according to the participants' beliefs and perceptions.

The team worked closely with USAID/Angola and a selected number of partners at the MOH to implement the inductive assessment approach in cycles—so that each cycle informed the next phase of the inductive process. In the **first cycle**, the assessment team conducted a thorough desk review of project and background documents provided by USAID/Angola, the HFA team, and available online. In the **second cycle**, the team gathered and reviewed secondary data, which informed the assessment team of HFA's internal management system and the external management of its activities. In this cycle, the assessment team also conducted key informant interviews (KIIs) with representatives from a number of stakeholders. In the **third cycle**, the assessment team conducted an online survey of those key informants that could not be interviewed virtually or in-person, and assessed a sample of top- and low-performing HFA-supported health facilities. For each visited health facility, the assessment team completed a KII with the officer in charge and filled out a checklist based on the Service Availability and Readiness Assessment (SARA) Tool developed by USAID and the World Health Organization (WHO). The objective of the second and third cycles was to gather first-hand evidence of effectiveness of the current design and assess and contrast the enabling factors and barriers to effective quality health care delivery.

This participatory approach allowed the assessment team to involve USAID/Angola and MOH authorities in the cyclical inductive process of this assessment. As an "honest broker," the team remained objective and unbiased while factoring the participation and experience of the USAID/Angola team.

## 3.2 DATA SOURCES

The assessment team used several data sources, including:

- Project and other relevant documents and secondary quantitative data
- KIIs (54 key informants/KIs)
- An online survey (46 respondents)
- An assessment of 20 HFA-supported health facilities (KIIs and Checklist).

### 3.2.1 Desk Document Review and Secondary Data

The assessment team reviewed 59 documents, including national development and MOH policies and reports, HFA project documents (e.g., the cooperative agreement, workplans, annual and quarterly reports, training manuals, success stories, M&E reports), and other relevant documents provided by various stakeholders (see Annex 3). As part of this process, the assessment team sent a document inventory form to the HFA team to gather all the tools, manuals, and documents developed by the project to date. The team identified additional relevant documents through the website of the prime and sub-grantees, and requested other documents when additional information related to the use of the project tools was necessary for the assessment. The team used a document extraction form to extrapolate the most important information in each document in relation to the AQs.

The assessment team also reviewed and analyzed a number of secondary data, including HFA's M&E data provided by the HFA team and data gathered through the Health Network Quality Information System (HNQIS), the project's supervision tool. They included health facility performance data, such as percentages of patients diagnosed and treated and supervision scores, which helped the assessment team group facilities into top- and low-performing (see Section 3.2.4 below).

### 3.2.2 Key Informant Interviews

The assessment team interviewed 54 KIs from various stakeholder groups (Table 1). The KIIs started with the USAID/Angola team and PMI staff involved in the HFA program, with representatives from academia and the private sector, and international development partners such as WHO, Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and other relevant organizations familiar with the project. Next, the assessment team interviewed the senior team at HFA and representatives of the prime recipient, sub-grantees, and other implementing partners (IPs) of USAID's projects and activities. Finally, the assessment team conducted KIIs with the GoA, including authorities at MOH, the National Malaria Control Program (NMCP), and provincial, municipal, and health facility staff. The last phase of KIIs took additional time to arrange, given the increased workload of the GoA due to the COVID-19 pandemic. A full list of the KIs is shown in Annex 3.

The KIIs gathered relevant information that helped answer the AQs and sub-AQs. The assessment team developed three KII guides in English and Portuguese: (1) a guide for the USAID/Angola team; (2) a guide for the MOH and other government stakeholders, United Nations (UN) agencies, WHO, the private sector, and other relevant partners; and (3) a KII guide for the HFA project team. The KII guides included a number of core questions for all stakeholders and additional questions tailored to each group (see Annex 2).

The assessment team conducted most KIIs virtually, via Zoom or by phone. A few KIIs were conducted in-person, including those with the Ministry of Social Action, Family and Women's Promotion (MASFAMU) and provinces' health staff, when it was determined safe to do so. In those cases, the assessment team followed the COVID-19 safety procedures. The KIIs were conducted in English or Portuguese.

**Table 1: Number of Key Informants by Stakeholder Group and Gender Level**

| Stakeholder | Male | Female | Total |
|---|---|---|---|
| USAID/PMI | 0 | 5 | 5 |
| MOH | 4 | 4 | |
| Other GoA institutions | 1 | 1 | 2 |
| HFA | 12 | 6 | 18 |
| Provincial/Municipal/Health Facility Staff | 7 | 1 | 8 |
| Other Ips | 2 | 1 | 3 |
| Other Development Partners | 5 | 5 | 10 |
| **Total** | **31** | **23** | **54** |

### 3.2.3 Online Survey

The assessment team sent an online survey to a number of informants who could not be interviewed virtually or in-person. The team used SurveyMonkey to administer the survey and analyze the data. The online survey questionnaire was developed based on the desk review and the KII findings. Similar to the KII guides, the survey questionnaire included a set of core questions and a number of stakeholder-specific questions about the respondent's role and experience working with the HFA project (see Annex 2). The questionnaire was administered in English or Portuguese. A total of 46 respondents replied, of which 21 were HFA team members (see Annex 3).

### 3.2.4 Health Facility Assessment (KIIs and Checklist)

The assessment team selected a purposive sample of 20 HFA-supported health facilities to collect information relevant to the assessment and contrast top- and low-performing facilities. For each selected health facility, the team completed a KII with the officer in charge (see Table 1) and filled out a checklist based on SARA, a tool designed by USAID and WHO to assess service availability and readiness that has become the standard for assessing health system gaps and opportunities for strengthening it. The checklist assessed the capacity of the selected facilities in terms of their human resources, diagnostic services, medicines, contraceptives, supplies, and recordkeeping. The assessment team took photographs of the pharmacy shelves, laboratory or testing areas, and medical records and consultation areas in order to assess the physical readiness of facility to deliver quality FP/RH, antenatal care (ANC), and malaria services, manage the pharmacy according to guidelines (well-organized shelves, presence of stock cards, etc.), correctly use medical records, and maintain privacy in the setting of FP/RH consultation areas. The photographs did not include any patients.

Due to the pandemic, in-person interviews or focus groups with patients or healthcare providers were not conducted. The assessment team conducted phone interviews of the person in charge of the facility in preparation for the facility visits.

## 3.3 SAMPLE SELECTION

For the KIIs, the assessment team prepared a list of all relevant stakeholder groups and reviewed several aspects related to their level of operation, involvement, and role in the HFA project and beyond. This included the level that the stakeholders operate, the opportunities and assets they offer, what matters to them, and how they can be better engaged (Table 2). For each stakeholder group, the assessment team selected a number of KIs; the final list was approved by USAID/Angola.

**Table 2: HFA Assessment Stakeholder Analysis Matrix**

| Stakeholder | At what level does the stakeholder function? | What opportunity does this stakeholder provide? | What matters to this stakeholder? | What assets can this stakeholder bring to the project? | How can this stakeholder be better engaged? |
|---|---|---|---|---|---|
| UNICEF | Central, community | Integrated Community Case Management (iCCM) Evidence | Data to advocate for ADECOS; continue to work on the interoperability of the community health data | ICCM: technical assistance | Support coordination platform through PHC for donors to engage on community health priorities |
| WHO | Central, provincial, community, facility | Coordination mechanism | Human Resources for Health (HRH) capacity building | WHO regional technical support | Advocacy to enhance country ownership |
| UNITEL | ALL | Community digital reporting; and payment process | Infrastructure, coordination | Free SMS; communication in rural remote areas | ADECOS; malaria case management |
| E-8 Elimination Southern African Development Community (SADC) | All | Malaria elimination; community capacity building | Malaria case management; entomological monitoring and surveillance | Technical expertise, HRH, Finances | National strategic plan; stakeholder coordination mechanism |
| Procurement Supply Management | Central, provincial | Distribution, warehousing at the last mile | Country ownership | eLIMS | Stakeholder coordination |
| Global Fund | Central, Provincial | Shift to Comprehensive MCM at the last mile | MOH Accountability | Partnership with PMI; Leverage financial investments | MOH and stakeholder coordination |
| Japan International Cooperation Agency (JICA) | Provincial | MCH; community collaboration | MCH handouts for all pregnant women | ADECOS training and supervision | Donor coordination mechanism |
| People's Development Organization (Ajuda de Desenvolvimento de Povo para Povo (ADPP) | Community | Cross border community health | Community case management | ADECOS | Community coordinating mechanism |

For the health facility component, the assessment team selected a purposive sample based on performance and geographic access. The team selected at least one top- and one low-performing municipality in each of the five HFA-focus provinces: Cuanza Norte, Malanje, and Zaire (three provinces where PSI and Mentor work to achieve Malaria Results 1 and 2); and Luanda and Huambo (the only two provinces where HFA implements FP/RH activities to achieve Result 4). In each municipality, the assessment team selected two top- and two low-performing facilities based on HFA M&E and HNQIS data.

USAID/Angola, MOH authorities, and the HFA team were involved in the sample selection and informed the process. USAID/Angola approved the selection criteria and the final list of selected facilities.

The health facility sample selection steps are summarized below:

1. Selection of five HFA-supported provinces: Cuanza Norte, Malanje, Zaire (malaria), Luanda and Huambo (FP/RH).
2. Selection of at least one municipality with high malaria prevalence in each of the selected provinces for a total of five municipalities.
3. For the malaria program, a total of 12 facilities were selected: six top performers and six low performers. They were HFA-designated, high priority facilities with the highest malaria cases. For the FP/RH program: eight facilities were selected, four top performers and four low performers. The assessment team considered geographic accessibility as one of the selection criteria, in order to complete the data collection within the timeline.
4. All facilities that provided ANC services were used to assess malaria in pregnancy (MiP).
5. All 20 facilities had HFA-trained staff who received formative supervision.

During the data collection, the assessment team had to make some adjustments in the health facility sample. For example, in Cuimba and Mbanza Congo municipalities in Zaire province, separate ANC facilities visited as the municipal hospitals did not provide ANC services. In another province, the facility director had passed away and the selected facility was closed in mourning.

Table 3 shows the health facilities selected to assess the design and implementation of the HFA malaria program.

**Table 3: Health Facilities (N=12) Selected to Assess Performance of the Malaria Program***

| Province | Municipality | Health Facility | Confirmed TX-ACT: 2020 | HNQIS: 2019-2021 |
|---|---|---|---|---|
| Cuanza Norte | Cazengo | **CS Kipata** | 100% | **70%** |
| Cuanza Norte | Cazengo | **CS Sassa** | 100% | **74%** |
| Cuanza Norte | Cazengo | **HP Kwanza Norte** | 100% | 82% |
| Cuanza Norte | Golungo Alto | **HM Golungo Alto** | 100% | **77%** |
| Malange | Caculama | **CS Muquixe** | 96% | **71%** |
| Malange | Caculama | **HM Caculama** | 84% | **78%** |
| Malange | Cambundi Catembo | **HM Cambundi Catembo** | 88% | 88% |
| Malange | Malange | **HM Malange** | **130%** | 96% |
| Zaire | Kuimba | **HM Cuimba** | **51%** | 92% |
| Zaire | Kuimba | **CS Luvaka** | **111%** | 89% |
| Zaire | Mbanza Congo | **HM Mbanza Congo** | **102%** | 82% |
| Zaire | Mbanza Congo | **CS Kianganga** | **48%** | **77%** |

**Note: In bold are low-performing HFs: <80% or incorrect data (above 100%)*

Table 4 shows the breakdown of all 20 selected facilities (12 for malaria and eight for FP/RH) by province and type (hospital or health center).[5]

**Table 4: Health Facilities Selected for Observation in HFA-Supported Provinces (N=20), by Type**

| Province | Cuanza Norte | Malanje | Zaire | Luanda | Huambo |
|---|---|---|---|---|---|
| Hospitals | 2 | 2 | 2 | 1 | 2 |
| Health centers | 2 | 2 | 2 | 3 | 2 |
| **Total** | **4** | **4** | **4** | **4** | **4** |

## 3.4 DATA MANAGEMENT AND ANALYSIS

The assessment team reviewed the relevant documents and secondary data, and analyzed the qualitative data to identify the main themes that emerged under each assessment domain: (1) Design, (2) Implementation, (3) Opportunities, and (4) Sustainability. The team conducted a thematic content analysis of the background documents and KII notes, organized in a table by AQ. The key themes included: the design assumptions, the degree to which the current implementation pathways have been effective to meet the project objectives and the needs of the population, how well co-implementation had worked, and how the **phased transition plan** had advanced sustainability, despite the COVID-19 pandemic. Data quality, a lack of FP focus on youth, and coordination issues also emerged as recurrent themes.

Next, these key themes were organized by stakeholder group and were triangulated with data from DHIS2 and facility assessment (KIIs and Checklist). Data from facility assessment were analyzed to assess top- and low- performing health facility profiles and to identify strengths, weaknesses, opportunities and threat patterns.

The main emerging themes and unique perspectives were summarized into a *findings, conclusions, and recommendations (FCR) matrix*. The FCR matrix helped understand the causal pathways included in the design of the HFA project and assess the implementation of project results and their sustainability. The FCR matrix provided the assessment team with a **line of sight** of the assessment's findings, conclusions, and recommendations. When appropriate or necessary, **illustrative quotes for each theme** have been included in this report. When reporting the findings or quotes, the identity of the assessment participants has not been disclosed, only the stakeholder group they represented.

The assessment team gave a presentation of the preliminary findings to the USAID/Angola team and shared the FCR summary table with them in order to validate the assessment findings, conclusions and recommendations.

## 3.5 ETHICAL CONSIDERATIONS

The assessment team ensured privacy and confidentiality in all data collection. The assessment team started all KIIs with an informed consent process and written statement in English and Portuguese that contained:[6]

- Introduction of interviewer
- Purpose of the assessment
- Purpose of interview

[5] Annex 5 presents the list of facilities visited and the final schedule of data collection.

[6] KIIs were developed in alignment with the Common Federal Policy for Protection of Human Subjects in Research (the Common Rule) adopted by USAID.

- Statement that all information provided is confidential and information provided would not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion and right to stop interview at any time
- Request for consent to record the interview prior to initiating data collection (i.e., interview)/discussion

The online survey questionnaire also included an informed consent statement as part of the introduction (see Annex 2). The assessment team did not interview any project beneficiaries due to the COVID-19 pandemic. Further, no one under the age of 18 years was interviewed or participated in the online survey.

Data were analyzed without any identifying information. The citations in this report do not include any names of the person who was quoted; the confidentiality of KIs is maintained by pooling and citing all input by stakeholder groups and anonymizing any quotations. To protect confidentiality, the interview notes, extraction forms, and recordings are saved in a safe folder within GH EvaLS and will be deidentified when the report is completed.

## 3.6 LIMITATIONS

This assessment took place during the COVID-19 pandemic, which placed limitations on travel and in-person data collection. Two members of the assessment team were in the United States and three in Angola, and they held regular online meetings. The data were collected virtually and in-person, with the local team members conducting the in-person data collection. Hence, a main concern was the safety of the assessment team members and assessment participants, including health staff and patients in the facilities. The assessment team followed strict guidelines in regard to COVID-19 testing, personal protective equipment, and social distancing.

For the qualitative component of the assessment, it was essential to gather the views of all stakeholders. Although most KIIs were conducted between February and March 2021, the interviews with MOH authorities did not take place until May 2021, due to their busy schedules and limited availability caused by COVID-19. Additionally, while a viable alternative, virtual KIIs can be very formal and hard to probe. The assessment team believes that having face-to-face interviews and consultations with all stakeholders would have made it easier for them to share opinions and views more freely.

The qualitative component of the assessment was based on the perceptions of informants and their understanding at the time of the assessment. Recall and halo bias may have influenced qualitative findings. Recall bias was mitigated by focusing on the current health situation and not asking about previous years before HFA began. Halo bias, that is, informants giving a positive response meant to please the interviewer, was mitigated by explaining to the informants that this was not an evaluation, that their responses are confidential and would not be revealed, and that the information would only be used to learn what really works and plan for the future project design.

In order to ensure a comprehensive assessment despite the current travel restrictions, the assessment team interviewed informants from various levels in the health system and with varying degrees of experience. The qualitative data were triangulated with data obtained through other methods. Quantitative data were limited to what DHIS2 data the HFA team provided to the assessment team. To mitigate this limitation, the assessment team worked closely with the USAID/Angola and the HFA teams to ensure they had access to the same amount and quality the HFA used in their daily operations and ascertain the magnitude of the limitations, if any.

# 4. FINDINGS

This section presents the assessment findings for each of the four domains and is organized by AQs and sub-AQs.

## 4.1 ASSESSMENT QUESTIONS 1: DESIGN

**AQ 1: To what extent has the HFA project design been *effective in achieving the desired results*?** The design was very effective in rolling the DHIS2 program to 60 municipalities and in improving LLIN distribution and malaria case management. It was not as effective in increasing access to malaria in pregnancy services or in strengthening and expanding FP/RH services.

1. **The HFA project design was reported to have been effective to achieve a number of outcomes and IRs for three vertical programs, especially, malaria and HIS and to the same extent in FP**. The project's design was reported to have improved as a result of the project's MTE recommendations and the creation of a new theory of change (TOC) for malaria, FP, and capacity building. Training accounts for 70 percent of the investment and has been the main intervention having reached over 5,000 health care workers (Source: KIIs, project's Monitoring, Evaluation, and Learning [MEL] plan and MTE report, and online assessment survey).

> *"We work well with HFA now after the MTE. They provide support and innovation such as the Kasai training."* – KI

2. **In terms of effective design strategy, the HFA TOC includes mostly training, toolkit development, and support to supervision** (Source: TOC in assessment's SOW and project's MEL plan). The design did not seem to include demonstrating the effectiveness of these interventions as part of a causal pathway, nor was the strategy designed to create a mechanism to sustain these interventions. Kasai, the online training that started in 2020, is being used for malaria and online FP training modules are being developed. It is reported to be well accepted by KIs (Source: TOC, workplans, M&E reports and KIs).

> *"HFA has trained over 4,200 health workers in live workshops and more than 1,000 online using the e-learning platform."* – Online Survey Respondent

3. **Mechanisms for co-diagnose, co-design, and co-implement, which were part of the project design, have not been developed yet at national, provincial or municipal levels** The project is reported to do its own planning and implementation in collaboration with the National Malaria Control Program (NMCP; Source: KIIs). The USAID-funded Public Financial Services Program is reported to be co-implemented effectively (Source: KIIs). This project, although not working in the health sector, is reported to be effective in co-implementing with the GoA. If effective, this model may help co-design and co-implement HFA activities.

4. **The design of the TOC did not include effective baseline and service delivery outcomes and targets.** The need to measure and see the impact of all the capacity building activities being carried out by HFA was reported not to be part of the original design. The current indicators are not perceived as effective to help inform decisions (Source: KIIs). HFA has output targets, such as numbers of people to be trained, but there are no outcome indicators as to whether that training improves program outcomes and/or if other interventions are needed. There is an expressed need to strengthen service delivery outcome targets, and to have indicators such as number of facilities that sustainably deliver malaria or FP services.

5. **The evidence indicates the current TOC of the project design does not include an effective integrated service delivery model.** Program management is reported to be vertical for

each of the three programs within the HFA project, while service delivery would need to integrate a number of services from various programs. Integration is now more important than at the start of the project because of the MOH's move towards an integrated Primary Health Care (PHC) approach. The separate TOCs of the HFA project and causal pathways illustrate a potential for improving vertical program management and but may fail to leverage inputs from other programs for greater impact (e.g., MiP and FP could have been integrated if a continuous integrated service delivery model could be designed) (Source: KIIs).

6. **Focus on youth and facilitating their access to malaria services was not included in the design or developed in the LOP.** Given the demography of Angola, where about half the population is under age 15 (see SOW, Annex 1), strategies to make malaria and FP services youth-friendly were reported to be important in increasing access and demand (Source: KIIs).
7. **The design of the DHIS2 rollout was reported by most stakeholders to be the most important achievement of the project.** MOH ownership was reported to be strong, as shown by the MOH decree, and the perceptions of MOH and USAID/Angola KIs. Including all the MOH departments in the design of the new health information system was reported as important.

### 4.1.1 AQ 1.a Findings

#### AQ 1.a: To what extent are the underlying assumptions still valid?

1. **The three design assumptions were reported to be partially valid.** Assumptions of having effective MOH involvement were fulfilled after the MTE, but having enough human resources, medicines, and commodities were reported to not have been met, and despite the project's efforts to mitigate the effects of the unmet assumptions, they may have worsened during the COVID-19 pandemic (Source: KIIs).
2. **Two design challenges regarding assumptions were found.** First, it is not clear how the assumptions were selected. Available project documentation does not explain how the design assumptions were chosen or what was the evidence supporting them. Second, the design did not include monitoring these assumptions or testing them to see if they were valid during the LOP.

#### AQ 1.a.i: MOH timely approves HFA activities: How timely and effective has the partnership been with the MOH?

1. **The country's health needs and the workload of the MOH have increased**. However, it was reported that the MOH has not had time to reorganize and modernize its administrative organizational capacity and procedures to meet the growing population needs. This limits the executive capacity of the MOH and internal administration and donor coordination have reportedly worsened during the COVID-19 pandemic. Needed improvements range from planning and budgeting to managing staff, filing and handling official correspondence. HFA has reported delays in getting activities approved (Source: KIIs). MOH KIs reported the need to improve how they coordinate the inputs of all development partners in the health sector.

> *"They [the MOH] need help to organize files."* – KI

2. **HFA was reported to be focused on central, provincial, and PMI-supported facility engagement, and not at the municipal level.** Stronger support at the municipal level was reported to be needed to sustain the facilities, as municipalities are managing human and other resources in health facilities (Source: KIIs).
3. **The partnership and engagement relationships between HFA and the MOH/NMCP were reported to have improved after the MTE, but HFA's financial management challenges make it hard for NMCP to work with the HFA project.** In the first two years of the project,

PSI was reportedly not effectively conveying their plans to NMCP, and their interventions were perceived to be unaligned with the MOH strategies. Following the MTE, the relationship was reported to have improved and is currently on a positive trajectory. Since the start of the project, PSI was reported to be late in paying per diems to NMCP and MOH staff when they traveled to implement project activities, sometimes months late. A long-term solution to ensure timely payments has not been found yet (Source: KIIs).

4. **Geographic selection criteria of malaria and FP districts and facilities is reported to not be well understood by all MOH counterparts**. Although the MOH reported that donors arrive in the country with the decisions regarding where to work geographically already made, USAID and HFA reported that they worked with the MOH jointly to determine the number and location of facilities to support. Involving all staff at various levels and sharing information through effective briefings and documents, as well as the MOH website[7] seems not to have been part of the original design. The future development and scale-up of the FP/RH program is not known by the MOH authorities. The basis for the design of the HFA project to work in only 42 facilities has not been documented or explained by the interviewed KIs.

### AQ 1.a.ii: Medicines and contraceptives are available: How has the supply chain worked in the LOP?

1. **Improving the functional and systemic coordination between supply chain and service delivery was not part of the project design.** While HFA and Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) do coordinate their work, working together to improve systemic challenges was not part of the design. Lack of medicines and supplies, both for malaria and FP have worsened during the COVID-19 pandemic.

2. Supply chain has improved as a result of the GHSC-PSM project. Both projects share information (e.g., HFA reports stockouts), but **integration of DHIS2 and electronic Logistics Management Information System (eLMIS) data and synergy of both projects was not part of the design and has been partially operationalized.** On an ad hoc basis, HFA reported providing logistical support to transport anti-malarial commodities from municipal and provincial warehouses to HFs to mitigate stockouts (Source: FY21Q1). MOH and HFA stakeholders and partners reported the need for stockout monitoring and greater integration of DHIS2 and eLMIS for better quantification. Quality data issues also contribute to the push-pull dysfunctions. Technical working groups of the NMCP Needs Assessment (February 2021) concluded that capacity development (institutional/organizational) at the municipal and provincial level are needed to promote better control over the production and use of accurate data, use of epidemiological information, and planning of interventions based on evidence, appropriate to each context.

3. **Quantification and procurement of malaria medicines and FP commodities remain a challenge to the MOH. The current financial crisis has made this weakness more evident and pressing. The design of the FP component of the HFA project did not include the procurement of contraceptive commodities because it was agreed that the GoA would procure contraceptives for the whole country.** In 2020, 88.1 percent of USG-assisted service delivery points experienced a stockout at any time during the reporting period of a contraceptive method that the service delivery point is expected to provide.[8] Recently, the U.S. government (USG) has procured contraceptives**..** The malaria component of the HFA project also suffered stockouts although they were less marked in project supported provinces because the USG provides medicines and supplies, as well as assistance to improve the pharmaceutical supply system. The need to assist

[7] www.minsa.gov.ao

[8] Global Fund Audit report-2020; GF-OIG-20-003 27 February 2020 Geneva, Switzerland

the MOH to improve the supply chain was reported by all KIIs and documented in numerous reports. For example, according to the 2020 Global Fund (GF) audit, "for malaria, the government was unable to provide adequate evidence to confirm that antimalarial commodity commitments were met. The Office of the Inspector General analysis validated 74 percent and 24 percent achievement in 2016 and 2017, respectively."

4. **Stockouts point to a number of systemic issues that need to be addressed at various levels and that are not part of the current design. The stockouts are a limiting factor in HFA's implementation, especially for malaria.** HFA works closely with the GHSC-PSM project which is responsible for ensuring product availability and avoiding stock outs. Of the 12 facilities assessed in PMI focus provinces, 17 percent reported more than one-week stockout of ACTs within the past three months. At the time of this assessment, 8 percent of the facilities visited had stockouts of rapid diagnostic tests (RDTs), 22 percent did not have SP on the shelves; and 50 percent did not have injectable artesunate for severe malaria management (Table 5). Stockouts occur for various reasons, including delayed shipment (up-country), delayed distribution, hard-to-reach areas, unreported stock situation; prolonged stockouts are due to unfulfilled government supply plans (Source: KIIs). There is a dysfunctional push-pull system involving the provincial, municipal/district and facility levels and eLIMS is not fully rolled out nationally yet or integrated in the HIS to improve stock levels and monitoring at health facilities (Source: KIIs).

**Table 5: Availability of Medicines and Commodities (%) Among the Visited Facilities, HFA Assessment**

| | |
|---|---|
| ACT | 92% |
| SP (Sulfadoxine + Pyrimethamine) | 67% |
| Artesunate rectal | 58% |
| Artesunate injection | 50% |
| LLINs | 100% |
| Artemeter injection | 67% |
| Stock-out of ACT in the past 3 months | 17% |
| ADECOS report monthly at this facility? | 33% |

### AQ 1.a.iii: HFs have required personnel and supplies: What percentage of the project-supported facilities meet the required standards of personnel?

1. **HFA reports to have trained over 5,000 health workers (HWs)**. This is an important achievement. However, the 2,816 HWs trained in Malaria Case Management (MCM) during FY20 represent only 52.5 percent of the project target (see Table 6 below). COVID-19 restrictions were reported to be the main factor responsible. Despite that, the HFA reported that online training helped overcome this limitation and in FY21 training is on track. Based on Q1 results, 30 percent of FY21 training has been achieved. Lack of a comprehensive human resource development plan may hinder the long-term impact of this investment in training. A replicable process, including a number of interventions to consistently deliver improved malaria

> *"Integrated community health platforms are the backbone of the health care system. In the context of shortages in human resources for health across sub-Saharan Africa, community health workers have emerged as a critical platform for accelerating progress on health goals."* – KI

> *"Districts are key implementers, but the program is designed to support NMCP not the municipal administration that controls resources at the district. They are political appointees, and we should engage [the] municipal level early. There is no accountability; if they don't train, nothing happens. Sustainability was not developed well in the design. We need to manage expectations."* – KI

care management seems to be in place (Source: KIIs). A remarkable improvement in key malaria indicators (testing of suspected cases and treatment of confirmed cases) may be attributed to training and supportive supervision investments. However, the program was not designed to track sustainability outcomes such as number of trained employees still employed after 12 months or successful Quality Improvement (QI) projects designed and led by trained staff, etc.

**Table 6: Achievements in HFA Training Targets, FY20**

| FY20 Training | Target (# of HWs) | Target (# of HWs) | Percent Coverage |
|---|---|---|---|
| MCM/ACT | 1,930 | 888 | 46% |
| MCM/RDT | 2,680 | 1,408 | 53% |
| Microscopy | 208 | 245 | 118% |
| IPTp | 542 | 275 | 51% |
| TOTAL | 5,360 | 2,816 | 52.5% |

*Source: HFA project documents*

2. **Significant shortage of qualified HWs was reported at all levels, particularly at subnational levels where the human resource shortages are reported to disrupt effective MCM particularly at the last mile.** Of the facilities visited, 7 percent had physicians, 62 percent had only nurses, and only 6 percent were reported to have CHWs linked to the facility. These findings are against the assumption that the HFA would perform in facilities with sufficient human resources. The project was designed to train and support existing staff, and not designed to increase the production of health professionals or to help recruit the required staff from among the recent unemployed graduates. The MOH decentralization plan to provinces developed about three years ago is reportedly not fully "operationalized." HFA may need to assist its provinces with HRH deployment to operate in a decentralized manner.

> *"HFA focuses on digital application of supportive supervision and training."* – KI

### 4.1.2 AQ 1.b Findings

**AQ 1.b Are the current causal pathways producing the required outcomes?**

Causal pathways were assessed for each of the HFA results: R1, R2, R4 and R5.

**Results 1 and 2. Malaria Program**

1. **The TOC adequately illustrates malaria service delivery pathways** and how targeted activities, outputs, and outcomes will contribute to reducing malaria-related mortality. However, approximately 70 percent of the outcomes relate to training and supervision and there are not many other interventions. The health system strengthening pathway is predominantly focused on health information system (DHIS2 rollout) and does not include strengthening other systemic causal pathways listed in the TOC for improving service delivery outcomes.
2. **Although mortality has decreased over time, reported malaria incidence is rising. This increase may be due to increased detection due to better diagnostic capacity and not a real increase in morbidity.** Test, Treat, and Track pathways are reported to be working but data provided by HFA show inconsistent performance across facilities in PMI provinces. Table 7 shows the observed performance among the assessed facilities. Although this is not a representative sample, our assessment showed that top do not differ much from the low performers, which also have the same staffing and other resources. The observed patterns suggest that higher HNQIS supervision scores

were associated, on average, with higher performance indicators (treatment of confirmed cases with ACT).

3. **Incomplete FY20 Q4 data shows a spike in malaria mortality in PMI-supported versus non-PMI provinces.** This is not a performance issue but most likely related to disruption in services caused by the COVID-19 pandemic coupled with the fact that PMI-focus provinces are amongst the provinces with the highest malaria transmission. DHIS2 expansion and improvement should help monitor incidence and mortality. Additional studies and data gathering would be required for understanding the factors that explain these data trends and their causes.

**Table 7: Comparison of Assessed Top- and Low-Performing Facilities (Malaria), HFA Assessment Facility Visits***

| Province | Municipalities | Health Facility | Cate-gory | ANC | FP | Con-firmed TX-ACT: 2020 | HNQIS: 2019-2021 | Super-vision | ACT stock-out (July 2021) | Data Use | ANC/ IPT Training | ADECOS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cuanza Norte | Cazengo | CS Kipata | High | Yes | Yes | 100% | 70% | Yes | No | No | Yes | No |
| Cuanza Norte | Cazengo | CS Sassa | High | Yes | Yes | 100% | 74% | Yes | No | No | Yes | No |
| Zaire | Mbanza Congo | CS Kianganga | High | Started ANC in 2021 No | Started ANC in 2021 No | 48% | 77% | Yes | No | No | No | No |
| Malange | Caculama | CS Muquixe | High | Yes | Yes | 96% | 71% | Yes | No | Yes | Yes | Yes, (World Vision) |
| Malange | Caculama | HM Caculama | High | Yes | Yes | 84% | 79.7% | Yes | No | Yes | Yes | Yes (World Vision) |
| Cuanza Norte | Golungo Alto | HM Golungo Alto | High | Yes | Yes | 100% | 77% | Yes | No | Yes | Yes | No |
| **Average of Low Performers** | | | | | | **88%** | **75%** | | | | | |
| Malange | Cambundi Catembo | HM Cambundi Catembo | High | Yes/ integrated | Yes | 88% | 88% | Yes | No | No | Yes | No |
| Malange | Malange | HM Malange | High | Yes/ integrated | Yes | 130% | 96% | Yes | Yes | No | Yes | No |
| Zaire | Kuimba | HM Cuimba | High | Maternity unit next to HM No | Maternity unit next to HM No | 51% | 92% | Yes | No | Yes | Yes | Yes |
| Zaire | Kuimba | CS Luvaka | High | Yes | Yes | 111% | 89% | Yes | No | No | Yes | Yes |
| Zaire | Mbanza Congo | HM Mbanza Congo | High | Yes Integrated | Yes | 102% | 82% | Yes | No | No | No | No |
| Cuanza Norte | Cazengo | HP Kwanza Norte | High | Yes | Yes | 100% | 82% | Yes | Yes | Yes | Yes | No |
| **Average of Top Performers** | | | | | | **97%** | **88%** | | | | | |

** Note: Red indicates facilities that: (1) have not reached the target of 80% coverage; (2) report coverage above 100% for any indicators; (3) have ACT stock-outs; (4) report no data use; (5) conduct no ANC/IPT training; and (6) have no ADECOS*

**Result 4. Causal Pathways of the FP/RH Program**

4. **The design of this component seems to have included only FP not RH activities** (such as integration with ANC/postnatal care, post-abortion care, sexually transmitted infections, etc.). The scope of the program may need to be reconsidered if achieving the IRs in the TOC and if USAID/Angola continues to consider impact on women's health an area of intervention.

5. **Despite having the ambitious outcome of providing facility and community-based integrated FP services and increasing contraceptive prevalence, the HFA causal pathways seem to have had limited impact.** The program is implemented in only 22 facilities in Luanda and 20 in Huambo. Program performance varies and is based on output measures using the HFA supervisory checklist and not FP outcomes (Table 8). In addition, contraceptive commodity stockouts are reported to be frequent. However, in all the facilities visited, at least three modern methods were available at the time of the assessment. Demand for FP continues to be stagnant in both provinces despite the support of four HFA-funded community workers (KIIs) in each facility (Source: KIIs).

**Table 8: Performance Among Family Planning Health Workers, HFA-Supported Health Facilities**

| Performance indicator PMP | Achieved target FY17 (%) | Achieved target FY18 (%) | Achieved target FY19 (%) | Achieved target FY20 (%) | Total number of HWs |
|---|---|---|---|---|---|
| Percent of health workers who successfully completed an in-service training program | 161,5% | 118,2% | 113,0 | 67,7% | 813 |
| Percent of people trained with USG funds | 98,3% | 81,0% | 103,3% | 80% | 956 |
| Percent of USG-assisted community workers providing FP information, referrals, and/or services during the year | 0 | 100% | 98,8% | 100% | 84 |

*Source: HFA M&E Annual Reports*

6. **The current design does not include a plan to expand coverage, increase the number of facilities, or to redesign a clear pathway** of how the current facilities will contribute to improve the FP program in the supported provinces.

7. **The HFA Project was designed to monitor FP outputs and outcomes based on targets.** The M&E design calls for output indicators (e.g., percentage of staff trained, etc.) (Table 9). For example, the project reports on numbers of staff trained, but it does not monitor numbers of new acceptors by method, or trends in new and returning users by facility to solve delivery problems and measure the outcomes of those trainings. Also, HFA supervision does not include assessing the quantity and quality of the RMA and *Juventude Informada, Responsavel e Organizada* (JIRO[9]) counseling and support. The four counselors observed had only one or two clients to counsel and were underutilized during the assessment team's visit.

**Result 5. Capacity building in DHIS2-60 municipalities, located in Zaire, Uíge, Cuanza Norte, Malanje, Lunda Norte, and Lunda Sul**

1. **The design of Result 5 has been effective but it does not seem to have followed the TOC. The causal pathway of Result 5 is part of the "Capacity Building Framework" that includes three IRs**:

[9] A youth non-governmental organization

a. IR1: Building sustainable platforms

b. IR2: Modernizing public administration

c. IR3: Strengthening public financial management

The financing of DHIS2, hardware and support has not been sorted out yet. WHO and the World Bank (WB) were reported to also be supporting the MOH to develop the HIS at the national level by sponsoring training for two programmers in system security.

2. **The causal pathway of the DHIS2 system did not include maintaining infrastructure.** The system has two servers (one provided by WHO and the other by the WB). The data are reported to be backed up in the "cloud," which is good because MOH does not have a generator to ensure continuity. A digital health platform in accordance with USAID's digital health policy has not been developed yet; and as said above, the design does not yet include the integration with eLMIS.

**Table 9: Family Planning Performance Among Health Facilities Visited for the HFA Assessment**

| Province | Health Facility | FP audit | Short-term methods | Long-term methods | Average |
|---|---|---|---|---|---|
| Luanda | HM Cacuaco | 95,8% | 100% | 99,5% | 98,6% |
| Luanda | Centro Materno Infantil Benfica | 83% | 98,5% | 98,3% | 92,4% |
| Luanda | CS Bairro Operário | 88,5% | 98,6% | 96,3% | 93,7% |
| Luanda | CS Rangel | 87,4% | 95,7% | 96,7% | 92,7% |
| Luanda | Maternidade Lucrécia Paim | 96,2% | 100% | 100% | 98,8% |
| Huambo | Hospital do Cambiote | 81,2% | 77,7% | 89,6% | 82,8% |
| Huambo | CMI Caála | 36,4% | 28,9% | 63,3% | 42,9% |
| Huambo | Hospital Geral Huambo | 91,2% | 85,5% | 97,5% | 91,4% |
| Huambo | CMI Mineira | 50,3% | 91,8% | 98,1% | 80,1% |
| **Total** | | **73,9%** | **83,8%** | **83,9%** | **80,3%** |

*Source: HNQIS data provided by HFA*

*Note: Green indicates good or very good performance (>80%); yellow indicates average to poor performance (60-80%); red indicates very poor performance (<60%).*

## 4.2 ASSESSMENT QUESTION 2: IMPLEMENTATION

### AQ 2: To what extent is the project's plan of implementation effective in achieving the desired results?

The assessment team answered this question by looking at the project's four result areas.

**Result 1. Implementation of LLIN distribution has been effective and access and use have increased by at least 30 percent**

1. **The HFA project has reported universal coverage of LLIN**. In 2017, Angola took a major step towards universal coverage of LLINs, conducting a nationwide mass campaign in 2017–2018. Actual access and use on a national scale will not be known until the next planned Demographic and Health Survey (DHS). The HFA project implemented a mass distribution of LLINs in February 2019, achieving "**universal coverage" in 13 provinces**, and reaching 12,073,097 people through 6,693,503 LLINs distributed(Table 10).

**Table 10: Coverage of Distributed LLINs by Year**

| Year | HFA Mass Campaign Number of LLINs | Percent Coverage |
|---|---|---|
| FY2017 | 2,445,544 | 36,5% |
| FY2018 | 2,483,612 | 37,1% |
| FY2019 | 1,764,347 | 26,4% |
| **Total** | **6,693,503** | **100%** |

*Source: HFA FY20 Q4 Report*

2. **Promoting and monitoring actual and effective LLIN use are reported to remain a challenge despite survey evidence.** MOH KIs wondered about the effective use of the LLINs given rising malaria incidence and anecdotal evidence of lack or misuse of LLINs. Following the campaign, a survey conducted in selected provinces demonstrated that if access to LLINs is adequate, then use is relatively high. In fact, entomological surveillance and testing was conducted in Lunda Sul and showed that pre-exposure to piperonyl butoxide (PBO) followed by deltamethrin resulted in 100 percent vector mortality (Source: VectorLink Project, 2020).

3. **Plans for the next (2022) mass campaign for LLIN distribution are reportedly on track with considerable engagement of the NMCP** (NMCP key informants). In the 2022 campaign, HFA is expected to use the above information (see Finding 2 immediately above) to help plan, distribute, and promote the use of 3.6 million standard LLINs. The assessment team was able to assess the activity plan of HFA and PSM for the campaign. The campaign plan included a number of meetings to coordinate activities and trainings of health staff and CHWs (*Activistas*). The plan also includes a number of population that will serve as a denominator to track effectiveness of the campaign.

4. **Routine LLIN distribution has been strengthened by PMI.** Based on DHS 2015–16 data (before the first mass campaign), PMI contributions to LLIN availability through HFA have increased the percentages of both availability and use, especially in the six northern PMI focus provinces (Malaria Operational Plan 2021). PMI plans to continue the procurement of LLINs for routine distribution in the six PMI provinces and proposes to allocate funds to contribute to the procurement of LLINs for the mass distribution campaign in FY22 (Sources: KIs).

5. **In alignment with the WHO Policy of Test, Treat, and Track, HFA made great progress in PMI-supported provinces towards achieving the NMSP's 2016–2020 strategic goal to test 100 percent of suspected malaria cases by either RDTs or microscopy**. Similarly, by the end of 2020 (October to December), 91 percent of confirmed malaria cases were treated with ACTs in PMI provinces, compared to 71 percent of suspected malaria cases in non-PMI provinces (NMCP DHIS2 2020). Performance varies across provinces, municipalities, and facilities (Table 11).

**Table 11: HNQIS and Test, Treat and Track Reported Coverage Among Selected HFA-Supported Health Facilities**

| Selected facilities | Children | General population | Pregnant women | IPT | RDT malaria | Quality of supplies register | Quality of registers | Total mean | Confirmed cases treated with ACTs: 2019 | Confirmed cases treated with ACTs: 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| PS Chindingo | 57,2% | 69% | 46% | | 95% | 70,3% | 100% | **81,8**% | 96% | 71% |
| PS Sautar | 63,2% | 74,5% | 61,2% | 78,8% | 94,8% | 88,9% | 100% | **82,5**% | 96% | 63% |
| PS Bangalas | 59,5% | 41% | | | 83% | 26% | 86% | **59,2%** | 45% | 100% |
| PS Bundo | 81,4% | 79,6% | | 100% | 95,5% | 70,9% | 90,7% | **84,9**% | 56% | 100% |
| HP Malange | | | 98% | 96,5% | | | | **97**% | 11% | 74% |
| HM Tomboco | 70% | 77,7% | | | 87,3% | 84% | 89,5% | **81,8**% | **33%** | 61% |
| CS Mongo Soyo | 73,1% | 79,9% | | | 85,2% | 85,8% | 95,8% | **84**% | 56% | 88% |

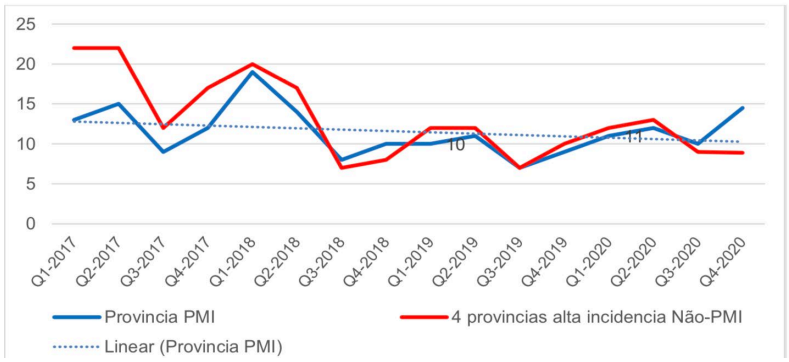
*Source: HFA FY21 Q1 Report*

*Note: Green indicates good or very good performance (>80%); yellow indicates average to poor performance (60-80%); red indicates very poor performance (<60%).*

6. In Fiscal Year 2020 (FY20), the pandemic affected the project implementation. Only 888 HWs were trained in ACT, achieving 46 percent of the target; 1,408 HWs were trained in RDTs, achieving 53 percent of the target; and 275 HWs were trained in IPTp, achieving 51 percent of the target. Despite travel restrictions within provinces because of COVID-19, HFA successfully facilitated municipal malaria and RH supervisors to conduct a total of **10,502** supervisions or observations during FY20. **FY21 Quarter (Q) 1 trainings are on track with an estimated 30 percent achievement of all key training indicators**.

7. **Malaria mortality has decreased substantially by more than 15 percent in PMI-focused provinces over the past three years** (Figure 1). The last quarter of 2020 demonstrated a concerning spike in malaria mortality in PMI-supported provinces compared to non-PMI provinces. However, this was most likely related to disruption in services caused by the COVID-19 pandemic coupled with the fact that PMI-focus provinces are amongst the provinces with the highest malaria transmission.

**Figure 1: Malaria Mortality by Year, Angola**




**Result 2. Malaria services throughout targeted municipalities have improved**

1. **In the FY20 (Project Year 4) Q4 report, HFA reported relatively high cumulative (92 percent) coverage rates of confirmed malaria cases treated with ACTs in PMI's six supported provinces. However, malaria M&E data show wide ranges and often percentages exceed 100 percent, raising questions about the available data.** Hence, it is difficult to assess progress. Although data for 2020 and 2021 are not final, the HFA FY21 annual report describes a dramatic increase in malaria morbidity between 2016 and 2020. This may be due to improved detection and diagnosis. By the end of 2020, malaria cases had increased by 132 percent, from 3,319,107 in 2016 to 7,716,910 (Figure 1). The HFA report compares incidence trends over the last four years in PMI and non-PMI high incidence provinces. The results in both cohorts demonstrate increasing incidence trends more notable in Malange, Uige, Lunda Norte, and Cuanza Norte. This was most likely attributed to an impressive increase of 61 percent in the number of patients who are seeking care through HFs or CHWs (Agentes de Desenvolvimento Comunitário e Sanitário or ADECOS in Portuguese), coupled with the COVID-19 pandemic, which may have contributed to the increase in registered malaria cases. ADECOS have reportedly diagnosed 18 percent of confirmed cases in PMI-focused provinces compared to 10 percent nationally (Source: NMCP DHIS2-March 2021).
2. **Malaria services have improved in 60 municipalities; however, there are differences across facilities.** FY21 Q1 trainings are reported to be on track with an estimated 30 percent achievement of the annual target. M&E information can help to focus the project's limited training resources on priority municipalities with the greatest need.

**Table 12: Health Facility Performance on Malaria Case Management by Province,** HFA-Supported Health Facilities

Table 5. **MCM Quality of Care: Percentage of HUs that Scored at Least 80% by Category**

| Province | Children | Pregnant Women | General Population | IPTp | RDT | Register Quality |
|---|---|---|---|---|---|---|
| Cuanza Norte | 61 | 57 | 72 | 87 | 97 | 75 |
| Lunda Norte | 73 | 81 | 74 | 86 | 96 | 93 |
| Lunda Sul | 78 | 87 | 68 | 100 | 100 | 87 |
| Malanje | 60 | 81 | 63 | 87 | 99 | 91 |
| Uige | 70 | 77 | 75 | 85 | 96 | 97 |
| Zaire | 63 | 94 | 68 | 94 | 98 | 97 |
| Total Average | 67.5 | 79.5 | 70 | 89.8 | 97.7 | 90 |

***Source:*** *M&E HFA Project* ***Color code:*** *Green (above 80%) – Yellow (between 60% and 79%) – Red (below 60%) of performance in supervision scoring.*

3. **Case management has improved due to increased supervision but it is limited by stockouts.** Table 12 demonstrates the results from observations and supervisions from the FY21 Q1 report, showing an overview of HFs performance by category in each province where municipal supervisors reportedly conducted a total of 3,286 observations/ supervisions. A cross-sectional health facility survey examining the quality of malaria care was supported by PMI in Uige and Huambo provinces in 2016. Uíge exhibited very high malaria positivity and the highest rates of ACT and RDT stock-outs. The survey suggested that HCWs in Uíge were largely cognizant of the role of malaria in the ill population they serve. Nevertheless, the weakest step in the case management pathway was the diagnostic testing step. The stock-out rates of individual formulations of ACT were reported to be high, making treatment of different age categories even more difficult for HCWs.[10] Stockouts due to incorrect quantification, insufficient buffer stocks and untimely requests are reported by various stakeholders.

> *"MiP is a serious concern. We are having meetings and debates at the national level. Lack of education by mothers to go to ANC [and] low level of education is more prevalent in the rural versus urban settings. Women who seek delivery of their children by local midwives don't go to ANC. ADECOS should help bridge gap with provision of community IPT."* – KI

4. **The HFA project has increased IPTp coverage from 18.5 percent in 2015–16 (DHS 2015–16) to 32.3 percent in 2019 in selected facilities** (Table 13). This achievement is far from the NMCP's strategic goal that by the end of 2020, 80 percent of pregnant women should have access to prenatal consultations and those eligible for IPTp (at least three doses of SP).

[10] "Evaluating malaria case management at public health facilities in two provinces in Angola", Malaria Journal 16-186 (2017)

**Table 13: IPTp Coverage in PMI Provinces, 2016-2019**

| SOURCE | | | | | |
|---|---|---|---|---|---|
| | Angola DHS 2015-16 | | 2019 (NMCP-DIHS2) | | |
| Province | # eligible women attending ANC | % at least 3 doses SP | # eligible women attending ANC | % at least 3 doses SP | % ANC/All HFs |
| Zaire | 183,000 | 28,1% | 14,615 | 70,6% | 60% |
| Uige | 274,000 | 10,4% | 55,070 | 28,7% | 22% |
| CN | 85,000 | 25% | 16,456 | 60,3% | 19% |
| Malange | 268,000 | 15% | 30,221 | 25,8% | 29% |
| LN | 177,000 | 20,9% | 32,473 | 20,9% | 44% |
| LS | 147,000 | 21,5% | 29,891 | 23,7% | 21% |
| **Total** | **1,134,000** | **18.5%** | **178,726** | **32.3%** | **28%** |

5. **Access to IPTp is still limited by the number of facilities that provide ANC.** Only an estimated 28 percent of HFA-supported facilities actually provide ANC, and more than 1 million women still do not have access to IPTp (Table 13). ANC availability is a challenge in Angola coupled with socio-economic and logistic realities that prevent women from traveling long distances to the ANC clinics. Although the trend in PMI provinces is that of incremental improvements (Figure 2), IPT coverage remains far below WHO's recommended levels. This data suggest a strong role for implementing community IPTp involving ADECOS.

> "ADECOS *can enhance IPTP at community level. ADECOS know where the pregnant women are in their communities"* – KI

6. **IPTp training coverage target is on track to be achieved based on FY21 Q1 data.** HFA's objective is to identify and correct knowledge and skill gaps among ANC service providers through training and supportive supervision; **51 percent of the IPTp training target has been achieved so far, according to the FY20 Q4 report.** FY21 Q1 trainings are on track with an estimated 30 percent achievement of the IPTp training indicator (HMIS 2020/HFA FY21 Work Plan narrative).
7. **HFA's implementation is aligned with the NMCP national strategic plan and WHO technical strategies, increasing its likelihood to be sustained.** Following HFA's MTE in 2018, PSI changed its management structure and staffing to provide more substantive technical support and supervision at subnational levels. In FY21, PMI intends to fund a health facility survey in the six PMI-focus provinces to assess quality of MCM, checking for the health facility infrastructure, stockouts, providers knowledge, data quality, and conducting client exit interviews. This information will be important to have a better picture of what is happening in the health system in each province (Source: KIIs).
8. **HFA reported to have successfully implemented malaria training modules in a phased approach using the Kasai platform**, and the digital formative supervision, HNQIS, in all 60 municipalities in the six provinces. Due to the COVID-19 pandemic, HFA has placed greater focus and investment on digital expansion of training and supportive supervision; there is evidence that knowledge is being improved as per pre- and post-test training results but not on performance yet (FY20 Q4 report). APPY is a new E-learning partner that is expected to improve digital capacity building efforts. However, creating this capacity in the MOH and the country's training institutions has not been implemented yet.
9. **In the FY20 Q4 report, HFA reported relatively high cumulative coverage rates (92 percent) of confirmed malaria cases treated with ACTs in PMI's six supported provinces and has also influenced other non-PMI provinces.** The HFA pathway has been effective. However, data quality problems remain. Malaria M&E data range widely and often percentages exceed 100 percent putting data quality in question. Hence, it is difficult to assess progress (Table 14). The use of data for program management did not used to be in the causal pathway ()but HFA is now focused on addressing data quality problems and use.

**Table 14: Range of Variation in Reporting and Data Quality Among HFA-Supported Health Facilities**

| 2020: Province | Kwanza Norte | Lunda Norte | Lunda Sul | Malanje | Uige | Zaire | Luanda | Huambo |
|---|---|---|---|---|---|---|---|---|
| **Total number of suspected cases** | 565,664 | 551,217 | 350,609 | 1,010,061 | 476,478 | 448,101 | 465,641 | 174,530 |
| **Total percent tested** | 99% | 99% | 99% | 96% | 99% | 99% | 103% | 101% |
| **Range of percentage tested among all HFA-supported facilities** | [76%-126% | [73%-110%] | [84%-114%] | [73%-120%] | [79%-108%] | [85%-125%] | [96%-247%] | [65%-124%] |
| **Total number of confirmed cases** | 299,769 | 321,894 | 189,874 | 622,446 | 319,051 | 253,451 | 174,066 | 57,468 |
| **Total number treated** | 298,329 | 238,318 | 130,256 | 573,516 | 331,919 | 208,696 | 117,114 | 37,965 |
| **Percent confirmed treated** | 99.50% | 74% | 69% | 92% | 104% | 82% | 67% | 66% |
| **Range of percentage treated among all HFA-supported facilities** | [75%-151%] | [11%-124%] | [8%-%129] | [23%-%130] | [50%-%200] | [9%-%227] | [23%-106%] | [23%-116%] |

*Source: DHIS2 FY20 Q4*

**10. Community malaria program is still under development and needs to be integrated with the HFA facility-based services.** MOH supports the program but needs help to develop it fully (NMCP informant). The aim of any CHW-focused project is to support isolated communities that lack access to health services. An evaluation by Elimination-8[11] indicated that for those individuals tested and treated by ADECOS in the Southern Provinces there has been a remarkable improvement in access to healthcare for

> "*We need support of a Community Health Strategy: The government has been building the evidence base (UNICEF ICCM pilot) and advocacy to convince the medical community to accept ADECOS beyond malaria (diarrhea, pneumonia). ICCM is currently only limited to malaria. The goal is to expand ADECOS to all provinces, especially in remote rural communities where doctors are reluctant to support.*" – KI

[11] The Elimination Eight Initiative (E8) is a coalition of eight countries working across national borders to eliminate malaria in southern Africa by 2030.

uncomplicated malaria cases.[12] Table 15 shows the important contribution ADECOS make to expanding coverage.

**Table 15: ADECOS Contribution to Coverage Expansion**

**Resultado 2(b) : Testagem e Tratamento da Malária a nível da comunidade**
**Proporção de casos confirmados em pacientes < 5 anos pelos ADECOS vs casos confirmados nas unidades sanitarias por trimester por município desde Out 2019 – Mar 2021)**

| Município | Total < 5 anos nas US Out 2019 – Março 2021 | Total < 5 anos nas US Out 2019 – Março 2021 | Contribuição (%) ADECOS |
|---|---|---|---|
| Cacolo | 5240 | 1,029 | 20% |
| Dala | 12032 | 2,505 | 21% |
| Kuimba | 14547 | 1,553 | 11% |
| Soyo | 11058 | 1,303 | 12% |
| Tomboco | 15726 | 4,024 | 26% |
| **Total** | **58,603** | **10,414** | **18%** |

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SAÚDEPARATODOS

Fonte: Kobocollect and DHIS2

11. **Data from the HFA assessment facility visits show that most staff have been trained and supervised, but medicines are not consistently available in the PMI-focused provinces. It is encouraging that use of DHIS2 data was reported in 42 percent of the facilities.** The findings suggest that training and supervision alone do not translate to data use for action to improve patient outcomes. Other organizational and management factors may be at play (Table 16).

**Table 16: Summary of Findings Among Selected Health Facilities (Malaria), HFA Assessment Facility Visits**

| Summary of Findings | Percentage of Facilities (N=12) |
|---|---|
| Supervision visit less than 3 months ago | 50% |
| Knowledge of HNQIS Score | 75% |
| Reported to submit reports to DHIS2 | 100% |
| Reported use the DHIS2 data | 42% |
| Received any ANC training in the last two years? | 75% |
| Received any training in IPTp in the last two years | 75% |
| Reported methods used for diagnosing malaria | Clinical-100%<br>RDT-100%<br>Microscopy-75% |
| Available timer for RDTs | 8% |

[12] Source: Effectiveness of Community Health Worker System using ADECOS in Provision of Access to Malaria Diagnosis and Treatment in Remote Communities- Q Partnership International re: Elimination 8; 10 March 2019

| Summary of Findings | Percentage of Facilities (N=12) |
|---|---|
| Stock-out of malaria RDT kits in the past 3 months for more than one week | 8% |
| National Malaria guidelines available | 50% |

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

1. **Result 4 has been partially achieved in selected facilities, but specific outcomes have not been achieved.** The HFA project has improved FP services in selected facilities but not expanded delivery or increased the number of acceptors. The following outcomes included in the results framework have not been achieved:
   a. ***Outcome 4.1***: Expanded integrated FP/RH facilities and community services, with coordinated SBCC
   b. ***Outcome 4.2***: Provider-initiated FP/RH services and counseling are strengthened, reaching youth more effectively
   c. ***Outcome 4.3***: Improved contraceptive security supported through an engaged RH Technical Working Group and Supply Chain Management Committee
   d. ***Outcome 4.4***: Integrated FP/RH services are expanded through private sector engagement
2. **Lack of FP commodities did not seem to affect FP work**. According to PSM, between June 2020 and January 2021, HFs in Luanda had stockout of all methods. Despite that, Luanda scored very well, according to PSI's HNQIS tool. PSM reported fewer stockouts in Huambo. Facilities visited in Huambo and Luanda all had contraceptives available, at least three modern methods in Luanda, and at least six in Huambo. All Luanda health facilities perform very well in the HNQIS: all 22 health facilities are green – above 80 points, but Huambo health facility performance was reported to be poorer by the HFA's HNQIS. The reasons for the different performance were attributed to personal differences.

**Result 5. Capacity building in DHIS2-60 municipalities, located in Zaire, Uíge, Cuanza Norte, Malanje, Lunda Norte, and Lunda Sul.**

1. **DHIS2 reporting is improving steadily, especially in the PMI provinces** (Table 17). Although internet access is an important barrier to timely reporting by municipalities, facilities are hampered by lack of registers. Despite these problems, the reporting rate increased to more than 80 percent in most provinces. Although average provincial completeness of reporting is improving, there is wide variation across facilities. HFA has reported that poor DHIS2 **data quality remains a concern.**

> *"…any difference in the data cannot be interpreted as real… one of the reasons for the bad quality of data we have encountered is lack of registry books at HU level which should be provided by [MOH]."* – KI

**Table 17: DHIS Malaria Reporting Rates**

| | DHIS2 Malaria Reporting Rates (Completeness) * | | | | | |
|---|---|---|---|---|---|---|
| **Provinces** | **Jan-Dec 2018** | **Jan-Sep 2019** | **Oct-Dec 2019** | **Jan-Mar 2020** | **Apr-Jun 2020** | **Jul-Sep 2020** |
| Zaire | 90.0% | 93.8% | 95.9% | 94.2% | 90.8% | 94.3% |
| Lunda Sul | 64.6% | 90.7% | 86.1% | 84.0% | 91.3% | 82.7% |
| Malanje | 65.9% | 89.1% | 91.0% | 85.8% | 79.5% | 94.7% |
| Cuanza Norte | 73.6% | 87.8% | 86.8% | 87.1% | 91.2% | 94.0% |
| Lunda Norte | 67.2% | 85.7% | 86.2% | 94.7% | 92.1% | 98.6% |
| Uige | 67.0% | 80.2% | 77.4% | 73.6% | 79.4% | 76.4% |
| Huambo | 81.5% | 88.7% | 87.5% | 90.9% | 91.6% | 100.0% |
| Moxico | 20.9% | 73.9% | 78.5% | 64.9% | 77.1% | 84.7% |
| Bengo | 80.6% | 88.7% | 83.3% | 88.9% | 78.4% | 95.3% |
| Cunene | 35.1% | 78.1% | 84.7% | 72.3% | 69.0% | 75.8% |
| Cuando Cubango | 16.7% | 49.4% | 54.9% | 41.0% | 50.2% | 61.1% |
| Cuanza Sul | 47.5% | 65.5% | 52.1% | 53.8% | 59.4% | 90.3% |
| Namibe | 14.5% | 84.1% | 53.2% | 38.6% | 72.6% | 81.0% |
| Huila | 42.9% | 66.3% | 66.3% | 55.3% | 49.7% | 85.2% |
| Bie | 40.2% | 78.3% | 51.0% | 59.7% | 54.4% | 95.3% |
| Benguela | 48.1% | 60.7% | 32.3% | 26.7% | 57.5% | 69.0% |
| Luanda | 29.4% | 40.5% | 25.8% | 21.4% | 21.8% | 73.6% |
| Cabinda | 2.7% | 22.0% | 13.9% | 39.4% | 55.7% | 72.3% |
| **National Average** | **50.5%** | **72.1%** | **64.6%** | **62.3%** | **67.1%** | **84.2%** |

2. **DHIS2 system currently does not have validation rules and Data Quality Assessments (DQA) are not routinely conducted yet** (Source: KIIs). HFA reported to be at work with MOH to create validation rules and use tools to improve data quality. In this way, DHIS2 would not allow anyone to enter an incoherent number and statisticians would need to go back to the health facility and check and correct the problem.

### 4.2.1 AQ 2.a Findings

**AQ 2.a: To what extent is the HFA project managed effectively (internally and externally; nationally and provincially)?**

1. **According to the approved design and implementation plan, the HFA project has effectively managed three vertical programs: malaria is implemented in selected high incidence malaria facilities in selected provinces, FP is implemented in selected facilities in two different provinces, and DHIS2 is implemented in 60 municipalities.** There are differences in the perceptions of the work of HFA. The return on USAID's investment in HFA activities and the difference HFA is making is not always clear to all stakeholders. By some, HFA is perceived as to be focused mainly on training staff in selected facilities. Although USAID/Angola reported HFA to be working at municipal level, other stakeholders reported HFA does not support municipalities, which are the ones responsible for managing staff and health facilities.

> *"Difficult to say which province is doing better because there are diverse differences. USAID provides the most support in malaria. Despite USAID's investments compared to GoA, we are not seeing the level of achievements expected. It's difficult to measure their prevention impact."* – KI

2. **MOH staff reported long delays in paying per diems**. In some cases, activities had to be cancelled. HFA's financial management department also manages the finances of VectorLink and GHSC-PSM. However, after five years, stakeholders have reported persistent delays in processing payments by HFA but not the other projects, which have caused delays in MOH receiving their per

diems. The HFA team reported that these delays are due to their bank requiring two weeks to wire funds, and due to HFA staff not always complying with their standard operating procedure of submitting funds requests at least ten days in advance.

> *"I would like to identify all challenges related to lateness of payments of trainers. Not only PSI is at fault but also NMCP. We must jointly find a solution since we work together."* – KI

3. **Nationally, the HFA project is managed by the Chief of Party and the PSI Country Representative, who are perceived as good managers by most stakeholders**. MOH key informants reported that management has improved since the project's MTE.
4. **Technical leadership in malaria was reported to need strengthening.** Several KIs expressed the need for a more proactive stance in establishing or supporting the development of a technical coordination forum. For example, there is a new Vector Control Technical Working Group (TWG) with participation of Mentor and VectorLink. Various stakeholders highlighted the need for other thematic work groups (MCM, MiP, supply chain, etc.) to provide the necessary technical leadership to improve coordination, communication, and collaborate effectively with the NMCP and key stakeholders (Source: KIIs).
5. **Weaknesses in organization, coordination and collaboration are reported at the provincial level**. Management and supervision at the subnational and facility level are reported to be still limited to filling checklists but staff do not interpret and use the data. This is reported to translate into ineffective MCM (Source: KIIs).

> *"…what is seen on paper is not reflected in the field."* – KI

### 4.2.2 AQ 2.b Findings

**AQ 2.b: What are the enabling factors critical to success and the barriers that impede implementation?**

**ENABLING FACTORS**

**PMI – Malaria Program**

1. The GF reported to have contributed to MOH's efforts to co-implement malaria activities and support PMI activities. An effective and well-coordinated partnership can strengthen the malaria program nationwide.
2. The NMCP team was very supportive and appreciative of the PMI support. Also, other MOH departments, such as the new PHC department, expressed eagerness to get involved, and the MOH's commitment to DHIS2 and improving data transparency and accountability were reported to be enabling factors.
3. Improved relationship and engagement with the MOH team since the MTE were also reported as enabling factors.
4. HFA reported starting to strengthen engagement with relevant sub-national actors, including provincial, municipal, HF, and community actors.

**FP Program**

1. The prior USAID-investment in Cyclebeads has been sustained despite not having beads, and not having introduced the App. The method is recognized as an effective "natural" method that helps families time pregnancies and achieve optimal spacing, especially among new acceptors.
2. Contraceptives are available in visited facilities, which can serve as demonstration centers of effective client-provider communication and continuous follow-up of new acceptors.

3. GoA supports FP2030 and created a TWG that should give USAID the opportunity to share its 15 years of FP experience in Angola.

**DHIS2 Program**

1. Country ownership of DHIS2 is an important enabling factor and the cornerstone for developing a "digital health platform" that [13]would include eLMIS and other digital health solutions and applications. The MOH decree sent to all government units states that DHIS2 is the only national health information system, which gives USAID the opportunity to create an evidence-based culture and a new malaria program management approach.
2. Having DHIS2 institutionalized in the MOH will eventually facilitate next steps to improve data quality and use for decision making nationwide .
3. DHIS2 has enabled the project to have and use data on how the malaria program and facilities are performing at national, provincial, and municipal levels and can now focus on improving low performers.

**BARRIERS**

1. In addition to the impact of COVID, the design issues listed above and the lack of an integrated approach are barriers to developing sustainable malaria and FP programs that make use of the strengthened DHIS2 system.
2. Another barrier is the lack of a sustainable solution for improving the clinical and case management skills of healthcare providers. There is a need to implement the transfer of the HFA training capacity to local academic institutions and the MOH.
3. The need for a clearer line of sight in the HFA causal pathways is a barrier for the MOH to replicate the HFA interventions.

> *" Malaria case management has gaps in supervision, frequency needs to improve."* – KI

4. GoA will need assistance to develop and implement a plan to recover from the current financial crisis, and the COVID-19 pandemic. While this is beyond the scope of work of the HFA project, it will be a barrier to its success as the GoA will need to focus on COVID-19 recovery, in addition to responding to prevalent diseases in the country.
5. Current data quality and information gaps are barriers that need to be solved in the PMI provinces. These provinces may serve as sentinel sites to the other provinces.
6. Continuous availability of ACTs and other supplies is still a barrier (stocks vary and never reach 100 percent).
7. An important barrier to sustainability of the FP program is that the GoA does not yet have contraceptive security, and a large number of the population is not covered.
8. Continued lack of infrastructure and lack of full-time employees at HFs and municipal levels is an ongoing issue. Electricity issues, absence of official registry books, and delays in payment all have impacted data collection, data entry, and low personnel motivation are barriers to improve data quality and reporting rates.
9. Remote municipalities still have internet connectivity problems, which prevent them from immediately uploading data on the cloud. This prevents provincial or central level officers/directors from using DHIS2 and HNQIS data for timely decision making (Source: HFA FY20 Q4 Progress Report; Executive Summary).

10. At the time of this assessment, the documents reviewed indicated that HFA supported the rollout of DHIS2 to 60 municipalities. Thanks to a strong MOH leadership and successful coordination, DHIS2 has now been rolled out to 164 districts, reaching over 80 percent of the facilities in the country. The main barrier is the current lack of internet coverage, equipment, and computer skills; these are changing rapidly as more provinces purchase computers and learn how to use DHIS2.

## 4.3 ASSESSMENT QUESTION 3: OPPORTUNITIES

### AQ 3: What are the current opportunities faced by the project?

**During this assessment, USAID/Angola reported that HFA will receive a cost-extension until July 2023. The extension presents the following opportunities:**

1. **Opportunity to manage a number of the ADECOS in PMI-focus provinces.** This represents an opportunity for PMI to strategically strengthen malaria case management at "the last mile" and expand community health to reach vulnerable populations in the hard-to-reach communities. ADECOS are community development workers who also perform a number of health tasks. They constitute Angola's CHW cadre, a viable solution to the lack of health care providers in communities hit hardest by malaria (Source: UNICEF KII). At this time, it is not yet clear what will be the design of this community component and how the referral and counter-referral mechanism will work with the HFA facility component (USAID/Angola communication). However, institutional and organizational capacity building of municipal authorities that manage the ADECOS is expected to be a priority.
2. **The next LLIN campaign is an opportunity to sustainably and fully transfer the campaign management to the NMCP.** Considerations include secondment of project staff to the NMCP and securing additional office space at the MOH.
3. **Opportunity to assist the MOH to add malaria and FP service guidelines to the national integrated PHC service delivery model.** The MOH has created an integrated PHC Division and is moving towards an integrated PHC service delivery approach. HFA is strategically positioned to transfer its case management model to be delivered as part of the PHC package.
4. **Opportunity to improve PHC facility organization and management in low-performing municipalities.** The project has strengthened a number of health facilities, but there is still a number of low-performing ones that need to be improved. Top-performing facilities are important assets to serve as models for the low-performing ones.

## 4.4 ASSESSMENT QUESTION 4: SUSTAINABILITY

### AQ 4: What mechanisms are in place by USAID and/or IPs to ensure the sustainability of the project's achievements?

#### 4.4.1 AQ 4.a Findings

### AQ 4.a: What has HFA done to ensure the sustainability of its interventions and achievements?

1. HFA's work to roll out DHIS2 is the main intervention that will ensure sustainability as it empowers managers to make informed decisions. DHIS2 also promotes country ownership as they can make their own improvements and focus their energies on the priority problems. The GoA has full ownership and administration control of the DHIS2 application and the data contained within it.

> *"The HFA design from the beginning did not factor in sustainability. Don't have metrics of transformation. It was not there at the beginning so unable to say a district or partner has been transformed."* – KI

2. HFA has created a sustainability matrix that needs to be translated into a sustainability plan. The HFA project has an M&E system that identifies top-performing facilities that can sustain malaria service delivery and help others when paired with low performers. The list of these facilities that meet performance sustainability standards should be one of the project outcomes.
3. HFA does not have a plan to sustain or replicate its FP interventions beyond the current 42 facilities. The effective handover of these facilities to serve as epicenters of scale up may be another opportunity to sustain the investment.
4. HFA was reported to not be required to measure capacity building outcomes. To sustain the investment in building capacity, HFA should consider defining a number metrics that will measure which facilities are able to sustain quality malaria test-treat-track and which need more support.

> "*There are no measurable capacity building indicators or metrics of transformation; consequently, it is not possible to define a district or partner as being sustainably transformed*" – KI

### 4.4.2 AQ 4.b Findings

**AQ 4.b: What have other IPs done that can be sustained?**

1. **WHO** is assisting to improve disease surveillance (Source: KIIs). This is important because an improved disease surveillance will help NMCP monitor the malaria program better along with other diseases that affect the Angolan population (TB, measles, etc.)
2. **UNICEF** has developed the ***evidence base for iCCM***. This evidence will help the MOH and its partners to expand iCCM nationwide.
3. A number of NGOs and FBOs, and other private sector providers, are active in Angola and also provide malaria and FP services. They may have lessons learned and effective practices that should be disseminated. However, this sector is usually untapped because they are usually not well coordinated and their results are not well known or disseminated. It would be helpful to assist GoA to coordinate and engage with the private sector, NGOs, FBOs, and community networks to learn and share what works best to strengthen the community response to control and eliminate malaria in the country.

> *"Integrated community health platforms are the backbone of the health care system. In the context of shortages in human resources for health across sub-Saharan Africa, community health workers have emerged as a critical platform for accelerating progress on health goals."* – KI

4. ***Exxon*** used to have a ***women's empowerment program*** that was canceled due to the oil crises and may be reinstated when oil prices go up. The program was not financially sustainable, but its approach to women's empowerment was reported to be a success. This could help increase demand for FP services. Coordinating with the Corporate Social Responsibility programs can help USAID expand its influence and expertise in FP.
5. The **Elimination-8** Technical committee is working in the south on a technical note to integrate other partners and Southern Africa Development Community (SADC) on elimination strategies, including a move towards targeted Indoor Residual Spraying (IRS) (Source: KIIs). We understand that USAID does not support IRS. It is good to know that other donors are supporting it. IRS may support USAID's vector control programs. We understand that Angola is in the control stage, not the elimination stage and thought it important to bring up what other partners are doing towards elimination that may complement what USAID is doing in high endemic provinces.

### 4.4.3 AQ 4.c Findings

**AQ 4.c: How much has the Angolan health information and LLIN and contraceptive supply systems been strengthened at national, provincial, municipal, and facility levels to deliver quality malaria and FP/RH services?**

1. **Coverage.** Despite the fact that DHIS2 has been rolled out in a large number of municipalities, its further expansion is still limited by internet access and connectivity. Some municipalities where the platform has been installed have no internet access. Some municipal staff reported using their own money to pay for the internet to send DHIS2 data.
2. **LLIN supply.** Routine distribution of LLINs has been strengthened with HFA and PMI support. Improving routine distribution channels through community and private sector stakeholders has emerged as an opportunity to improve access and use of LLINs in the next campaign.
3. **Prevention of MiP.** The assessment team realizes that this may not seem a priority during the COVID-19 pandemic. However, there is a need to expand routine LLIN distribution through an expanded ANC program (Source: KII). This is an opportunity for the HFA project in at least some of the top-performing facilities that do not provide ANC services yet.
4. **Supply chain**. Although PSM has strengthened management and distribution of commodities at central and provincial levels, weak institutional and organizational capacities at municipal and facility levels are the next challenge. As the system is in transition, this translates into dysfunctional push-pull systems and frequent stock-outs of LLINs at the facility level (Sources: KII). Stock control and management at facility level still need to be strengthened for LLINs and all malaria supplies.

### 4.4.4 AQ 4.d Findings

**AQ 4.d: How and how much has capacity building been institutionalized at national and provincial levels?**

1. **There is evidence of improved knowledge among HWs trained in the HFA focus health facilities. However, there is indirect evidence of improved practice through supervision. There is a need of tracking patients to a clear line of sight that capacity building has led to improved patient outcomes**. In addition, there is evidence that knowledge has improved (based on pre- and post-test training results), but capacity building has not been institutionalized in the MOH yet. The move to online training caused by the pandemic has been well received and reports indicate this is an important opportunity to sustain training capacity in the MOH. The institutionalization objective was not part of the HFA project design and there is no institutionalization outcome. There is partial evidence that demonstrates that training has improved performance or facility outcomes in selected top-performing facilities, but the M&E system of the project was not set up to measure outcomes of capacity building activities so this assessment may not be accurate. Further evaluation of the capacity building component would be required.
2. **Supervision capacity building**. HFA has successfully invested in digital expansion of HRH training and supportive supervision that proved to be useful during the COVID-19 pandemic. This capacity has not been handed over to the MOH yet. Successes of the digital application of supportive supervision and online training need to be sustained through non-proprietary options and monitored through performance outcome indicators (KIIs).
3. **DHIS2 capacity building.** HFA has achieved rapid scale-up due to enabling strong country ownership. Capacity building of DHIS2 personnel shows encouraging results that must be sustained and institutionalized in the MOH. The DHIS2 program needs to continue capacity building to improve the collection and use of quality data in all 60 municipalities.

4. **Institutionalization of all training in MOH and academic institutions**. In-service training capacity should be handed over to the MOH. Training of the healthcare providers should be conducted in collaboration with the new PHC Division and the country's Nursing Technical Training Schools. Sorting out challenges of collaboration between MOH and Ministry of Education will be the first step towards improving lasting HW capacity and updating pre- service malaria and FP/RH curricula and standards.
5. **Malaria and contraceptive supply capacity has not yet been fully strengthened and work needs to continue to institutionalize this capacity**. There were stockouts of malaria supplies in the visited facilities, and Luanda had stockouts in 2020, while Huambo had enough commodities. HFA does not have evidence of how this has affected new and current users.

# 5. CONCLUSIONS

This section presents the conclusions of the assessment for each of the four domains: design, implementation, opportunities, and sustainability.

## 5.1 ASSESSMENT QUESTION 1: DESIGN

1. The HFA project is performing according to the approved workplans and deliverables, and it has implemented the MTE recommendations. However, the manner in which it is doing so does not match the original design, which called for the project to co-diagnose and co-implement with the MOH and other stakeholders.
2. The assessment team found partial evidence of the effectiveness of the three TOCs (one for malaria, one for FP, and one for capacity building). The M&E system does not seem to be aligned with the TOCs. The results framework for FP and capacity building have indicators that are not being monitored.
3. We concluded that the underlying assumptions were not fully valid or realistic, and although HFA has tried to mitigate them, the project was not designed to do so. There are a number of ways in which the project attempted to address this design flaw. First, a successful partnership has been developed with the NMCP, especially after the MTE. However, the NMCP is very limited in staff, funding, and office space, which will need to be addressed to ensure the program is sustainable. Furthermore, HFA has helped improve the malaria supply chain in collaboration with GHSC-PSM. No functional linkages have been developed with the new PHC Department at the MOH, which has been recently restructured yet.
4. MOH ownership of the DHIS2 program was observed at various levels and an effective partnership with the NMCP has been reported, especially after the MTE. Stakeholders reported that the HFA project is working closely with the MOH to ensure that more than 80 percent of the facilities report and data quality is improved. However, KIs from some stakeholders are unclear about what will be in place at the end of the HFA project and how many facilities will have achieved a desired level of performance in malaria. Keeping all stakeholders informed and involved may be necessary for a smooth handover.
5. The HFA design included a large training component. HFA has trained over 5,000 HWs, which is an important achievement. However, the assessment team was not able to determine if and how MOH will keep track of who has been trained and who has not, or who is in need of a refresher. MOH was reported to lack an effective HRH strategy and plan.
6. The FP causal pathways are partially effective in achieving the desired outcomes. The design of the FP component of HFA includes only 42 facilities – 22 in Luanda and 20 in Huambo provinces – where FP services have remained stagnant. The objective of increasing contraceptive prevalence has not been met in these 42 facilities. The objective of improving contraceptive security seems to have been partially achieved in collaboration with GHSC-PSM. Although stockouts were reported in most facilities, our assessment found at least three methods were available in the visited facilities. The objective of expanding FP services in the private sector has not been implemented.
7. The design of the FP component did not include other RH activities, nor the replication of the FP model in new facilities. The current design monitors facility outputs and not population coverage targets.

## 5.2 ASSESSMENT QUESTION 2: IMPLEMENTATION

1. The HFA project has mostly been implemented, managed, and monitored in response to the MTE findings. Implementation also responded to the impact of COVID and HFA created online training

programs to make up for the lockdown restrictions. A number of implementation traits, especially those related to design assumptions, the large investment in mostly training, and the selection of output M&E indicators can be attributed to the original design.

2. MOH approves HFA plans and HFA supports supervision as part of their co-implementation approach, but some stakeholders reported not having been involved in the project and not being aware of the effectiveness of the project interventions. A co-implementation approach document was not available for assessment.

3. The malaria service delivery pathway adequately illustrates how targeted activities, outputs, and outcomes will contribute to reducing malaria-related mortality; however, most outputs are training activities and not outcomes. This is the case of the LLIN campaign plan too. The health system strengthening (HSS) pathway is predominantly focused on DHIS2 roll out only. Other HSS activities listed in the results framework are not being implemented.

4. The HFA implementation baseline and endline are not clear in terms of malaria coverage and access outcomes to be achieved. An Angola DHS survey is likely to be conducted in 2022, and will help define where the next project will pick up and build on where HFA has left off. At the time of the assessment, HFA was not able to estimate which municipalities or facilities will be able to sustain the HFA improvements and which will need to be the focus of the next project. This is likely to be determined by the end of the extension period in July 2023.

5. Implementation of Result 1 was reported to have been effective. Routine LLIN distribution has been integrated in ANC- and EPI-accredited clinics in the six PMI-focus provinces to ensure all pregnant women entitled to a bed net receive one.

6. Regarding implementation of Result 2, the HFA project has achieved 92 percent coverage towards meeting NMCP Test-Treat-Track targets. The percentages of patients diagnosed and treated showed some provinces have performed better than others. The reason for this difference could not be ascertained. Operational research would be required to do so. MCM is in alignment with the WHO Policy of Test, Treat, and Track. Continuous availability of supplies and commodities for effective case management has been a longstanding challenge in Angola. Stockouts are reported to be usually due to lack of timely requisitions or incorrect stock management. HFA has taken actions to mitigate stockouts through supervision and coordination with PSM.

7. Implementation of MiP has been partially effective. HFA has supported the facilities that provide ANC and as of **FY20 (Project Year 4), 30 percent of pregnant women attending the first ANC visit receive at least three SP doses.** The NMCP has a three-pronged approach to malaria prevention and control during pregnancy: IPTp with SP, LLIN use, and diagnosis and treatment of clinical illness. Based on DHIS2 data, despite incremental increases in the percentage of eligible pregnant women receiving IPTp, the NMCP's 80 percent target has not been and will likely not be achieved by the end of the project period.

8. HFA reports encouraging data regarding treatment of confirmed malaria cases. However, poor data quality limits the ability to conclude the actual magnitude of the result.

9. HNQIS is reported to be an effective supervision tool for malaria and FP programs. However, the output of HNQIS scores is not well correlated to the outcomes of improved quality of care. Measuring the correct indicators and their trends will allow USAID to see which facilities and municipalities are improving, worsening or can sustain adequate performance standards.

10. Building on the PMI, Global fund and Bill and Melinda Gates foundation experience in Angola working with ADECOS to support malaria prevention and community case management of uncomplicated malaria is expected to enhance sustainability of HFA community-based interventions.

11. Regarding implementation of Result 4, the FP component is small in scale and has had no demonstrable impact in terms of the expected outcomes. The HFA project does not have population coverage targets or use denominators to measure progress of this FP program in terms of increasing numbers of new acceptors or reduced unmet need**.** They also do not have progressive cumulative geographic coverage targets to track progress over time: e.g., FP is supported in 22 facilities in Luanda and there is no plan to "graduate" these facilities and move on to another set of 22, nor are there plans for developing how these facilities may serve as epicenters for scale up access to services.

12. Online training was reported to be effective to improve knowledge in malaria and FP. As with training in person, HFA has not assessed whether HCWs actually change their behaviors and patient outcomes have improved. It is expected that after the COVID-19 pandemic is under control, they should be able to assess the effectiveness of online training and make adjustments as necessary. MOH does not have a policy on online training or is it prepared to take over the design and management of online programs yet.

13. Regarding Result 5, DHIS2 implementation has been reported to be the most successful aspect of the HFA project. DHIS2 has been scaled up to 60 municipalities and HFA has reported to be working to effectively address data quality and use concerns. This is likely to continue in the project extension and be effectively handed over to the MOH.

## 5.3 ASSESSMENT QUESTION 3: OPPORTUNITIES

The assessment found a number of opportunities for addressing systemic challenges, improving the quality of malaria services, and expanding the coverage of malaria and FP programs in the PMI provinces. The strong ties and coordination with the GF program will allow USAID/Angola and the GF to compare progress and lessons learned. The GF is implementing its malaria program in two provinces and USAID/PMI in six. Together, they cover eight of the 18 provinces in Angola, and can reach a critical population mass to significantly impact malaria mortality in the country.

1. Malaria and FP services are part of Angola's integrated PHC program and the new PHC package of services. This is an opportunity for USAID/Angola to help the newly created integrated PHC Division implement an effective delivery of the malaria and FP components of the integrated PHC package in the target provinces.

2. Because HFA is working in hundreds of facilities, it can help develop a new and more efficient facility organization and management model that allows HW to test, treat and track and every patient. This is particularly important in the context of COVID-19, to differentiate and diagnose and treat both malaria and COVID-19 correctly.

3. DHIS2 and the increased availability of data creates the opportunity to have a new set of outcome indicators that will need to be developed for NMCP and the FP managers monitor and manage their programs.

## 5.4 ASSESSMENT QUESTION 4: SUSTAINABILITY

The HFA project does not have an effective sustainability strategy yet. The project has developed a matrix that estimates the likelihood a number of activities will be sustained, but it does not include what the project will hand over to the MOH nor when and how. A detailed sustainability implementation plan will need to be developed and implemented during the two-year extension. Sustainability milestones will need to be monitored and followed closely quarterly over the next two years for USAID to ensure its investments are sustained and this project serves as a foundation to the next project. In the recommendations sections we propose a number of essential components to the HFA sustainability plan.

Sustainability is likely to be significantly affected by the COVID pandemic though. Assessing the impact of COVID-19 was not part of this assessment, so it will be essential to determine its impact as part of the HFA endline. The next Angola DHS should also demonstrate the pandemic's impact.

# 6. RECOMMENDATIONS

## 6.1 RECOMMENDATIONS FOR SUSTAINABLY IMPROVING THE HFA OUTCOMES BY JULY 2023

Below are proposed recommendations for consideration from the HFA project to ensure that the project sustainably contributes to the next LLIN campaign and effectively transfers its training experience and capacity in the MOH. This will allow the next project to build on that capacity and address systemic issues and decentralized program management.

1. Develop a detailed plan for the role HFA will play in the next LLIN campaign and a monitoring plan to ensure HFA's contribution is on track and aligned with the work of other partners. The assessment team understands that such a macro-plan is available and microplanning will start soon and suggests that the plan measures coverage in PMI provinces and actual LLIN use in the targeted households, to compare it with morbidity patterns in those provinces.
2. Strengthen quality data for decision-making and action. Establish cross-cutting routine DHIS2 data audits and quality assessments. Consider short-term secondment of HFA technical staff to address data quality issues at national and subnational levels. The assessment team understands that this recommendation is also already underway, and they recommend that USAID/Angola monitor quarterly the number of facilities and municipalities that demonstrate they have improved the quality of their data and use the data to improve service delivery. USAID/Angola should see the number increase every quarter.
3. Assist MOH to develop DHIS2 expansion plan so they can start looking for additional funding sources to expand the system nationwide over the next ten years. Possible sources of funding include Gates Foundation and Inveneo[14] grants. In the course of preparing this report, USAID/Angola informed the assessment team that such a roadmap already exists. The team was not able to assess it, so it can only recommend that the roadmap include the eventual handover of the online training platform and the integration of DHIS2 and eLMIS, and that all software be open source and interoperable.
4. Assist the MOH to establish or revitalize TWGs to improve coverage of sustainable outcomes towards WHO 2030 Technical Strategy and help create effective thematic work groups to address MiP, MCM, vector control, and supply chain. The new integrated PHC Division at the MOH is a viable platform to enhance coordination and integration of service delivery at all levels including community actors.
5. Transfer training toolkits and tools to a newly created MOH In-service Training Team that will oversee the capacity development of the Angolan health workforce with the help of local institutions and a critical mass of Angolan HFA-trained malaria experts.
6. Transfer eLearning platform and link to the MOH website, and create a team of trainers in the MOH that can continue and set up an eLearning platform for health staff to access training nationwide.
7. Implement the online FP program, transfer the training capacity to the FP team in the MOH and add the program to the MOH eLearning platform.
8. Train all NMCP, PHC and HIS MOH program staff on how to develop new open-source online training programs in malaria Test, Treat, and Track and other topics, such as: LLIN distribution, health facility pharmacy management and stock control, lab testing, ANC, IMCI, promotion of LLIN use, IPTp, etc.

[14] http://www.inveneo.org/

9. Assist each of the MOH trainers to develop at least one online program and demonstrate online training capacity has been transferred and will be sustained by the MOH.
10. Work with the new MOH PHC Division to ensure HFA contributes to Angola's FP2030 targets and use the lessons learned of having supported 42 facilities to develop a scale up plan to achieve the FP2030 targets.
11. Support MASFAMU/MOE to tackle FP/RH misconceptions and taboos. For instance, supporting the Menstrual Hygiene Program (in partnership with UNFPA) could help increase FP demand. Support to the "Comité Genero do MINSA"at the MOH is also desirable; for instance, supporting their sexual education program, and advocating for the establishment of SOPs to enhance integration of service delivery with ANC services. The recommendation about integration is in line with the new decree that creates the PHC department.

# ANNEXES

# ANNEX 1. EVALUATION SOW

Assignment #: 006 [*assigned by GH EvaLS*]

**Global Health Assessment and Learning Support Project (GH EvaLS)**

**Contract No. GS-10F-154BA**

**ASSESSMENT OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)**

Date of Submission: July 31, 2020

Last update: September 28, 2020

**INSTRUCTIONS**: Complete this template in MS Word to develop a SOW an assessment, assessment, or other analytic activity. Please be as thorough as possible in completing this SOW. Your GH EvaLS Technical Director/Senior Assessment Advisor and project management team will assist you in finalizing your SOW.

Some of the sections below have been pre-populated with information that is common to most analytic activities. Please review these details and edit as needed to fit the needs of your specific analytic activity.

*Refer to the USAID How-To Note: Assessment SOW and the Assessment SOW: Good Practice Examples when developing your SOW.*

**I. Title**: Design and Implementation Assessment of the Angola Health for All Project

**II. Funder/Requester / Client**

USAID Country or Regional Mission

Mission/Division: USAID/Angola

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

| | | |
|---|---|---|
| HIV | PIOET | **X** FP/RH |
| TB | Other public health threats | WSSH |
| **X** Malaria | MCH | Nutrition |
| | | Other (specify): |

**IV. Budget Ceiling: Omitted** (Note: GH EvaLS will provide a cost estimate based on this SOW)

**V. Performance Period**

Expected Start Date (on or about): 15 October, 2020

Anticipated End Date (on or about): March 19, 2021

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

| |
|---|
| A combination of remote from and in Angola. |

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

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

## VIII. BACKGROUND

If an assessment, Project/Program being evaluated:

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

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*)

**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 Government of the Republic of Angola (GRA)'s malaria goals. Insecticide Treated Net (ITN) ownership remains low, with 29% of households with at least one ITN in 2015 and 20% of population having access (Angola Demographic and Health Survey/ADHS 2015-16). Access to, and quality of, malaria services are also inadequate to meet the National Malaria Control Program (NMCP)'s targets for case management and malaria prevention and treatment during pregnancy. Only 45% of the population has access to a public HF (Plano Nacional de Deselvolvimento Sanitariá[15]/PNDS 2012-2015); 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 19% of pregnant women receive at least three doses of intermittent preventive treatment in pregnancy (IPTp). Less than a quarter (24.5%) of children under five with a recent fever received any diagnostic test (ADHS 2015-16).

**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) (ADHS 2015-16). 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.

**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 "HFA will directly engage Ministry of Health (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 HFA 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 sources 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 4: Strengthened, expanded and integrated FP/RH services at provincial, and municipal levels (FP).
- Result 5: Capacity building in DHIS2- 64 municipalities, in Zaire, Uíge, Cuanza Norte, Malanje, Lunda Norte, & Lunda Sul. The Team will consult closely with USAID, the National Malaria Control Program (NMCP), DPS, and municipal leaders to finalize selection and update new prevalence data is available.

Theory of Change of target project/program/intervention:

**DESCRIPTION OF THE INTERVENTION TO BE EVALUATED AND THEORY OF CHANGE**

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 needs LLIN mass distribution in 13 provinces with support from selected local partners. PSI also supervises and provides TA to LLIN Continuous Distribution (CD), including routine health services**.** For Result 2, PSI develops Provider Behavior Change Communication aimed to improve the percentages of people seeking for health services, women attending ANC consultations receiving at least 3 SP doses and people sleeping under the mosquito net; methodology and tools for quality assurance as well as collection and management of aggregated service delivery data through information systems through continuous capacity building of strategic information staff, on-site mentorship and supervision.

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 Norte, Malanje, Uige and Zaire. For Result 4, PSI leads and implements all FP activities (including competency mentorship of health providers, gender integration in FP programming), and for Result 5, PSI leads implementation of HMIS (DHIS-2) for data integration into the M&E and surveillance system for NCMP, as well as provide staff seconded to NMCP.

Rede Mulher Angola (RMA) implements SBCC activities in FP, in Result 4 through its network of 80+ local organizations in Luanda and other provinces as appropriate. RMA also leads capacity-building training for local organizations on topics including gender, organizational management, and budgeting. For Result 5, RMA leads advocacy for gender equity in allocation of resources.

The MENTOR Initiative leads the distribution of LLINs in Uige 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 HFA 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.

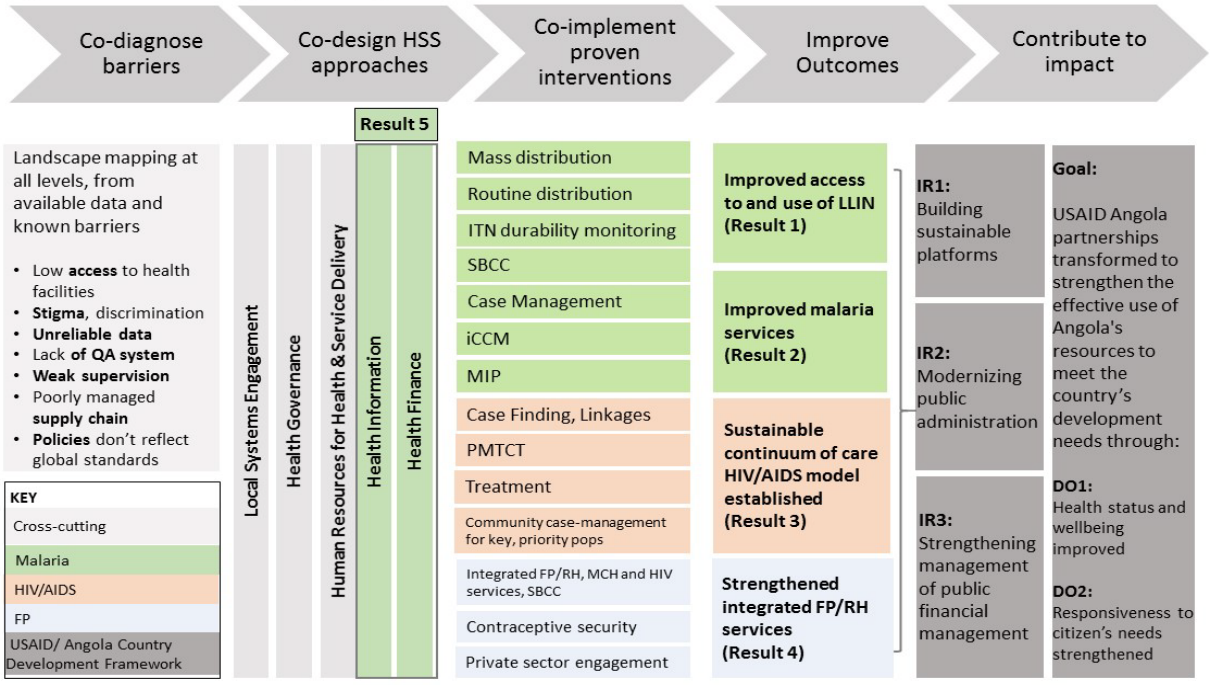
**Health for All Capacity Building Framework**

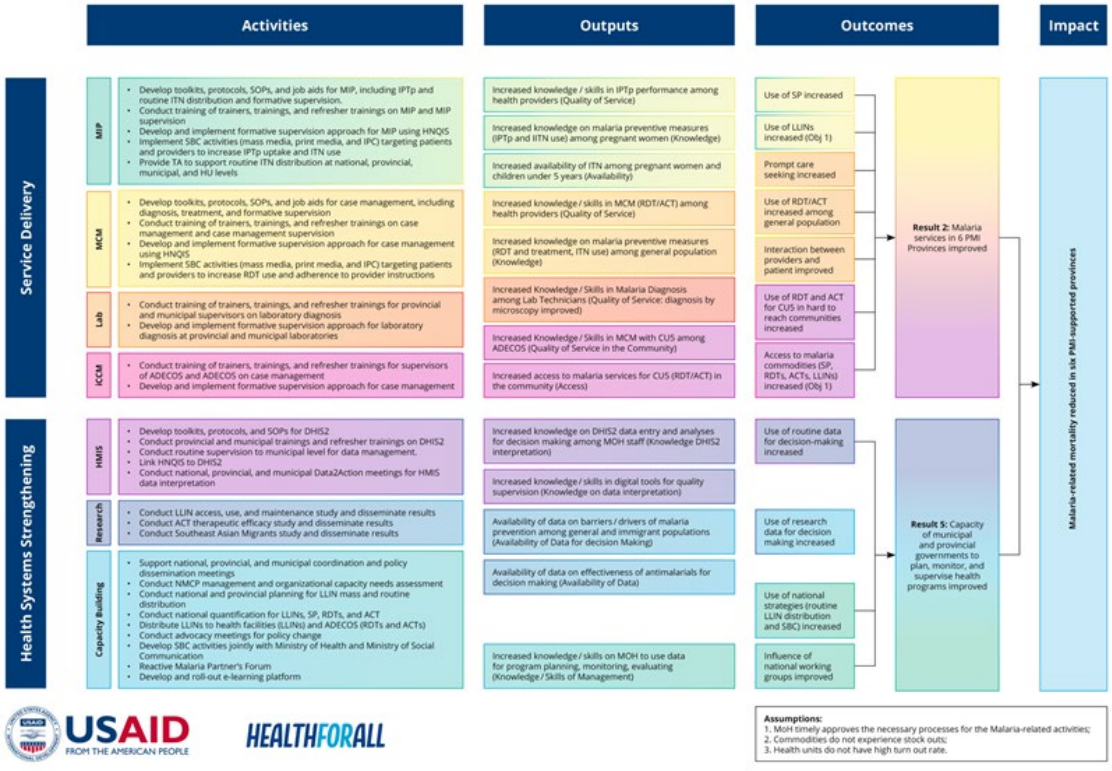
**Theory of Change for Malaria and Family Planning**

**i) Malaria**

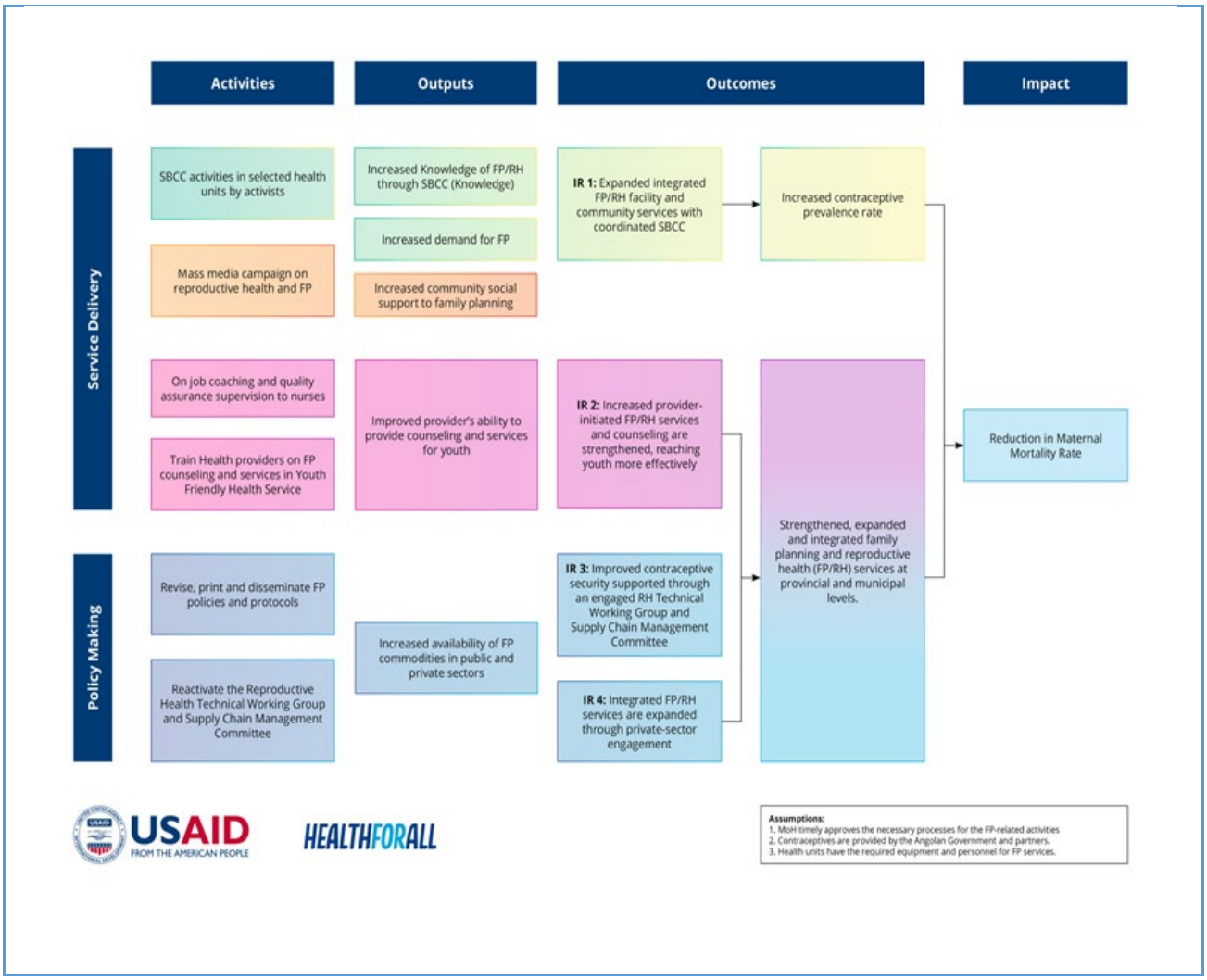
[15] National Plan for Health Development

**Figure 1:** Health for All Capacity Building Framework




## ii) Family Planning


Activities
Outputs
Outcomes
Impact
Service Delivery
SBCC activities in selected health units by activists
Mass media campaign on reproductive health and FP
Increased Knowledge of FP/RH through SBCC (Knowledge)
Increased demand for FP
Increased community social support to family planning
IR 1: Expanded integrated FP/RH facility and community services with coordinated SBCC
Increased contraceptive prevalence rate
On job coaching and quality assurance supervision to nurses
Train Health providers on FP counseling and services in Youth Friendly Health Service
Improved provider's ability to provide counseling and services for youth
IR 2: Increased provider-initiated FP/RH services and counseling are strengthened, reaching youth more effectively
Policy Making
Revise, print and disseminate FP policies and protocols
Reactivate the Reproductive Health Technical Working Group and Supply Chain Management Committee
Increased availability of FP commodities in public and private sectors
IR 3: Improved contraceptive security supported through an engaged RH Technical Working Group and Supply Chain Management Committee
IR 4: Integrated FP/RH services are expanded through private-sector engagement
Strengthened, expanded and integrated family planning and reproductive health (FP/RH) services at provincial and municipal levels.
Reduction in Maternal Mortality Rate
USAID
FROM THE AMERICAN PEOPLE
HEALTHFORALL
Assumptions:
1. MoH timely approves the necessary processes for the FP-related activities
2. Contraceptives are provided by the Angolan Government and partners.
3. Health units have the required equipment and personnel for FP services.

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

**PROJECT OR ACTIVITY MONITORING, ASSESSMENT, AND LEARNING (MEL) PLAN**

USAID/Angola is in a unique position where the Office has only one project as defined through a PAD. Achieving the results set forth in the Projecto de Angolanizacão's Project's Logical Framework will achieve the results established in the CDCS' Results Framework. Therefore, the project level M&E Plan becomes synonymous with the Mission's Performance Management Plan (PMP). The PMP is an essential tool to plan and manage the process of monitoring, evaluating, and analyzing progress towards achieving results identified in the CDCS Results Framework (RF) and the PAD Logical Framework. The PMP includes indicator reference sheets for each indicator, information on how data quality will be assured during project implementation, and targets for each indicator. It informs decision making processes, resource allocation, learning, and adapting activities.

The HFA project hence has a variety of data sources which includes:

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 Government of Angola (GoA) counterparts

j. 2018 HFA Mid-Term Assessment

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

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

For **Result I** the geographic coverage for LLIN mass distribution was in 15/18 provinces (2017/2018); project will support the transition from a national campaign led by PSI (through PMI funding) to a national campaign lead by NMCP, where PMI will fund LLIN procurement and continuous distribution in 6 PMI focus provinces (Cuanza Norte, Lunda Norte, Lunda Sul, Malange, Uige, and Zaire; "Next Campaign 2022").

For **Results II** and **V** the geographic coverage is all 61 districts of the 6 PMI focus provinces listed above. HFA also provides TA to NMCP as needed.

For **Result IV** the geographic coverage is Luanda and Huambo.

Assessment should include at least 2 field sites in 2-4 of the 6 focus provinces (Cuanza Norte, Lunda Norte, Lunda Sul, Malange, Uige, and Zaire).

## IX. Purpose, Audience & Application

A. **Purpose**: Why is this 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.

USAID/Angola is implementing the Health for All (HFA) project from January 2017 to end January, 2022. HFA is a consortium led by Population Services International (PSI) Angola, and consortium members include: Rede Mulher Angola (Local Partner), Tropical Health LLP, Management Sciences for Health, and The MENTOR Initiative. The project 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," HFA directly engages the Ministry of Health (MOH), civil society, private sector, and beneficiary partners to co-diagnose fundamental barriers, co-design approaches to strengthen health systems, and co-implement proven interventions, thus building ownership and skills to transform HFA interventions into measurable and sustainable outcomes beyond program end.

As the HFA project approaches the endpoint of its implementation in January 2022, USAID Angola would like to conduct a detailed design and implementation assessment of the Project overall and its principal activities. The purpose of the assessment is to i) have an external review of the project design and its implementation to see how it supports the stated goals, and ii) to identify and recommend adaptation measures as learned from its inception phase that can be used to enhance the management, implementation, applicability, sustainability, and accountability in the new design.

This assessment is not expected to focus on the performance of results as this was extensively covered through the mid-term performance assessment carried out in 2018 but is expected to gather evidence that informs future decisions about HFA project design and programming. However, the Assessment Team will provide recommendations to the USAID Angola office, particularly the US President's Malaria Initiative (PMI) team, for the development of the next projects and activities for the next five years.

**Specific Assessment Objectives**

To achieve the above-mentioned purpose, the assessment has the following objectives:

**Design:**

1. To assess the applicability of the project design by identifying areas that need to be modified/ improved to increase the likelihood of success of the new project.

- Provide specific information about the gaps and opportunities for the project that can be used to strengthen the new design (Opportunities).
- Assess if the project design is likely to result in the anticipated changes – health for all – i.e. assessing the validity of the causal linkages (Theory of change).
- Assess the relevance of underlying assumptions in relation to the changing context (Sustainability).
- Understand how primary stakeholders envisioned the HFA project and anticipated results (Co-creation and partnerships).

**Implementation**

2. To provide formative feedback on the program implementation for continuous improvement in the new programming.

- Analyze the project implementation and management arrangements (Management).
- Analyze contextual factors either enabling or hindering implementation (Challenges).
- Assess the monitoring and assessment systems used to manage the interventions (Performance management).

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

The intended audience and use of these results will be USAID/Angola as we plan for the new bilateral project to follow Health for All. The results will help the Mission to learn from the management and implementation challenges within Health For All to build a strong project from the start to follow. USAID/Angola would like a public and internal report. A public-facing document to be shared with the MOH and implementing partners interested in applying for the next bilateral project to inform their plans as well. The public document should be uploaded in the Development Experience Clearinghouse (DEC).

In addition to the public document, USAID/Angola would like an internal report for USG-only use that has key recommendations geared for USG program managers who will be designing the follow-on award.

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

The findings from this assessment will inform future decisions about HFA project design and programming. More broadly, the Assessment Team will also provide recommendations to the USAID Angola office, particularly the US President's Malaria Initiative (PMI) team, for the development of the next projects and activities for the next five years.

## X. Assessment/Analytic Questions & Matrix:

This assessment acknowledges the assessment questions answered by the midterm performance assessment; hence only focuses on assessing the theory of change and the theory of action to help inform the next project design and implementing parameters. Findings from the mid-term performance assessment were noted and a post-assessment action plan was developed to manage the implementation of the recommendations. The questions below will help in measuring and analyzing the project design and its implementation to provide quality, timely feedback for improvement. The assessors are expected to review and finalize these suggested assessment questions in collaboration with USAID prior to finalizing the assessment design.

| Focus | Assessment Question* | Suggested Data Sources | Suggested Data Collection Methods | Data Analysis Methods |
|---|---|---|---|---|
| **Design** | To what extent is the HFA project design applicable to Angola?<br>- To what extent are the underlying assumptions still valid?<br>- Are the causal pathways producing the required outcomes? | Program Description (PD) with goals and results, work plans, PMP, quarterly reports, key informant interviews, site level record reviews. | Key informant interviews, desk review, FGDs, Theory of change workshop | Qualitative analysis of key informant interviews and FGDs |
| **Implementation** | To what extent is the project's plan of implementation effective in achieving the desired results?<br>- To what extent is the HFA project managed effectively (internal and external; nationally and provincial)?<br>- What are the enabling factors critical for success and barriers that impede implementation?<br>- What are the key strategic, programmatic, technical, and managerial features of the Project that should be taken into account when designing and implementing the next project in Angola? | Selection of three or more products, activities, and tools across health elements (FP and malaria). Review SOPs,<br>Project documents (organogram, management functions, financial records, HR records, process documents, meeting minutes and notes, etc.) | Key informant interviews (project and USAID staff in Angola), technical analysis of SOPs, FGDs<br>Desk reviews | Rating of tools using checklist against standards. (Checklist to be developed by the Assessment Team.)<br>Rating of implementation tool.<br>Qualitative analysis of key informant interviews and FGDs |
| **Opportunities** | What are the current opportunities faced by the Project?<br>- What are the areas of additional opportunities beyond the current mandate? | Portfolio reviews, stakeholders' reports | Document review, stakeholder workshop | Benchmarking, scoring |

| Focus | Assessment Question* | Suggested Data Sources | Suggested Data Collection Methods | Data Analysis Methods |
|---|---|---|---|---|
| **Sustainability** | What mechanisms are in place by USAID and/or the implementing partners, to ensure sustainability of the Project's achievements? | Portfolio reviews, stakeholders' reports | Document review, stakeholder workshop | |

* *The assessment may not answer each sub-question. The sub-questions will be used for probing.*

**XI. Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be **aligned with the 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.

This assessment is envisaging to focus more on a qualitative analysis approach, which involves an interpretive and detailed description of situations, interactions, observed behaviors and direct quotations from people about their experiences and thoughts. This is going to be a qualitative assessment looking for information that will strengthen the next project design. It is inductive in nature leading to the development or creation of a theory rather than the testing of a preconceived theory of hypothesis. This is not an outcomes-based assessment, so an inductive approach can be fully utilized. However, it can be narrow in scope as it is mainly applicable to specific situations and experiences and is not intended for generalization to broad situations. When used in combination with a quantitative analysis, a more complete or holistic set of findings can be achieved.

The assessors shall work with USAID Angola PMI team in this assessment. As stated above, this qualitative analysis generally results from fieldwork where the assessors spend a significant amount of time observing the project sites and/or with people beneficiaries, thus it uses assessors as the primary means of data collection. Since this will be a non-experimental design, qualitative research methods such as,

i. Key informant interviews (KIIs)
ii. Focus group discussions (FGDs)
iii. Desk review (documents, data relevant to the PAD, etc.), and
iv. Project site observations,

will be used to collect the evidence. The assessors will be the primary means of data collection through a multimethod and purposively sampled qualitative study.

*KIIs/FGDs*

KIIs/FGDs with primary stakeholders will help provide pertinent information on the plausibility of the project design and scrutinize the validity and applicability of the HFA theory of change in the Angola context. This will help USAID understand emerging issues and needs from the GRA and help understand some of the nuanced challenges, which are hindering implementation, at the same time identifying enablers that can facilitate better implementation.

Given the GRA has instituted a 14-day quarantine on any international travelers coming into the country, there is a strong preference for identifying in-country evaluators to conduct this work.

Currently travel within the country is possible and fieldwork expected. The assessors should be prepared to be flexible and able to adapt to remote work if needed due to GRA policy changes. The Assessment Team has the flexibility to propose innovative ways to gather the information that will address the assessment objectives and answer the questions. The Assessment Team, in collaboration with USAID, will finalize the assessment methods before fieldwork begins.

*Desk review*

USAID expects that, at a minimum, the Assessment Team will:

- Familiarize themselves with documentation about the project and USAID's current assistance in the Malaria and Family Planning areas in Angola;
- Review and assess the existing performance monitoring and management systems;
- Conduct site visits for observations on programs (when applicable and feasible)
- Meet and interview USAID project beneficiaries, partners, and host government counterparts at appropriate levels; and
- Interview USAID staff and a representative number of experts working in the sector.

The desk review includes at a minimum:

- USAID HFA PAD and/or SOW;
- HFA materials: Annual and Quarterly Reports, Annual Work Plan, MEL Plans, sector assessments, trip reports, performance reports, gender analyses, relevant sections of the Project Appraisal Document,
- Various thematic reports from other sources
- 2018 HFA mid-term assessment

USAID will ensure that documentation is available to the team at least 2 weeks prior to planned interviews or fieldwork.

The contractor will submit the preliminary assessment design for review by USAID. The design matrix should include a data analysis plan for each assessment question, including explicit description of major limitations in data collection and analysis. The Contracting Officer's Representative (COR) will approve the finalized design two weeks or more prior to the team's arrival in the country.

**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 *assessment*. Documents and data to be reviewed include:

- USAID HFA PAD and/or SOW
- HFA materials: Annual and Quarterly Reports, Annual Work Plan, MEL Plan and theory of change, sector assessments, trip reports, performance reports, gender analyses, relevant sections of the Project Appraisal Document
- Various thematic reports from other sources
- 2018 HFA Mid-Term Assessment

**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 |
|---|---|---|
| NSP 2016-2020 | | |
| NSP end term review | | |

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

- HFA CR, COP, Deputy COP; Malaria Director;

- NMCP Coordinator and Deputy Coordinator; NMCP MCM Focal Point; NMCP ADECOS Focal Point; NMCP SBC Focal Point and/or NMCP head of epidemiology/M&E department;

- Focal person of DHIS2 at GNTI/MOH; - Focal person of ADECOS at FAS/MOH;

- Provincial and or district Health Directors at target provinces;

- MENTOR Initiative Angola portfolio manager;

- Representative of other organizations, including WHO malaria focal person, World Vision or SADC E8 COP, etc.

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

To be determined.

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

## 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 assessment questions.

Thematic review of qualitative data will be performed, connecting the data to the assessment questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. If relevant, qualitative data will be used to substantiate secondary quantitative data and answer questions where other data do not exist. Further, the contractor is requested to provide disaggregated data (e.g., sex, age, geography, or other relevant aspects of beneficiaries) whenever possible.

The Assessment Report will describe analytic methods employed in this assessment, including the methods used to ensure reliability of coding and identifying themes in qualitative data.

The Assessment Team, in collaboration with USAID/Angola, will finalize the assessment methods before fieldwork begins.

## 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 assessment and will be provided prior to the assessment launch. This desk review will provide background information for the Assessment 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 assessment 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 assessment 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 assessment work plan for USAID's approval
- Develop a preliminary draft outline of the assessment report
- Assign drafting/writing responsibilities for the assessment report

**Workplan and methodology** submitted and followed by review meeting. Workplan will include:

- Assessment questions
- Proposed methodology
- Data collection strategy (including data collection instruments that include interview questionnaires)
- Data analysis plan describing procedures that will be used to analyze qualitative data from key informant and other stakeholder interviews, and how the assessment will weigh and integrate qualitative data from these sources with IAPHL records to reach conclusions about the effectiveness and efficiency of the project
- Assessment timeline
- Data and resource requirements

- List of key informants, focus group discussions, project sites, etc.

Unless exempted from doing so by the COR, the assessment workplan will be shared with partner country stakeholders as well as with the implementing partners for comments and feedback before being finalized.

The data analysis plan will clearly describe the Assessment Team's approach for analyzing the qualitative data (as applicable), including proposed sample sizes, specific data analysis tools, and any software proposed to be used, with an explanation of how/why these selections will be useful in answering the assessment questions for this task. Qualitative data will be coded as part of the analysis approach, and the coding used should be included in the appendix of the final report. Gender, geographic, and role (beneficiary, implementer, government official, NGO, etc.) disaggregation must be included in the data analysis where applicable.

All dissemination plans will be developed with USAID and include information on audiences, activities, and deliverables, including any data visualizations, multimedia products, or events to help communicate the assessment findings and recommendations.

If applicable based on the Disclosure of Conflict of Interests Forms submitted with the awardee's proposal, the assessment design will include a conflict of interest mitigation plan.

USAID offices and relevant stakeholders are asked to take up to ten working days to review and consolidate comments through the COR. Once the Assessment Team receives the consolidated comments on the initial assessment design and work plan, they are expected to return with a revised design and work plan within ten working days.

**In-briefing:**

The Assessment Team will meet with the PMI team for introductions and to discuss the team's understanding of the assignment, initial assumptions, assessment questions, methodology, and work plan, and/or to adjust the SOW, if necessary.

**Mid-term Briefing and Interim Meetings:**

The Assessment Team is expected to hold a mid-term briefing with USAID Angola on the status of the assessment, including potential challenges and emerging opportunities. The team will also provide the assessment activity manager and COR with periodic briefings and feedback on the team's findings, as agreed upon during the in-briefing. If desired or necessary, weekly briefings by phone can be arranged.

**Final Exit Briefing:**

The Assessment Team is expected to hold a final exit briefing to discuss the status of data collection and preliminary findings. This presentation will be scheduled as agreed upon during the in-briefing.

**Preliminary Presentation:**

The Assessment Team is expected to hold a preliminary presentation either in person or by virtual conferencing software to discuss the summary of findings and conclusions with USAID, and to draft collaboratively any requested recommendations. Any presentations will be scheduled as agreed upon during the in-briefing. Please note that within the assessment report, findings and conclusions are standard but recommendations are optional. If you do request recommendations, they should be based on findings and conclusions and developed in collaboration with USAID in order to ensure the most relevant and feasible recommendations possible.

**Final Presentation:**

The Assessment Team is expected to hold a final presentation in person or by virtual conferencing software to discuss the summary of findings and conclusions (and recommendations, if applicable) with USAID. This presentation will be scheduled as agreed upon during the in-briefing.

**Draft Assessment Report:**

The draft assessment report should be consistent with the guidance provided in Section IX, Final Report Format. The report will address each of the questions identified in the SOW and any other issues the team considers having a bearing on the objectives of the assessment. Any such issues can be included in the report only after consultation with USAID. The submission date for the draft report will be determined in the work plan. Once the initial draft report is submitted, USAID will have 10 working days in which to review and comment on the initial draft, after which point the COR will submit the consolidated comments to the Assessment Team. The Team will then be asked to submit a revised final draft report within 10 working days, and again the USAID Angola will review and send comments on this final draft report within 7 days of its submission.

**Final Assessment Report:**

The Assessment Team under the leadership of the Team Lead will develop a report with findings and recommendations. Report writing and submission will include the following steps:

1. Team Lead will submit assessment report to GH EvaLS for review and formatting
2. GH EvaLS will submit the draft assessment report to USAID
3. USAID will review the draft assessment report in a timely manner, and send their comments and edits back to GH EvaLS
4. USAID will manage implementing partner(s)'s (IP) review of the report and compile and send their comments and edits to GH EvaLS. (*Note: USAID will decide what draft they want the IP to review.)*
5. GH EvaLS will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH EvaLS
6. GH EvaLS will review and reformat the final assessment report, as needed, and resubmit to USAID for approval.
7. Once the final assessment report is approved, GH EvaLS will re-format it for 508 compliance and post it to the DEC.

**Submission of Dataset(s) to the Development Data Library:**

Per USAID's Open Data policy (see ADS 579, USAID Development Data) the contractor must also submit to the COR and the Development Data Library (DDL), at www.usaid.gov/data, in a machine-readable, non-proprietary format, a copy of any dataset created or obtained in performance of this award, if applicable. The dataset should be organized and documented for use by those not fully familiar with the intervention or assessment. Please review ADS 579.3.2.2 Types of Data To Be Submitted to the DDL to determine applicability.

**Submission of Final Assessment Report to the Development Experience Clearinghouse:**

Per USAID policy (ADS 201.3.5.18) the contractor must submit the assessment final report and its summary or summaries to the Development Experience Clearinghouse (DEC) within three months of final approval by USAID.

## 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.

| Activity/Deliverable | Timelines & Deadlines (estimated) |
|---|---|
| Launch briefing/In-Brief with USAID | Week 1 (o/a October 19) |
| Desk review | Weeks 1-4 (October 19-November 13) |
| Team Planning Meeting (with USAID in attendance) | Week 2 (week of October 26) |
| Workplan submission (includes assessment questions, methods, timeline, data analysis plan, data collection tools, and the assessment report outline) | 15 days following in-brief with USAID |
| Workplan and methodology briefing with USAID/In-brief with target project | Week 4 (week of November 9, 2020) |
| Data collection | Weeks 5-10 (November 16-December 25) |
| Routine briefings/progress reports | Weekly |
| Data analysis | Weeks 11-13 (December 28-January 15) |
| Key findings/Out-brief with USAID (Power Point presentation) | Week 14 (post data analysis, week of January 18) |
| First draft of the assessment report | Weeks 15-17 (January 25-February 12) |
| USAID reviews first draft of the assessment report and sends feedback | Weeks 18-19 (February 15-26) |
| Incorporating of USAID feedback in the final draft of the assessment report | Week 20 (March 1-5) |
| USAID reviews and signs off on final draft of the assessment report | Weeks 21-22 (March 8-16) |
| Final report editing, formatting, 508 compliance | GH EvaLS submits assessment report to USAID by March 19 |
| Report Posted to the DEC | |

**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)

The COR may observe all of the data collection efforts. USAID will also delegate one or more staff members to work full-time with the Assessment Team or to participate in selected assessment activities. The COR will inform the contractor in writing about any full-time or part-time USAID delegates no later than 5 working days after the submission of a draft assessment work plan. USAID will pre-define any staff's level of involvement by indicating the purpose of their inclusion, their role on the team and in which components of the assessment they will participate, their expertise in the topic or sector, their expertise in assessment design or implementation, and their anticipated LOE. USAID maintains primary responsibility for management of its own staff. USAID will outline collaboration, delivery, and performance expectations for its staff as well as reporting lines and how staff management roles and responsibilities will be coordinated between USAID, the contractor, and the Assessment Team lead. This plan will be finalized in consultation with the contractor and the Assessment Team lead, with final approval by the COR, to ensure it is feasible and appropriate to the assessment objectives and USAID Angola's needs and that it addresses mitigation of risk of impeding assessment implementation or biasing findings. All costs associated with the participation of full-time or part-time USAID Angola delegates in the HFA assessment will be the responsibility of USAID.

**Overall Assessment Team requirements:**

- Experience in assessment design, methods, management, and implementation.
- Technical subject matter expertise.
- Background in USAID's cross-cutting program priorities, such as gender equality and women's empowerment, youth, etc.
- Country experience; and
- Local language skills (Portuguese).

**Team Lead/Senior M&E Specialist (Key Staff 1)**: The Team Lead (TL) should have significant experience conducting and leading project evaluations and/or assessments and a strong background on malaria.

Roles & Responsibilities: The TL will be responsible for:

- Providing team leadership
- Managing the team's activities
- Ensuring that all deliverables are met in a timely manner
- Serving as a liaison between the USAID/Angola and the Assessment Team, and
- Leading briefings and presentations

Qualifications:

- At least 10 years of experience in M&E procedures and implementation which included experience leading malaria program evaluation/assessments, utilizing both quantitative and qualitative methods

- At least 5 years managing M&E, including evaluations/assessments
- Experience in design and implementation of evaluations/assessments
- Strong knowledge, skills, and experience in qualitative and quantitative analytic tools
- Experience implementing key informant interviews, focus groups, observations and other evaluation and assessment methods that assure reliability and validity of the data
- Experience in data management and able to analyze quantitative and qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies
- Experience conducting secondary analysis of existing quantitative datasets
- Has demonstrated experience in USAID project design.
- Strong communication, supervision, and management skills required
- 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; ability to manage
- Excellent skills in project management including ability to internally manage complex tasks and interdisciplinary teams for evaluation
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Familiarity with USAID policies and practices

**Senior Malaria Specialist/Subject Matter Expert (Key Staff 2):** The Senior Malaria Specialist will provide expertise on malaria program design, implementation, and evaluation.

Qualifications:

- Extensive experience (at least 10 years) in malaria program design, implementation and evaluations/assessments
- Knowledge and experience in the design and implementation of malaria evaluations/assessments, including use of quantitative and qualitative methods
- At least 5 years managing M&E, including evaluations and/or assessments
- Experience implementing key informant interviews, focus groups, observations and other evaluation and assessment methods that assure reliability and validity of the data
- Experience in data management and able to analyze quantitative and qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies
- Has demonstrated experience in USAID project design
- 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; ability to manage

- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Familiarity with USAID policies and practices

**Local Malaria Specialist (Key Staff 3)**: The Local Malaria Specialist will support the Assessment Team with his/her expertise in and knowledge of the national malaria program. S/he should have strong skills, knowledge, and extensive experience (at least 10 years) in USAID malaria program design, implementation and/or evaluations.

***Local Family Planning/Reproductive Health Specialist (Key Staff 4):*** *The Local FP/RH Specialist will support the Assessment Team with his/her expertise in and knowledge of Angola's FP/RH program. S/he should have strong skills, knowledge, and extensive experience (at least 10 years) in FP/RH program design, implementation and/or evaluations.*

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

***Local Evaluation Specialist/Facilitator:*** *The Local Evaluation Specialist/Facilitator will support the local team with evaluation specialist expertise. S/he will be responsible for assisting with the design and implementation of the evaluation tools in country. S/he must have extensive experience working with M&E in Angola (at least 10 years), specifically carrying out activity evaluations and assessments. Experience evaluating malaria programs strongly preferred.*

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 assessment or assessment activity.

Some Involvement anticipated – If yes, specify who: Joana Rosario, USAID/PMI Resident Advisor; Arciolanda Gravata, USAID/PMI Program Management Specialist; Sarah Labuda, CDC/PMI Resident Advisor

**Staffing Level of Effort (LOE) Matrix:**

The LOE Matrix shows the LOE (in days) for each team member to implement this assessment.

| Activity/Deliverable | | Evaluation/Analytic Team | | | | |
|---|---|---|---|---|---|---|
| | | **Team Lead (Key Staff 1)** | **Senior Malaria Specialist (Key Staff 2)** | **Local Malaria Specialist (Key Staff 3)** | **Local FP/RH Specialist (Key Staff 4)** | **Local Evaluation Specialist/ Facilitator** |
| Number of persons ® | | 1 | 1 | 1 | | 1 |
| 1 | Launch briefing/In-brief with USAID | 1 | 1 | 1 | 1 | 0.5 |
| 2 | Desk review | 10 | 3 | 1 | 1 | 0 |
| 3 | Preparation for Team Planning Meeting/Team convening in-country | 1 | 1 | 1 | 0.5 | 0.5 |

| Activity/Deliverable | | Evaluation/Analytic Team | | | | |
|---|---|---|---|---|---|---|
| | | **Team Lead (Key Staff 1)** | **Senior Malaria Specialist (Key Staff 2)** | **Local Malaria Specialist (Key Staff 3)** | **Local FP/RH Specialist (Key Staff 4)** | **Local Evaluation Specialist/ Facilitator** |
| 4 | Team Planning Meeting | 4 | 4 | 2 | 2 | 1 |
| 5 | Workplan and methodology briefing with USAID/In-brief with target project | 1 | 1 | 1 | 1 | 0 |
| 6 | Workplan submission (includes assessment questions, methods, timeline, data analysis plan, data collection tools, and the assessment report outline) | 4 | 3 | 2 | 1 | 1 |
| 7 | Data collection | 10 | 6 | 20 | 20 | 25 |
| 8 | Data analysis | 5 | 3 | 4 | 1 | 1 |
| 9 | Key findings/Out-brief with USAID (Power Point presentation) | 1 | 1 | 1 | 1 | 1 |
| 10 | Draft report | 10 | 5 | 5 | 1 | 0 |
| 11 | GH EvaLS Report QC Review & Formatting | 0 | 0 | 0 | 0 | 0 |
| 12 | Submission of draft report to USAID | 0 | 0 | 0 | 0 | 0 |
| 13 | USAID Report Review | 0 | 0 | 0 | 0 | 0 |
| 14 | Revise report per USAID comments | 3 | 2 | 2 | 0.5 | 0 |
| 15 | Finalize and submit report to USAID | 0 | 0 | 0 | 0 | 0 |
| 16 | USAID approves report | 0 | 0 | 0 | 0 | 0 |
| 17 | Final copy editing and formatting | 0 | 0 | 0 | 0 | 0 |
| 18 | 508 Compliance editing | 0 | 0 | 0 | 0 | 0 |
| | Eval Report to the DEC | 0 | 0 | 0 | 0 | 0 |
| | **Total LOE** | **50** | **30** | **40** | **30** | **30** |

A 6-day workweek permitted: **Yes X** No

6-day workweek approved for travel to/from work locations: **Yes X** No

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

| |
|---|
| To be determined. |

## XVI. LOGISTICS

Billing up to seven (7) days in any consecutive seven (7)-day period is approved when traveling to or from the Consultant's home of record: **Yes X** No

### Visa Requirements

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

- Signed passport valid for 6 months with at least one blank page
- Visa application form
- Two passport photos
- Invitation letter from USAID Angola
- Letter of Financial Responsibility from ME&A
- Travel Itinerary

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

| **Name of Country** | **Type of Visa** | | |
|---|---|---|---|
| | Tourist | Business | No preference |
| | Tourist | Business | No preference |
| | Tourist | Business | No preference |
| | Tourist | Business | No preference |

### Clearances & Other Requirements

***Note***: Most Assessment/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 EvaLS can submit an application for it on the consultant's behalf.

GH EvaLS 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 EvaLS 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)

**X** 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)

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

## XVII. GH EvaLS ROLES AND RESPONSIBILITIES

GH EvaLS will coordinate and manage the 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 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 and assist with development of methods, workplan, analytic instruments, reports, and other deliverables as part of the quality assurance oversight, as appropriate
- 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 EvaLS 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 EvaLS, 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 in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

**After Field Work**

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

## XIX. ASSESSMENT REPORT

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

A final report will be produced in English, not to exceed 25-pages. The draft report will be shared with USAID Angola relevant offices for review and comment over a two-week period. The final report should include:

- Abstract
- Executive Summary
- Assessment Purpose
- Background on the Context and the Strategies/Projects/Activities being assessed
- Assessment Questions
- Methodology
- Limitations to the Assessment
- Findings, Conclusions, and (If Applicable) Recommendations
- Annexes

The abstract of no more than 250 words should describe what was assessed, assessment questions, methods, and key findings or conclusions. The executive summary should be 2–5 pages and summarize the purpose, background of the project being assessed, main assessment questions, methods, findings, and conclusions (plus recommendations and lessons learned, if applicable). The methodology shall be explained in the report in detail. Limitations to this assessment shall be disclosed in the report, with particular attention to the limitations associated with the methods (e.g., in sampling; data availability; measurement; analysis; any potential bias such as sampling/selection, measurement, interviewer, response, etc.) and their implications for conclusions drawn from the findings.

Annexes to the report must include:

- Assessment SOW (updated, not the original, if there were any modifications);
- Methods;
- All data collection and analysis tools used in conducting the assessment, such as questionnaires, checklists, and discussion guides;
- All sources of information or data, identified and listed;
- Statements of difference regarding significant unresolved differences of opinion by funders, implementers, and/or members of the Assessment Team, if applicable;
- Signed disclosure of conflict of interest forms for all Assessment Team members, either attesting to a lack of or describing existing conflicts of interest; and
- Summary information about Assessment Team members, including qualifications, experience, and role on the team.

## XX. USAID CONTACTS

| | Primary Contact | Alternate Contact 1 | Alternate Contact 2 |
|---|---|---|---|
| Name: | Joana Rosario | Arciolanda Gravata | Sarah Labuda |
| Title: | USAID/PMI Resident Advisor | USAID/PMI Program Management Specialist | CDC/PMI Resident Advisor |
| USAID Office/Mission | Angola | Angola | Angola |
| Email: | jdorosario@usaid.gov | agravata@usaid.gov | slabuda@usaid.gov |
| Telephone: | | | |
| Cell Phone: | +244 943026988 | +244 943026987 | +244 943 026 991 |

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH EvaLS management team staff)

| | Technical Support Contact 1 | Technical Support Contact 2 |
|---|---|---|
| Name: | Theresa Takavarasha | Biggie Chidzvondo |
| Title: | Regional Senior Monitoring, Assessment, and Learning Specialist | Monitoring, Assessment & Learning Specialist |
| USAID Office/Mission | Pretoria, South Africa | Pretoria, South Africa |
| Email: | ttakavarasha@usaid.gov | bchidzvondo@usaid.gov |
| Telephone: | +27 12 452 2036 | +27 12 452 2096 |
| Cell Phone: | +27 83 308 0471 | +27 83 408 8143 |

## XXI. OTHER REFERENCE MATERIALS

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

[Preliminary list of potential documents- Staff to GENERATE DOCUMENTS LIST]

HFA cooperative agreement, HFA Program description; ADECOS national policy

NMCP strategic plan 2016-2020 and 2021-2025

Malaria Program Review (2020)

NMCP Needs Assessment report (PSI, 2020)

´assessment Pos assessment Action Plan (2019)

Mentor Initiative "*A Rapid Assessment of Severe Malaria Case Management Practices and Constraints in Angola*"

• Plano Nacional de Desenvolvimento Sanitário 2012-2025 (National Health Strategy) (PNDS)

• Plano Nacional Desenvolvimento (2018-2022)

• USAID Country Development Cooperation Strategy 2014-2019

• USAID Landscape Analysis and Business Case for mHealth Investment in Angola

• U.S. President's Malaria Initiative FY 2020 Guidance

• GLOBAL TECHNICAL STRATEGY FOR MALARIA 2016–2030 (WHO 2015)

• Plano Estratégico do Sistema Informático da Saúde (national Strategic Plan for Information in health)

• World Bank Project Appraisal Document, Angola Health System Performance Strengthening Project

• Decision Support Tools for Malaria Prevention and Treatment

• Plucinski, M. et al. "Evaluating Malaria Case Management at Public Health Facilities in Two Provinces in Angola"

• PMI FY 2018, 2019, and 2020 Malaria Operational Plans

• Relatório de Avaliação Nacional do Sistema de Informação Sanitária(SIS) (Health Information System Assessment Report)

• Routine Health Information System Malaria Reporting Structures Angola Profile

## XXII. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (*To be completed after Assignment Implementation by GH EvaLS*)

All modifications to the required elements of the SOW of the contract/agreement, whether in assessments, design and methodology, deliverables and reporting, Assessment Team composition, schedule, and/or other requirements will be agreed upon in writing by the COR. Any revisions made will be noted in the SOW annexed to the final Assessment Report.

Due to delays outside of the control of the evaluation team and the unexpected sickness of a team member, the report submission date was pushed back.

# ANNEX 2. DATA COLLECTION TOOLS

I. Document Data Extraction Sheet and HFA Document and Tool Inventory

II. Key Informant Interview Guide: USAID

III. Key Informant Interview Guide: MOH, UN, WHO, Other Partners

IV. Key Informant Interview Guide: HFA Stakeholders

V. Interview Guidelines

VI. Facility Checklist and Key Informant Interview

VII. Online Survey

## I. Document Data Extraction Sheet and HFA Document and Tool Inventory

| | |
|---|---|
| **REVIEWER:** | |
| **TITLE:** | |
| **AUTHORS (APA FORMAT):** | |
| **CITATION (APA FORMAT):** | |
| **REVIEWER'S CONCLUSIONS** | |

| **Assessment Question/ Sub-questions** | **Cut and paste evidence** | **Supports** | **Does not support** |
|---|---|---|---|
| **DESIGN**<br>**1.To what extent has the HFA project design *effective to achieve the desired results*?**<br>**1.a. To what extents are the underlying assumptions still valid?** | | | |
| i. MOH timely approves HFA activities: How has HFA mitigated delays and facilitated and empowered the MOH to coordinate and manage its activities? | | | |
| ii. Medicines and contraceptives are available: How has the supply chain worked in life of the project (LOP)? | | | |
| iii. Health facilities have required personnel and supplies: What % of the project-supported facilities meet the required standards of personnel? | | | |

| | | | |
|---|---|---|---|
| **1.b. Are the current causal pathways producing the required outcomes?**<br>To be assessed by result area<br>R1 LLIN Distribution<br>R2 Malaria Services<br>R4 FP/RH Services<br>R5 DHIS2 strengthening | | | |
| **IMPLEMENTATION**<br>**2. To what extent is the project's plan of implementation effective in achieving the desired results?** | | | |
| 2.a. To what extent is the HFA project managed effectively (internal and external; nationally and provincially)? | | | |
| 2.b. What are the enabling factors critical to success and the barriers that impede implementation? | | | |
| 2.c. What are the key strategic, programmatic, technical and managerial features of the project that should be taken into account when designing and implementing the next project in Angola? | | | |
| **OPPORTUNITIES**<br>**3. What are the current opportunities faced by the project?** | | | |
| **SUSTAINABILITY**<br>**4.What mechanisms are in place by USAID and/or implementing partners (IPs) to ensure the sustainability of the project's achievements?**<br>*4.a. What has HFA done to ensure the sustainability of its interventions and achievements?* | | | |

| | | | |
|---|---|---|---|
| *4.b. What have other IPs done that can be sustained?* | | | |
| *4.c. How much has the Angolan health information and LLIN and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services?* | | | |
| *4.d. How and how much has capacity building been institutionalized at national and provincial levels?* | | | |

## Document Inventory Sheet

(please add more rows and columns as necessary)

| Title | Author | Year | Level C, F, M, P, N | User | In use now? | Institu-tionalized | Type: Hard/ Soft copy | Copies availa-ble | Comments |
|---|---|---|---|---|---|---|---|---|---|
| **Malaria Program tools** | | | | | | | | | |
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| **FP/RH program tools** | | | | | | | | | |
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| **Training manuals and other related documents** | | | | | | | | | |
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| **Supervisory, mentoring and coaching tools** | | | | | | | | | |
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| **DHIS2 tools** | | | | | | | | | |
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| Title | Author | Year | Level C, F, M, P, N | User | In use now? | Institu-tionalized | Type: Hard/ Soft copy | Copies availa-ble | Comments |
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# II. Key Informant Interview Guide

## USAID Stakeholders

| | |
|---|---|
| **Interviewer:** | **Interview Date:** |
| | **Start time:** |

| | |
|---|---|
| **Interviewee's Name:**<br>**First:** | **Last:** |
| **Current Position:** | **Org:** |
| **Contact email:** | **Phone (Optional):** |

**Has the KI affirmed Informed Consent? Y____ N____**

**(Interviewer's initials)**

**Respondent's Unique ID:** _____

| | Questions / Topics | Responses |
|---|---|---|
| **I. Background** | | |
| 1. | What activities are you responsible for in _____ (the stakeholder organization)? | |
| 2. | How long have you worked in _____ (the organization)? | |
| 3. | What have been the three main successes of the project? In your opinion, are these sustainable? Why or why not? | |

| | Questions / Topics | Responses |
|---|---|---|
| **II. Core Questions for All** | | |
| 1. | To what extents are the underlying assumptions still valid? (AQ1a)<br>How has HFA mitigated delays and facilitated and empowered the MOH to coordinate and manage its activities?<br>How has HFA managed the available of supplies and mitigated stockouts?<br>How has HFA assisted to address shortages of HR? | |
| 2. | Have meds and supplies been available? Barriers or challenges? (AQ1a) | |
| 3. | Do you think the HFA interventions were appropriate to achieve the desired outcomes?<br>Are the current causal pathways producing the required outcomes? (AQ1b)<br>Result 1 for LLIN distribution:<br>Is distribution sustainable?<br>How do you know? Why or Why not? | |
| 4. | Result 2 for Malaria Services, quality and coverage:<br>Are malaria services sustainable?<br>How do you know? Why or Why not? | |
| 5. | Result 4 FP/RH services:<br>Are FP/RH services sustainable?<br>How do you know? Why or Why not? | |

| | Questions / Topics | Responses |
|---|---|---|
| 6. | Result 5 Health information system:<br>Is DHIS2 sustainable?<br>How do you know? Why or Why not? | |
| 7. | To what extent is the HFA project managed effectively (internal and external; nationally and provincially)? (AQ2a)<br>How do they manage? | |
| 8. | What are the enabling factors critical to success and the barriers that impede implementation? (AQ2b) | |
| 9. | What are the key strategic, programmatic, technical and managerial features of the project that should be taken into account when designing and implementing the next project in Angola? (AQ2c) | |
| 10. | What are the current opportunities faced by the project? (AQ3) By Angola? | |
| 11. | What are the areas of additional opportunities beyond the current mandate, that is malaria, FP/RH and Health information? (AQ3a) | |
| 12. | What possible partnerships will help advance improve in the health system?<br>Probe about health financing opportunities such as insurance, etc. | |
| 13. | What reasonable assumptions need to be considered in the design of the next project (health status, health system, USAID funding, other funding, etc.) (AQ3b) | |

| | Questions / Topics | Responses |
|---|---|---|
| 14. | What has HFA done to ensure the sustainability of its interventions and achievements? (AQ4a)<br>Is the sustainability plan progressing as planned?<br>Are your predictions supported by evidence? | |
| 15. | How much has the Angolan health information and LLIN and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services? (AQ4c) | |
| 16. | How much has the capacity of Angolan health providers and facilities improved? (AQ4d) | |
| **III. Questions tailored for different stakeholder groups: USAID, HFA Team, and MOH (national, provincial and municipal)** | | |
| 1. | How satisfied are you with the performance of the HFA project? What would you keep and what would change in the next activity? | |
| 2. | How well were you able to monitor the performance? What tools or information would you like to have at hand to know if the project is moving the needle? | |
| 3. | What partnership have been improved or strengthened? Which partnerships have not been supported? What potential partners need to be involved in the next activity? | |
| 4. | What has been done by HFA that can be sustained?<br>Scaled up to the rest of the country? | |

| | Questions / Topics | Responses |
|---|---|---|
| 5. | What do you think needs to happen for Angola to achieve UHC by 2030? | |
| | Other comments: | |
| | **Time at End of Interview:** | |
| | Interviewer's observations and main findings: | |

# III. Key Informant Interview Guide

## MOH Stakeholders, UN, WHO, Other Partners

| | |
|---|---|
| **Interviewer:** | **Interview Date:** |
| | **Start time:** |
| **Interviewee's Name:**<br>**First:** | **Last:** |
| **Current Position:** | **Org:** |
| **Contact email:** | **Phone (Optional):** |

**Has the KI affirmed Informed Consent? Y____ N____**

**(Interviewer's initials)**

**Respondent's Unique ID:** _____

| | Questions / Topics | Responses |
|---|---|---|
| **I. Background** | | |
| 1. | What activities are you responsible for in _____ (the stakeholder organization)? | |
| 2. | How long have you worked in _____ (the organization)? | |
| 3. | What have been the three main successes of the project? In your opinion, are these sustainable? Why or why not? | |

| | Questions / Topics | Responses |
|---|---|---|
| 4. | Was this project different from previous USAID-Funded projects? Why or why not? How could it have been better? | |
| **II. Core Questions for All** | | |
| 1. | To what extents are the underlying assumptions still valid? (AQ1a)<br>How has HFA mitigated delays and facilitated and empowered the MOH to coordinate and manage its activities?<br>How has HFA managed the available of supplies and mitigated stockouts?<br>How has HFA assisted to address shortages of HR? | |
| 2. | Have meds and supplies been available? Barriers or challenges? (AQ 1a) | |
| 3. | Do you think the HFA interventions were appropriate to achieve the desired outcomes?<br>Are the current causal pathways producing the required outcomes? (AQ1b)<br>Result 1 for LLIN distribution:<br>Is distribution sustainable?<br>How do you know? Why or Why not? | |
| 4. | Result 2 for Malaria Services, quality and coverage:<br>Are malaria services sustainable?<br>How do you know? Why or Why not? | |

| | Questions / Topics | Responses |
|---|---|---|
| 5. | Result 4 FP/RH services:<br>Are FP/RH services sustainable?<br>How do you know? Why or Why not? | |
| 6. | Result 5 Health information system:<br>Is DHIS2 sustainable?<br>How do you know? Why or Why not? | |
| 7. | To what extent is the HFA project managed effectively (internal and external; nationally and provincially)? (AQ2a)<br>How do they manage the project activities? | |
| 8. | What are the enabling factors critical to success and the barriers that impede implementation? (AQ2b) | |
| 9. | What are the key strategic features of the project that should be taken into account when designing and implementing the next project in Angola? (AQ2c)<br>Probe for programmatic, technical and managerial features | |
| 10. | What are the current opportunities faced by the project? (AQ3)<br>By Angola? | |
| 11. | What are the areas of additional opportunities beyond the current mandate, that is, beyond, malaria, FP/RH and Health information? (AQ3a) | |

| | Questions / Topics | Responses |
|---|---|---|
| 12. | What possible partnerships will help advance improve in the health system? Probe about health financing or insurance. | |
| 13. | What reasonable assumptions need to be considered in the design of the next project (health status, health system, USAID funding, other funding, etc.) (AQ3b) | |
| 14. | What has HFA done to ensure the sustainability of its interventions and achievements? (AQ4a)<br>Is the sustainability plan progressing as planned?<br>Are the scores on the matrix supported by evidence? | |
| 15. | How much has the Angolan health information and LLIN and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services? (AQ4c) | |
| 16. | How much has the capacity of Angolan health providers and facilities improved? (AQ4d) | |
| **III. Questions tailored for different stakeholder groups: MOH (national, provincial and municipal)** | | |
| 1. | What national policies and strategies have been supported and/or strengthened by HFA?<br>Which have not?<br>Which need support? | |
| 2. | How well has HFA assisted with coordination and collaboration with you, the MOH stakeholders? | |

| | Questions / Topics | Responses |
|---|---|---|
| 3. | What priorities does the MOH have in relation to the capacity building of its Human Resources for Health? Particularly probe for the FP/RH and HIS?<br>How sustainable is the HFA training and mentoring activities? | |
| 4. | What has been done by HFA that can be sustained?<br>Scaled up to the rest of the country? | |
| 5. | What do you think needs to happen for Angola to achieve UHC by 2030? | |
| | Other comments: | |
| | **Time at End of Interview:** | |
| | Interviewer's observations and main findings: | |

# IV. Key Informant Interview Guide

## HFA Stakeholders

| | |
|---|---|
| **Interviewer:** | **Interview Date:** |
| | **Start time:** |

| | |
|---|---|
| **Interviewee's Name:**<br>**First:** | **Last:** |
| **Current Position:** | **Org:** |
| **Contact email:** | **Phone (Optional):** |

**Has the KI affirmed Informed Consent? Y____ N____**

**(Interviewer's initials)**

**Respondent's Unique ID:** _____

| | Questions / Topics | Responses |
|---|---|---|
| **I. Background** | | |
| 1. | What activities are you responsible for in _____ (the stakeholder organization)? | |
| 2. | How long have you worked in _____ (the organization)? | |
| 3. | What have been the three main successes of the project? In your opinion, are these sustainable? Why or why not? | |

| | Questions / Topics | Responses |
|---|---|---|
| 4. | Was this project different from previous USAID-Funded projects? Why or why not? | |
| **II. Core Questions for All** | | |
| 1. | To what extents are the underlying assumptions still valid? (AQ1a)<br>How has HFA mitigated delays and facilitated and empowered the MOH to coordinate and manage its activities?<br>How has HFA managed the available of supplies and mitigated stockouts?<br>How has HFA assisted to address shortages of HR? | |
| 2. | Have meds and supplies been available? Barriers or challenges? (AQ 1a) | |
| 3. | Are the current causal pathways producing the required outcomes? (AQ1b)<br>Result 1 for LLIN distribution:<br>Is distribution sustainable?<br>How do you know? Why or Why not? | |
| 4. | Result 2 for Malaria services, quality and coverage:<br>Are malaria services sustainable?<br>How do you know? Why or Why not? | |
| 5. | Result 4 FP/RH services:<br>Are FP/RH services sustainable?<br>How do you know? Why or Why not? | |

| | Questions / Topics | Responses |
|---|---|---|
| 6. | Result 5 Health information system:<br>Is DHIS2 sustainable?<br>How do you know? Why or Why not? | |
| 7. | To what extent is the HFA project managed effectively (internal and external; nationally and provincially)? (AQ2a)<br>How do they manage? | |
| 8. | What are the enabling factors critical to success and the barriers that impede implementation? (AQ2b) | |
| 9. | What are the key strategic, programmatic, technical and managerial features of the project that should be taken into account when designing and implementing the next project in Angola? (AQ2c) | |
| 10. | What are the current opportunities faced by the project? (AQ3)<br>By Angola? | |
| 11. | What possible partnerships will help advance improvement in the health system?<br>Probe about health financing or insurance. | |
| 12. | What are the areas of additional opportunities beyond the current mandate, that is malaria, FP/RH and Health information? (AQ3a) | |

| | Questions / Topics | Responses |
|---|---|---|
| 13. | What reasonable assumptions need to be considered in the design of the next project (health status, health system, USAID funding, other funding, etc.)? (AQ3b) | |
| 14. | What has HFA done to ensure the sustainability of its interventions and achievements? (AQ4a)<br>Is the sustainability plan progressing as planned?<br>Are your predictions supported by evidence? | |
| 15. | How much has the Angolan health information and LLIN and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services? (AQ4c) | |
| 16. | How much has the capacity of Angolan health providers and facilities improved? (AQ4d) | |
| **III. Questions tailored for different stakeholder groups: USAID, HFA Team, and MOH (national, provincial and municipal)** | | |
| 1. | How much support did you receive from USAID? How did that help? In hindsight, what other support would have liked to have? | |
| 2. | How much effort was put into each of the 5 objectives, particularly in 1, 2,4 and 5? | |
| 3. | Knowing what you know now. What would you do differently in your work? | |
| 4. | What new and existing priorities do you see in Angola at this time? In 5 years? | |

| | Questions / Topics | Responses |
|---|---|---|
| 5. | What has been the main contribution of each of the HFA partners?<br>PSI<br>RMA<br>MSH<br>Tropical Health<br>Mentor<br>How do they complement each other? | |
| 6. | What partnerships have been transformed by HFA? Which could be included or strengthened? | |
| 7. | What do you think Angola should do differently to achieve UHC by 2030?<br>Probe for malaria, and FP/RH | |
| | Other comments: | |
| | **Time at End of Interview:** | |
| | Interviewer's observations and main findings: | |

# V. Interview Guidelines

## Informed Consent Statement

My name is _____, and as you know, I am an independent consultant working for GH EvaLS project that evaluates and assesses projects for USAID. Thank you for making the time to talk with me today.

USAID/ANGOLA has asked GH EvaLS to assess the design, implementation and sustainability of the Health for All Project and to identify opportunities for designing a new project that builds on the strengths of HFA and addresses its challenges.

You were suggested as a key person to inform this assessment and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your experience. Our interview will take about one hour.

Before we begin, I want to inform you that any information or examples we gather during this interview process will not be attributed to any specific person, or otherwise attributed to you. If we include quotations from our interview in the final assessment report they will be attributed only to a stakeholder group (such as the MOH Partner, HFA team or USAID Mission). You are also free to not respond to any of our questions or to stop or pause the interview at any time.

If you are comfortable, I would like to record this interview to ensure that I do not miss any important points when writing up my summary. Please know that anything you say during the interview will be kept confidential within the GH EvaLS team, and that our interview notes and any recordings will be erased when the assessment report is completed.

Do I have your permission to record? Yes: _____ No: _____

Do I have your permission to begin? Yes: _____ No: _____

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

### Declaração de consentimento informado

Meu nome é _____ e, como você sabe, sou um consultor independente trabalhando para o projeto GHEvaLS que avalia os projetos para a USAID. Obrigado por reservar um tempo para falar comigo hoje.

A USAID/ANGOLA solicitou ao GHEvaLS que avaliasse o desenho, implementação e sustentabilidade do Projeto Saúde para Todos e identificasse oportunidades de desenho de um novo projeto que se baseie nos pontos fortes do HFA e aborde seus desafios.

Você foi sugerido como uma pessoa-chave para informar esta avaliação e apreciamos muito sua perspectiva, experiências e opiniões sobre os sucessos, desafios, barreiras e lições aprendidas com sua experiência. Nossa entrevista levará cerca de uma hora.

Antes de começar, gostaria de informar que quaisquer informações ou exemplos que coletarmos durante o processo de entrevista não serão atribuídos a nenhuma pessoa específica, ou de outra forma

atribuídos a você. Se incluirmos citações de nossa entrevista no relatório de avaliação final, elas serão atribuídas apenas a um grupo de partes interessadas (como o Parceiro do MOH, equipe do HFA ou Missão da USAID). Você também tem a liberdade de não responder a nenhuma de nossas perguntas ou interromper ou pausar a entrevista a qualquer momento.

Se você se sentir confortável, gostaria de gravar esta entrevista para garantir que não perca nenhum ponto importante ao redigir meu resumo. Saiba que tudo o que você disser durante a entrevista será mantido em sigilo pela equipe do GHEvaLS e que nossas anotações de entrevista e todas as gravações serão apagadas quando o relatório de avaliação for concluído.

Não tenho sua permissão para gravar? Sim não: _____

Eu tenho sua permissão para começar? Sim não: _____

Antes de começarmos, você tem alguma pergunta sobre esta entrevista?

# VI. Guidance on Conducting KIIs for the Facility Assessment

**A. Before the interview:**

1. Send an email or call to introduce yourself and invite the informant to participate in the KII. Agree on a good date and time to conduct the interview, and tell informant that you will send a MS Teams or Zoom link to conduct the interview. The interview should take about an hour or less.
2. Open the KII guide file and enter the informant's information and save the file using the right coding:
    a. Filing and Coding Instructions: **Stakeholder-date-interviewer.**
        i. USA-1-19-21 XB
        ii. HFA-1-19-21 APP
        iii. MOH 1-19-21 MdC
        iv. UN 1—19-21 EB
    b. If more than one KII on the same date, add a numeral after your initials. See example for Xiomara below:

        USA-1-19-21 XB1; USA-1-19-21 XB2, and USA-1-19-21 XB3
3. Open the consent file to have it ready to read it to the informant. You might consider having a printed copy to read too. Either one is fine.
4. About 5 minutes before the interview, start the platform to be ready.
5. Give access to informant

**B. Starting and During the Interview:**

a. Thank the informant stressing the importance of the meeting.

b. Explain you will now read the Consent form and ask if it is Ok to record and start recording

c. Ask if the informant has any questions before you start the interview.

d. Start with the first question and take notes.

e. Allow sufficient time for informant to respond to each question and to elaborate on answers.

f. Balance taking accurate notes with the need to focus on listening. Make eye contact with informant every few minutes to show you are paying attention. Show interest: Nodding, "I see", "yes", "Thank you for that comment." "That is helpful to know."

g. Listen carefully for perceptions, ideas and themes and for recurring and new opinions or beliefs, and mark, underline or circle important points made in your notes.

h. Clarify meanings of responses and request detail: "Can you explain that a bit? Can you describe how that happened in more detail?"

i. Use proper probing techniques to encourage informants to include detail in their responses without leading their responses. For example, repeat part of the question and ask for more

detail; or paraphrase answer back to informant to confirm interpretation; or ask neutral questions such as: "Could you please tell me more about that?" o "Can you given an example?" or "Is there an example?" or "What else?" or "Anything else?

j. Use who, what, why, when, and where when appropriate to get details and understand the informant's answer fully.

k. At the end of the interview, ask the key informant if they have any questions or final comments.

**C. After the interview:**

a. Allow for Zoom to convert the recording and save the audio file using the same code as the notes.

b. Review your notes and fix any answer or gaps listening to that section of the recording again.

c. Write your summary of the findings at the bottom of the interview and any comment or insight:

   i. What did you learn about the Design of the HFA project?

   ii. What did you learn about the Implementation of the HFA project?

   iii. What did you learn about the Sustainability of the HFA project?

   iv. What did you learn about the Opportunities for the follow-on project?

   v. Knowing what you know today, what would you recommend the future project focus on?

d. Compare with previous findings in the FCR table and write top (one to five max) findings in the FCR table if appropriate. Indicate the corresponding KII code as the source.

e. Save both, the audio and your notes in the corresponding SharePoint folder

f. Send thank you email. Say why you appreciated the informant's contribution and ask if it is OK to call back for some additional question or clarification. Wish the informant the best.

# Facility Observation Checklist and Key Informant Interview

## Facility Observation Check List

## (Adapted from WHO Service Availability and Readiness Assessment) - SARA

***Establish good Rapport and obtain telephone number for brief confidential KII***

| **1. Identification Questions (P1)** | **Answer of Responsible** | **Observations** |
|---|---|---|
| Person in charge:<br>Name:<br>Position:<br>Phone number:<br>Email: | Name of facility:<br>Province:<br>Municipality:<br>Barrio or Comuna: | |
| **2. STAFFING** | A) assigned/ employed/ seconded: # | B) part time # |
| a. Generalist medical doctors | | |
| b. Specialist medical doctors | | |
| c. Paramedical Professionals | | |
| d. Nursing professionals | | |
| e. Midwifery professionals | | |
| f. Pharmacists | | |
| g. Laboratory technicians | | |
| h. Medical Records: Catalogadoras | | |
| i. Community health workers (ADECOS/ activistas) that are linked to the facility | | |
| **3. INFRASTRUCTURE** | | |
| a. Does this facility have a *functioning land line telephone* that is available to call outside at all times client services are offered? | Yes No DK | |
| b. Does this facility have *a functioning land line or cell phone*? | Yes No DK | |
| c. Does this facility have *a functioning computer?* | Yes No DK | |

| | | |
|---|---|---|
| d. Does this facility have *a functioning tablet?* | Yes No DK | |
| d. Does this facility have *a functioning SMART phone?* | Yes No DK | |
| e. Is there *access to email or internet* within the Facility today? | Yes No DK | |
| f. Does this facility have potable water for directly observed therapy (DOT)? | Yes No DK | |
| **4. TRANSPORT FOR EMERGENCY** | | |
| Does this facility have access to an ambulance or other vehicle for emergency transport for clients: That is stationed at another facility or that Operates from another facility in near proximity | Yes No DK | |
| **5. SUPERVISION** | | |
| a. When was the last time this facility received a supervision visit from the municipality, Province or a Mentor or PSI supervisor? | 1. This month:<br>2. In the last 3 months<br>3. More than 3 months ago<br>4. Don't know | |
| During the supervision visit, did the supervisor assess the following? | | |
| b. Pharmacy (e.g. Drug stock out, expiry, records, etc.) | Yes No DK | |
| c. Staffing (e.g. Staff available and training) | Yes No DK | |
| d. Did any staff participate in Kasai Training? | Yes No DK | |
| e. Do staff know their HNQIS Formative Supervision Score? | Yes No DK | |
| f. Data (e.g. Completeness, quality, and timely reporting) | Yes No DK<br>Yes No DK | |
| g. Do you submit reports to DHIS2? | Yes No DK | |
| h. Do you get reports back? | | |
| i. Do you use the DHIS2 data? | Yes No DK | |
| **6. BASIC EQUIPMENT** | | |

| | | | |
|---|---|---|---|
| a. Is there an adequate supply of Personal Protective Equipment (PPE)? Enough for staff and services | Yes | No | DK |
| b. Working Adult weighing scale | Yes | No | DK |
| c. Working Child weighing scale- 250-gram gradation | Yes | No | DK |
| d. Thermometer | Yes | No | DK |
| e. Stethoscope | Yes | No | DK |
| f. Blood Pressure apparatus | Yes | No | DK |
| g. Light source (flashlight acceptable) | Yes | No | DK |
| h. Intravenous Infusion Kit | Yes | No | DK |
| **7. FAMILY PLANNING SERVICES (P2)** | | | |
| Does this facility offer family planning Services? | Yes | No | DK |
| **8. Does this facility *provide* or *prescribe* any of the following modern methods of family planning:** | | | |
| a. Combined estrogen progesterone oral contraceptive pills? | Yes | No | DK |
| b. Progestin-only contraceptive pills | Yes | No | DK |
| c. Combined estrogen progesterone injectable contraceptives | Yes | No | DK |
| d. Progestin-only injectable contraceptives | Yes | No | DK |
| e. Hormone implants | Yes | No | DK |
| f. Male condoms | Yes | No | DK |
| g. Female condoms | Yes | No | DK |
| h. Intrauterine contraceptive device (IUCD) | Yes | No | DK |
| i. Implants | Yes | No | DK |
| j. Cycle beads for standard days method | Yes | No | DK |
| k. Emergency contraceptive pills | Yes | No | DK |
| **l. Vasectomy services provided** | Yes | No | DK |
| m. **Female sterilization – tubal ligation provided** | Yes | No | DK |

| | | |
|---|---|---|
| a. Please tell me if the following documents are available in the facility today: | Yes, Observed; No: | |
| b. National family planning guidelines<br>c. Any family planning check-lists and/ or job-aids | Yes, Observed; No:<br>Yes, Observed; No | |
| Have you or any provider(s) of family Planning services: | | |
| d. Received any family planning training in the last two years? | Yes No DK | |
| e. Received any training in adolescent sexual and reproductive health in the last two years? | Yes No DK | |
| **9. ANTENATAL/CHILD HEALTH** | | |
| a. Does this facility offer antenatal care (ANC) services? | Yes No DK | |
| b. Does this facility provide Intermittent Preventive Treatment in Pregnancy (IPTp) for malaria? | Yes No DK | |
| c. Does this facility distribute long-lasting insecticide nets (LLINS) mosquiteros? | Yes No DK | |
| Have you or any provider(s) of ANC services: | | |
| d. Received any ANC training in the last two years? | Yes No DK | |
| e. Received any training in IPTp in the last two years? | Yes No DK | |
| Are any of the following child health Medicines available in the facility today? | | |
| f. Oral Rehydration Salts (ORS) sachets | Yes No DK | |
| g. Paracetamol syrup/ suspension | Yes No DK | |
| **10. MALARIA SERVICES:** Speak to the responsible or most knowledgeable about malaria services (P1) | | |
| a. Do providers in this facility diagnose malaria? | Yes No DK | |

| | | |
|---|---|---|
| a. Which of the following methods are used at this facility for diagnosing malaria? | ☐ Clinical symptoms<br>☐ Microscopy (Thick and Thin Smear)<br>☐ Rapid Diagnostic testing (RDT) | |
| b. IF FACILITY CONDUCTS MALARIA RDTS:<br>Does this facility have malaria rapid diagnostic test kits (with valid expiration date) in stock in this service site today? CHECK TO SEE IF VALID (NOT EXPIRED) | Yes No DK | |
| c. Does this facility have a timer for RDTs? | Yes No DK | |
| d. Does this facility conduct the following tests onsite or offsite? | ☐ Hemoglobin testing<br>☐ General microscopy/wet mounts<br>☐ Malaria Thick smear<br>☐ Malaria Thin smear | |
| e. Has there been a stock-out of malaria RDT kits in the past 3 months for more than one week? | Yes No DK | |
| f. How many days of stock-out? | | |
| g. Do providers in this facility prescribe treatment for malaria? | Yes No DK | |
| h. Do you have the national guidelines for the diagnosis and treatment of malaria available in this facility today?<br>IF AVAILABLE, ASK TO SEE THE DOCUMENT | Yes No DK | |
| i. Have you or any provider(s) of malaria services received any training in malaria diagnosis with RDTs in the last two years? | Yes No DK | |
| j. Have you or any provider(s) of malaria services received any training in malaria treatment in the last two years? | Yes No DK | |

| | | |
|---|---|---|
| k. I would like to know if the following general equipment items are available and functional today.<br>ASK TO SEE THE ITEMS | ☐ Glass slides and cover slips<br>☐ Light microscope<br>☐ Lancets<br>☐ Giemsa stain | |
| **11. MEDICINES AND COMMODITIES**<br>Are any of the following malaria medicines and commodities available today in this Facility?<br>CHECK TO SEE IF AT LEAST ONE OF EACH MEDICINE/COMMODITY IS VALID (NOT EXPIRED) | ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE MEDICINES AND OTHER SUPPLIES ARE STORED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT STORAGE AND MANAGEMENT OF MEDICINES AND SUPPLIES IN THE FACILITY. | |
| a. ACT | Yes No DK | |
| b. Artemisinin monotherapy (oral) | Yes No DK | |
| c. Artesunate rectal | Yes No DK | |
| d. Artesunate injection | Yes No DK | |
| e. SP (Sulfadoxine + Pyrimethamine) | Yes No DK | |
| f. Insecticide treated bed nets for patients and their families and households | Yes No DK | |
| g. Insecticide treated bed net vouchers for patients and their families and households | Yes No DK | |
| h. Chloroquine (oral) | Yes No DK | |
| i. Quinine (oral) | Yes No DK | |
| j. Primaquine (oral) | Yes No DK | |
| k. Clindamycin (oral) | Yes No DK | |
| l. ARTEMETER INJECTION | Yes No DK | |
| m. QUININE INJECTION | Yes No DK | |
| n. Has there been a stock-out of ACT in the past 3 months for more than one week? | Yes No DK | |

## 12. DATA VERIFICATION - LAST MONTHLY REPORT VS REGISTER BOOK

a. HF sent the last 6 monthly reports on time? Yes No DK

b. Do ADECOS report monthly at this facility? Yes No DK

| **Indicators:** | **Facility Register Dec 2020** | **Facility Register Jan 2021** | **DIHS2-Municipal Dec 2020** | **DIHS2-Municipal Jan 2021** |
|---|---|---|---|---|
| Total # Malaria Suspected Cases | | | | |
| Total # Malaria Confirmed Cases | | | | |
| Total # Confirmed Malaria Cases treated with ACTS | | | | |
| Total # ADECOS Confirmed Cases | | | | |
| Total # ADECOS Referrals | | | | |

**13. Photos to be taken:**

Please check when photo was taken. No people, just infrastructure.

- ☐ Entrance: to show signage and safety of facility
- ☐ Waiting room: to show degree of cleanliness and how crowded the area is
- ☐ FP consultation area: to show privacy and available posters and aids to explain methods.
- ☐ ANC consultation area: to show privacy and cleanliness and equipment available.
- ☐ Outpatient consultation area: to show privacy and cleanliness and equipment available.
- ☐ Lab: to show organization of work, cleanliness and equipment available.
- ☐ Pharmacy: to show cleanliness, safety and medicines are available and have stock cards
- ☐ Medical Records: to show filing system, cleanliness and order
- ☐ Storage: to show supplies are stored in a clean and well aired space and there is a lock for safely (are there LLINs)
- ☐ Female Patient Restrooms: to show privacy and cleanliness
- ☐ Male Patient Restrooms: to show privacy and cleanliness
- ☐ Female staff restroom: to show privacy and cleanliness
- ☐ Male Staff restroom: to show privacy and cleanliness
- ☐ Staff meeting room: to show cleanliness

- Staff meeting minutes: to show the team meets and keep records of decisions.
- Other: computer, printer, tablets, smart phones, DHIS2 reports, other relevant findings

## Abbreviated Key Informant Interview Guide for Health Facility Stakeholder

| | |
|---|---|
| **Interviewer:** | **Interview Date:** |
| | **Start time:** |

| | |
|---|---|
| **Interviewee's Name:**<br>**First:** | **Last:** |
| **Current Position:** | **Facility** |
| **Contact email:** | **Phone (Optional):** |

**Has the KI affirmed Informed Consent? Y_____ N_____**

**(Interviewer's initials)**

**Respondent's Unique ID: _____**

| | Questions / Topics | Responses |
|---|---|---|
| **I. Background (These questions may not be necessary if it is the same person that responded to the checklist)** | | |
| 1. | What activities are you responsible for in _____ (Facility)? | |
| 2. | How long have you worked in _____ at the facility/ | |
| 3. | How well has HFA assisted you, at this facility? | |
| **II. Core Questions** | | |
| 3. | Result 1 Has helped with LLIN distribution effectively? How do you know? Why or Why not? | |
| 4. | Result 2- Has HFA helped improve for Malaria Services, In this facility?<br>How well? | |

| | Questions / Topics | Responses |
|---|---|---|
| 5. | Result 4 Has HFA helped you improve FP/RH services?<br>How? | |
| 6. | Result 5 Health information system:<br>Are you still using registers? Why? How much time do you spend on registers?<br>Who does the manual data aggregation and data entry at your HU ?<br>When was the last monthly report submitted?<br>Is there a data quality check process before data are submitted?<br>Is the DHIS2 sustainable?<br>How would you improve DHIS 2? | |
| 9. | How do you like the HNQIS supportive supervision system?<br>Why or Why not?<br>How do you like the KASAI learning modules effective and sustainable? Why or Why not?<br>How does HFA supportive supervision identify HW and/or HU gaps on MCM?<br>Is the mentorship and capacity building provided by HFA improving the quality of malaria services that is delivered at the facility? How do you know? Why or Why not? | |
| 10 | Is there anything else I should know about the work of the HFA Project | |
| 11. | What priorities does the MOH have in relation to the capacity building of its Human Resources for Health?<br>Is HFA coordinating with the MOH to maximize training opportunities?<br>Have you participated in any MOH or HFA sponsored trainings or other continuous professional education activity during the past 18 months? If yes, which ones? | |
| 12. | What are the 3 main priorities for improving health of the people in this municipality?<br>What would really help you do a better job at delivering health services for the people of this municipality? | |
| | Final comments? | |

| | Questions / Topics | Responses |
|---|---|---|
| | **Time at End of Interview:** | |
| | Interviewer's observations and main findings: | |

# VII. Online Survey

**Instructions - Instruções:**

*This survey is in English and Portuguese.* Esta pesquisa está em inglês e português.

*USAID/ANGOLA has asked the GH EvaLS team to assess the design, implementation and sustainability of the Health for All (HFA) Project and to identify opportunities for designing a new project that builds on the strengths of HFA and addresses its challenges.*

*You were suggested as a key person to inform this assessment and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your experience. Your responses are confidential and your identity will be kept anonymous by the by the team leader.*

*Your feedback on the work of the HFA project is important because it will inform the future of work of the HFA project and future projects. Your opinion is very important. Please take some time now to answer all the questions. The survey will be available until by Monday, May 3, 2021.*

*Thank you for participating in this survey.*

A USAID/ANGOLA solicitou à equipa do GH EvaLS que avaliasse o desenho, implementação e sustentabilidade do Projeto Saúde para Todos (SPT) e identificasse oportunidades na elaboração de um novo projecto que se baseasse nos pontos fortes do SPT e abordasse seus desafios.

Seu nome foi indicado como informante-chave neste processo de avaliação e apreciamos muito sua perspectiva, experiências e visão sobre os sucessos, desafios, barreiras e lições aprendidas com base a sua experiência. *Suas respostas são confidenciais e sua identidade será mantida anônima por todos os membros da equipa.*

Seu feedback no trabalho do projecto SPT é importante porque irá informar o futuro do trabalho do projeto SPT e outros projectos futuros. Sua opinião é muito importante. Reserve um tempo agora para responder à todas as perguntas. Este inquérito esterá disponível até segunda-feira, dia 3 de Maio de 2021.

Obrigado/a por responder ao questionário.

| | **Questions (English)** | **Team Member's Response** |
|---|---|---|
| 1. | *What is your name?* | Qual é o seu nome? |
| 2. | *What is your position in the HFA Project or your relationship with the project or its activities?* | Qual é a sua posição no Projeto SPT ou sua relação com o projeto ou suas actividades? |
| 3. | *When did you start working in your current position?*<br>*Year* _____ | Quando começou a trabalhar em sua posição actual?<br>Ano _____ |
| 4. | *In case the team leader needs to contact you to ask a clarification question, what is your telephone number and or email?* | Caso a líder da equipa precise entrar em contato consigo para um esclarecimento, qual é o seu telefone e ou email? |
| 5. | *What is your main role in improving the health system in Angola?* | Qual é o seu papel na melhoria do sistema de saúde em Angola? |
| 6. | *What has been the main contribution of the HFA project so far?* | Qual foi a principal contribuição do projecto SPT até agora? |
| 7. | *How would you rate the project's performance and the results achieved so far in a scale of 1 to 4, 4 being the highest, and 1 the lowest? Please explain and tell us how you based your rating.* | Como classificaria o desempenho do projecto e os resultados alcançados até agora em uma escala de 1 a 4, sendo 4 o mais alto e 1 o mais baixo? Explique e diga-nos em que aspectos baseou sua classificação por favor. |
| 8. | *On a scale from 1-4, how much support do you receive from the project?*<br>*Please explain and tell us how you based your rating.* | Em uma escala de 1 a 4, quanto apoio você recebe do projeto?<br>Explique e diga-nos em que aspectos você baseou sua classificação por favor. |
| 9. | *On a scale from 1-4, how much does the HFA project involve and support provincial authorities in their malaria activities?*<br>*Please explain and tell us how you based your rating.* | Em uma escala de 1 a 4, quanto o projeto SPT envolve e apoia as authoridades provincias em suas atividade contra a malária?<br>Explique e diga-nos em que aspectos você baseou sua classificação por favor. |

| | Questions (English) | Team Member's Response |
|---|---|---|
| 10. | *On a scale from 1-4, how well does the HFA project coordinate the implementation of the reproductive health/ Family Planning (FP/RH) activities in Luanda and Huambo provinces?*<br>*Please explain and tell us how you based your rating.* | Em uma escala de 1-4, quão eficiente você considera o projeto SPT coordena as actividades de saúde sexual reprodutiva / planeamento familiar (SSR/PF) nas provincias de Luanda e Huambo?<br>Explique e diga-nos em que aspectos você baseou sua classificação por favor. |
| 11. | *Which tools/strategies are in place to coordinate HFA project malaria activities with provincial and municipal authorities, local partners and other organizations?* | Quais ferramentas ou estratégias existem para coordenar as actividades de malária do projecto SPT com as autoridades provinciais e municipais, parceiros locais e outras organizações? |
| 12. | *Can you tell me about a time when there was a significant delay in a planned activity or an activity had to be cancelled? What was the activity? What was the reason or the barrier?* | Poderia partilhar uma ocasião em que houve um atraso significativo em uma actividade planeada ou a actividade que teve de ser cancelada? Qual foi a actividade? Qual foi o motivo ou constragimento? |
| 13. | *What do you think are three main barriers for families to use LLINs?* | Quais você acha que são as três principais barreiras no uso de MTILDs pelas famílias? |
| 14. | *How well have malaria services been integrated into other health services in the HFA supported health facilities?* | Até que ponto os serviços de malária foram integrados aos outros serviços prestados nas unidades sanitárias apoiadas pelo SPT? |
| 15. | *On a scale from 1-4, how much more supervision of malaria services still needs to be improved? Please explain and tell us how you based your rating.* | Em uma escala de 1-4, quanto mais você considera que a supervisão dos serviços de malária ainda precisam de ser melhoradas?<br>Explique e diga-nos em que aspectos você baseou sua classificação por favor. |
| 16. | *On a scale from 1-4, how much more supervision of FP/RH services still needs to be improved?*<br>*Please explain and tell us how you based your rating.* | Em uma escala de 1 a 4, quanto você considera que a supervisão dos serviços de Saúde Sexual Reprodutiva (SSR) ou planeamento familiar (PF) ainda precisa ser melhorada?<br>Explique e diga-nos em que aspectos você baseou sua classificação por favor. |

| | Questions (English) | Team Member's Response |
|---|---|---|
| 17. | *Can you describe two strategies HFA uses to engage with youth, and particularly Adolescent Girls and Young Women in malaria, and FP/RH services?* | Pode descrever duas estratégias que o SPT usa para envolver os jovens e, particularmente, as meninas adolescentes e as jovens mulheres na malária e nos serviços de SSR/PF? |
| 18. | *What have been the three main successes of the project? In your opinion, are these sustainable? Why or why not?* | Quais foram os três principais sucessos do projecto? Na sua opinião, eles são sustentáveis? Porquê ou por quê não? |
| 19. | *What has been the most successful intervention you have been involved in?* | Qual foi a intervenção de maior sucesso em que esteve envolvido? |
| 20. | *What have been the three main challenges the project has faced or is facing?* | Quais foram os três principais desafios que o projecto enfrentou ou está (tem estado) a enfrentar? |
| 21. | *Do you have written performance goals and targets for the next quarter? If yes, how are they set up and how often are they measured and reviewed?* | Foram-lhe fornecedidosmetas e objetivos de desempenho para cada trimestre? Em caso afirmativo, como são configurados e com que frequência são avaliados e revistos ? |
| 22. | *What 3 factors have helped you succeed in your work?* | Quais são os três factores que o ajudaram a obter sucesso no seu trabalho? |
| 23. | *Considering the impact of the COVID-19 pandemic and other factors that may have affected the health system in Angola, in your opinion, what main 3 barriers prevent you from achieving all your health targets?* | Considerando o impacto da pandemia COVID-19 e outros factores que podem ter afectado o sistema de saúde em Angola, em sua opinião, quais são os três maiores desafios que o impedem de atingir (todas) as metas preconizadas de/em saúde? |
| 24. | *What do you think will be the main legacy of the project that will be still ongoing 5 years after the project?* | Na sua opiniao, qual será o principal legado do projecto que ainda estará em curso 5 anos após o encerramento do projecto? |
| 25. | *What is important for USAID to know and consider when designing another project similar to HFA?* | O que é importante que a USAID saibe e considere na elaboracao de outro projecto semelhante ao SPT? |

| | Questions (English) | Team Member's Response |
|---|---|---|
| 26. | *Do you have any suggestions for changes that would improve how the HFA Project can work in next two years?* | Tem alguma sugestão de mudanças que poderiam ser ponderadas para melhorar a forma como o Projecto SPT deve funcionar nos próximos dois anos? |
| | *Other observations or comments on the work of the HFA project and to strengthen the GOA's health system*<br>Outras observações ou comentários sobre o trabalho do projecto SPT e/ ou para fortalecimento do sistema de saúde de Angola poderão ser inseridos aqui. | |

# ANNEX 3. DATA SOURCES

**List of Reference Documents**

| Reference Document | Source: Link/Attachment |
|---|---|
| 1. Cosep Consultoria, Consaúde, and ICF International (2011). Angola Malaria Indicator Survey 2011. Calverton, Maryland: Cosep Consultoria, Consaúde, and ICF International | https://dhsprogram.com/pubs/pdf/MIS11/MIS11.pdf |
| 2. Davlantes *et al* (2018). 'Efficacy and safety of artemether–lumefantrine, artesunate–amodiaquine, and dihydroartemisinin–piperaquine for the treatment of uncomplicated Plasmodium falciparum malaria in three provinces in Angola, 2017. Malaria Journal (2018) 17:144 | https://doi.org/10.1186/s12936-018-2290-9 |
| 3. Dragan L et al (2018). 'Prevalence of molecular markers of artemisinin and lumefantrine resistance among patients with uncomplicated Plasmodium falciparum malaria in three provinces in Angola, 2015.' Malaria Journal (2018) 17:84 | https://doi.org/10.1186/s12936-018-2233-5 |
| 4. Dimbu et al (2019). Therapeutic efficacy monitoring of artemether-lumefantrine and artesunate-amodiaquine in Angolan sentinel sites, 2019 survey report | Email |
| 5. HEARD (2020). Linking Policy to Programming: Situational analysis on young key populations' sexual and reproductive health and rights in Angola | Email |
| 6. HFA FY20 Quarter 4 report | Email |
| 7. HFA FY21 work plan | Email |
| 8. HFA MEL | Email |
| 9. HFA Performance Management plan | Email |
| 10. HFA Mid-term Evaluation report 2019 | Email |
| 11. Global Integrity (2019). African Indicators | https://aii.globalintegrity.org/scorecard?country=angola&year=2019 |

| Reference Document | Source: Link/Attachment |
|---|---|
| 12. Global Fund Funding Request 2020-2022 | Email |
| 13. Government of Angola (2018). National Development Plan (PND) 2018-2025 | https://www.cabri-sbo.org/en/documents/national-development-plan-pnd-2018-2022 |
| 14. Government of Angola (2019b). National Sustainability Strategy for HIV, TB and Malaria 2020-2025. 2 December 2019 | |
| 15. Ljolje et al (2015). Prevalence of molecular markers of artemisinin and lumefantrine resistance among patients with uncomplicated Plasmodium falciparum malaria in three provinces in Angola, 2015 Malaria Journal (2018) 17:84 | https://doi.org/10.1186/s12936-018-2233-5 |
| 16. Lopes S et al (2020). 'Malaria Test, Treat and Track policy implementation in Angola: a retrospective study to assess the progress achieved after 4 years of Program implementation'. Malar J. 2020; 19:262 | https://doi.org/10.1186/s12936-020-03338-x |
| 17. Mentor Initiative (2019). Rapid Assessment of Severe Malaria Case Management Practices and Constraints in Angola | https://www.thementorinitiative.org/a-rapid-assessment-of-severe-malaria-case-management-practices-and-constraints-in-angola/ |
| 18. MOH (2012). Plano Nacional do Desenvolvimento da Saúde (PNDS) 2012-2025 | Email |
| 19. MOH (2016a). National Strategic Supply Chain Plan (PNECA) 2016-2021 | Email |
| 20. MOH (2019). ITN Use and Care Evaluation. Final Report. 23 September 2019 | Email |
| 21. MOH/Department of Human Resources (DNRH) (2019) Annual Report on Human Resources | |
| 22. MOH/GEPE (2011). Strategic Health Information System Plan (PESIS) 2011-2015. May 2011 | |

| Reference Document | Source: Link/Attachment |
|---|---|
| 23. MOH/GEPE (2016). Diagnostic and Performance Improvement Proposals for the Health Sector in Angola | |
| 24. MOH/GEPE (2020). Human Resources. Excel spreadsheet | Email |
| 25. MOH/NMCP (2016a). National Strategic Plan for the Control of Malaria in Angola, 2016-2020 | Email |
| 26. MOH/NMCP (2016b). Opportunities and Barriers for the Efficient Delivery of IPTp-SP in Angola: The Perceptions of Providers and Users. Draft Report. September 2016 | Email |
| 27. MOH/NMCP (2018) Malaria Operational Plan for Southern Angola (2019-2021) | Email |
| 28. MOH/NMCP (2020). Malaria Program Review (MPR) | Email |
| 29. National Institute of Statistics/INE (2014). Angola National Census | https://data.humdata.org/dataset/angola-census-2014-final-and-preliminary-population-results |
| 30. National Institute of Statistics/INE et al (2017). Inquérito de Indicadores Múltiplos e de Saúde em Angola 2015-2016 (IIMS)/Multiple Indicator and Cluster Health Survey (MICS) 2015-2016. Luanda, Angola and Rockville, Maryland, EUA: INE, MINSA, MINPLAN and ICF International | https://dhsprogram.com/publications/publication-fr327-dhs-final-reports.cfm |
| 31. National Institute of Statistics/INE (2019). Final Report of the Expenditure and Revenue Survey (IDR) 2018-2019 | http://www.angop.ao/angola/en_us/noticias/economia/2019/11/49/Monetary-poverty-rate-rises-percent-Angola,c96d1f24-0361-42d3-b661-d30aefd0bb23.html |
| 32. OHPI (2020). Global Multidimensional Poverty Index (MPI) | https://ophi.org.uk/global-mpi-2020/ |

| Reference Document | Source: Link/Attachment |
|---|---|
| 33. Plucinski MM et al (2015). Efficacy of artemether-lumefantrine and dihydroartemisinin-piperaquine for treatment of uncomplicated malaria in children in Zaire and Uíge Provinces, Angola. Antimicrobial Agents Chemother 59:437– 443 | https://doi:10.1128/AAC.04181-14 |
| 34. Plucinski et al (2016). Evaluating malaria case management at public health facilities in two provinces in Angola. Malaria Journal (2017) 16:186 | https://doi:10.1186/s12936-017-1843-7 |
| 35. PSI VectorLink Project Angola (2020). Annual Entomology Report. May 2019–April 2020. Rockville, MD. The PMI VectorLink Project, Abt. Associates Inc. | Email |
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| 37. PSI (2016b). Reach and Recall Study in OUAKULA: Integrated Health Social Marketing report Q2 FY 2016. 1 January-31 March 2016. PMI/USAID. | Email |
| 38. RDCS Southern Africa 2025 | Email |
| 39. SADC (2018a). Targeting sources of infection in southern Angola to drain malaria sinks in Namibia Project Final Report (SADC Elimination 8, 2018) | |
| 40. Post- Evaluation Management Plan | Email |
| 41. Relatório da performance do programa nacional de controlo da malária | Email |
| 42. SADC (2018b). SADC Malaria Report 2017-2018. Gaberone: SADC. | |
| 43. UN Angola and the World Bank, Socio-economic Impact of COVID-19 on Angola: Brief Analysis. May 2020.: Luanda. | Email |
| 44. UNDP (2018). Assessment of M&E and Data Quality in Angola, Cohort 2017. Draft. 13 August 2018. | |

| Reference Document | Source: Link/Attachment |
|---|---|
| 45. UNDP (2020a). Draft Program Assessment Report: Assessment of UNFPA Adolescent Girls and Young Women (AGYW) Component of the UNDP Project: Strengthening the National Response to HIV/AIDS in Angola. | Email |
| 46. UNDP (2020b). Angola: Legal Environment Assessment for HIV, and the Right to Sexual and Reproductive Health Rights, (forthcoming). | |
| 47. UNFPA Angola (2020). Country Data. | https://www.unfpa.org/data/AO |
| 48. USAID/PMI (2020). The PMI VectorLink Project Angola, Annual Entomology Report. May 2019–April 2020. Rockville, MD. The PMI VectorLink Project, Abt Associates Inc. | |
| 49. World Bank (2020a). Angola Poverty and Equity Brief, April 2020 | https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/SM2020/Global_POVEQ_AGO.pdf |
| 50. WHO (2002). National Health Accounts: Concepts, Data Sources and Methodology | https://www.who.int/health-accounts/documentation/en/NHA_concepts_datasources_methodology.pdf |
| 51. WHO (2016a). Yellow fever — Angola | https://www.who.int/csr/don/14-june-2016-yellow-fever-angola/en/. |
| 52. WHO (2017a), Tracking Universal Health Coverage: 2017 Global Monitoring Report | www.who.int/healthinfo/universal_health_coverage/report/2017/en/ |
| 53. WHO (20120) World Malaria Report 2020 | See WHO website |

## Individuals Contacted for the Online Survey

| Name | Title | Area |
|---|---|---|
| Paulo Proto | Chefe de Equipa do Projecto HFA | PSI |
| Rukaaka Mugizi | Chefe de Equipa Adjunto e Coordenador Operacional nas províncias | PSI |
| Luis Bolanos | Director Tecnico da Malaria | PSI |
| Tanya Manuel | Oficial Administrativa da Malária | PSI |
| Kiamuangana Nkongolo | Especialista Sénior iCCM/ADECOS | PSI |
| Carolina Miguel | Especialista Sénior de Laboratório | PSI |
| Mamede Joaquim | Gestora de Supervisão Formativa | PSI |
| Rafael Pedro | Gestor de Finanças e Conformidade | PSI |
| Zango Cacambo | Assistente de Logistica | PSI |
| Luis Bernardo | Logistico | PSI |
| Francisca Romeu | Coordenador Provincial | PSI |
| Sivi Nunes | Administrativo Logistico | PSI |
| Eduarda Cufuna | Oficial de Supervisão Formativa | PSI |
| Veronica Cassai | Oficial de Supervisão Formativa | PSI |
| Danilo João | Oficial de Supervisão Formativa | PSI |
| Bernardo Makonda | Motorista | PSI |
| Natalia Lucas | Auxiliar de Limpez | PSI |
| Juscelino Alberto | Oficial DHIS2 | PSI |
| Victoriono Costa | Coordenador Provincial | PSI |
| Julio Bento | Administrativo Logistico | PSI |
| Manuel Pascoal | Oficial em Gestão de Manejo de Casos de Malária | PSI |
| Sara Gonçalves | Oficial em Gestão de Manejo de Casos de Malária | PSI |
| Gerson Ngola | Oficial de DHIS2 | PSI |
| João Wyango | Administrativo Logistico | PSI |
| Helena Muachissaco | Oficial de Supervisão Formativa | PSI |
| Judite Antonio da Costa | Oficial de Supervisão Formativa | PSI |
| Jose Xilieno | Motorista | PSI |

| Name | Title | Area |
|---|---|---|
| Policarpo Inacio | Motorista | PSI |
| Mahata Pinto | Auxiliar de Limpez | PSI |
| Adalberto Jone | Oficial de DHIS2 | PSI |
| Hita Baby | Coordenador Provincial | PSI |
| Leonofro Cipriano | Adminstrativo Logistico | PSI |
| Ingracia Andre | Oficial de Supervisão Formativa | PSI |
| Yona Agostinho | Oficial em Gestão de Manejo de Casos de Malária | PSI |
| Paulo Joao | Motorista | PSI |
| Flora Samunoca | Auxiliar de Limpez | PSI |
| Milton Mateus | Oficial de DHIS2 | PSI |
| Suse Emiliano | Directora Geral | PSI |
| Helder Nunu | Gestor Senior programa | PSI |
| Lucelia Cipriano | Gestora de Capacitação Técnica | PSI |
| Anaisia Otavio | Supervisora de Controle e Qualidade | PSI |
| Lucinda Fernando | Técnica de Controle e Qualidade | PSI |
| Maria de Carvalho | Técnica de Controle e Qualidade | PSI |
| Marisa Junior | Técnica de Controle e Qualidade | PSI |
| Eliana Sebastião | Adminstrativa | PSI |
| Maria de Morais | Técnica de Controle e Qualidade | PSI |
| Alberto Zingany | Gestor Jr. de Comunicação Interpessoal | PSI |
| Catrino Quihixi | Assistente de Controlo de Qualidade de Dados | PSI |
| João Francisco | Técnico de Monitoria e Avaliação | PSI |
| Laura Leal | Gestora Senior | PSI |
| Azevedo Cambuta | Coordenador Provincial | PSI |
| Damião Pedro | Oficial de DHS2 | PSI |
| Zeferina Herculano | Supervisora de qualidade | PSI |
| Alberto Festo | Motorista | PSI |
| Benjamin Nieto | Director de Pesquisa & Monitoria | PSI |
| Vencislau Pelenda | Gestor Jr. de Pesquisa & Monitoria | PSI |
| Admilde Jose | Assessor Técnico Júnior em Inovação Digital | PSI |

| Name | Title | Area |
|---|---|---|
| Jose da Cunha | Oficial de Monitoria & Avaliação e Pesquisa | PSI |
| Edivaldo Silva | | PSI |
| Pedro Kiambe | | PSI |
| Keven Chantre | | PSI |
| Ernesto Ngunza | Analista e Programador Java | PSI |
| Ezequiel Amaral | Assistente Técnico de DHIS2 | PSI |
| Helder Resquino | Oficial de DHIS2/DHIS2 Officer | PSI |
| Fernanda Ricardo | Directora Geral | RMA |
| Carolina Miranda | Sub-directora Geral | RMA |
| Henrique Sungeti | Director de Finanças | RMA |
| Manuel Mais | Gestor de Recursos Humanos | RMA |
| Marcolino Cambumba | Coordenador Logistico | RMA |
| Ladi Stephen | Director Geral | PSM |
| Celestino Chingue | Gestor Senior | PSM |
| Fernado David | Sub Director Tecnico | PSM |
| Ulika Kupatia | Forecasting and Supply Planning Specialist | PSM |
| Josefa | Operações e Aprovisionamento | PSM |
| Erna Van Goor | Directora Geral | MENTOR |
| Kenedy Mumo | Director financeiro | MENTOR |
| Joana Fraude | Malaria Program Coordinator – Angola | MENTOR |
| Dofilia Paquissi | Administradora da base Zaire | MENTOR |
| David Sunda | Coordenador Provincial Uige | MENTOR |
| Manuel Jorge | Coordenador Provincial Zaire | MENTOR |
| Pedro Beirao | Director | APPY SAUDE |
| Daniel Coen | Director Financeiro | APPY SAUDE |
| Franco Martins | Coordenador do Programa Nacional de Controlo da Malária | DNSP/PNCM |
| Pedro Dimbu | Coordenador Nacional Adjunto PNCM | DNSP/PNCM |
| Elisa Miguel | Responsável Manejo de casos de Malária e TIP | DNSP/PNCM |
| Marilia Afosnso | Consultora/Formadora | DNSP/PNCM |
| Joana Bunga | | DNSP/PNCM |
| Mario Hossi | Monitoria e Avaliação | DNSP/PNCM |

| Name | Title | Area |
|---|---|---|
| Ana Candido | Biologa | INIS |
| Antonia Ribeiro | | DNSP/PNCM |
| Luis Dembo | Supervisor Provincial da Malária | DNSP/PNCM |
| Yolanda Ndosa | Chefe do departamento Provincial da Saude Publica | DNSP/PNCM |
| Alvantino Sebastião | Director de Saude Publica | DNSP/PNCM |
| Gonçalo Tandala | Supervisor Provincial da Malária | DNSP/PNCM |
| Cruz Domingo | Director de Saude Publica | DNSP/PNCM |
| Evaristo Quexilemba | Supervisor Provincial da Malária | DNSP/PNCM |
| Filomena Simão | Directora de Saude Publica | DNSP/PNCM |
| Ana Paulino | Supervisor Provincial da Malária | DNSP/PNCM |
| Domingos Tchikenge | Director de Saude Publica | DNSP/PNCM |
| Luciano Sangueve | Supervisor Provincial da Malária | DNSP/PNCM |
| Adelina Bonga | Supervisora Provincial de Planeamento Familiar | DNSR |

## Individuals Contacted for Key Informant Interviews

| Name | Title | Area |
|---|---|---|
| Julie Nenon | USAID/Angola Country representative | USAID/Angola |
| Joana do Rosario | USAID/PMI Resident Advisor | PMI, USAID/Angola |
| Sarah Labuda | CDC/PMI Resident Advisor | PMI, CDC/Angola |
| Arciolanda Gravata | USAID/PMI Program Management Specialist | PMI, USAID/Angola |
| Caroll Vasquez | Supervisory General Development Officer | USAID/Angola |
| Anya Fedorova | PSI Country Representative | PSI Luanda |
| Paulo Proto | PSI Chief of Party | PSI Luanda |
| Rukaaka Mugizi | PSI Deputy Chief of Party | PSI Luanda |
| Luis Bolanos | Malaria Technical Director | PSI Luanda |
| Benjamin Neto | PSI M&E Advisor | PSI Luanda |
| Suse Emiliano | PSI Marketing & Communication Director | PSI Luanda |
| Marcelino Uyango | ITN Campaign Coordinator | PSI Luanda |
| Kiamuangana Nkongolo | POC ADECOS | PSI Luanda |
| Hita Baby | HFA Provincial Coordinator/Lunda Sul | PSI Lunda Sul |
| Manuel B. Jorge | HFA Provincial Coordinator/Zaire | PSI Zaire |
| Francisca Romeu | HFA Provincial Coordinator/Malange | PSI Malange |
| Milton Mateus | HFA DHIS2 Provincial focal point/Lunda Sul | PSI Angola |
| Jucelino Alberto | HFA DHIS2 Provincial focal point/Malange | PSI Angola |
| Hélder Restino | Luanda | |
| Damião Pedro | Huambo | |
| Jairo Manuel | Zaire | |
| Oasia Octavio | HFA FP/RH Provincial focal point/ Luanda | PSI Angola |
| Sergio Lopes | Portfolio Manager | MENTOR |
| Manuel Gonga | Project Manager | RMA (Rede Mulher Angola) |
| Dra Helga Freitas | National Public Health Director | MOH/National Public Health Directorate |
| Dr Peliganga Baiao | Chief of Disease Control Department | MOH/National Disease Control Department |
| Dr Jose Franco Martins | National Malaria Control Program Coordinator | National Malaria Control Program |

| | | |
|---|---|---|
| Dr Pedro Rafael Dimbu | Deputy National Malaria Control Program Coordinator (Lab POC) | National Malaria Control Program |
| Dr Cani Pedro | Senior Entomology Specialist | National Malaria Control Program |
| Dra Elisa Miguel | Case Management Focal Point including MIP | National Malaria Control Program |
| Manzambi Ferreira | Head of PSM/Logistic | National Malaria Control Program |
| Dra Fatima Joao | SBCC Focal Point | National Malaria Control Program |
| Dr Marques Gomes | ADECOS Focal Point | National Malaria Control Program |
| Mario Dumbo Hossi | M&E Officer | National Malaria Control Program |
| Fernanda Guimarães | Epidemiologist | National Malaria Control Program |
| Dr Eusebio Manuel | Director Epidemiological Surveillance | |
| Dr. Joao Cunha | Infant Health Coordinator/ Interim Head of the SRH Department | MOH/National Public Health Directorate |
| Isabel Lemos Gomes | Women's Section | MOH/National Public Health Directorate |
| Dr. Mansitambi Joao Luz | Head of the Cabinet of the vice Minister of Health | MOH |
| Maria Georgina Marques | Head of the Statistics Department | MOH GEPE |
| Ana Paula Jordao Machado | Director of Information Technology (GTI) | Office of Technology and Information |
| Clementina Silva | MOH/Information Technology Officer | Office of Technology and Information |
| Edson Pereira | Director of the Technology and Information | Office of Technology and Information |
| Daniel Miji | Community Health Worker Program (ADECOS) – Manager | Ministry for Territorial Administration - Social Support Fund |
| Maria Filomena C. Wilson | Director of Provincial Health Office (*Director do Gabinete Provincial da Saude*) | Provincial Health Office of CUANZA NORTE |
| Cruz Manuel Domingos | Chief of Provincial Public Health Department | Provincial Health Office of CUANZA NORTE |
| Goncalves Tandala | Malaria Provincial Supervisor | Provincial Health Office of CUANZA NORTE |
| Victorino Filipe Costa | HFA Provincial Coordinator /Lunda Sul | Provincial Health Office of CUANZA NORTE |
| José Gimi Nhunga | Director of Provincial Health Office (*Director do Gabinete Provincial da Saude*) | Provincial Health Office of LUNDA NORTE |

| | | |
|---|---|---|
| Mamede Joaquim | Chief of Provincial Public Health Department | Provincial Health Office of LUNDA NORTE |
| Evaristo Quexilemba | Malaria Provincial Supervisor | Provincial Health Office of LUNDA NORTE |
| Viegas Antonio de Almeida | Director of Provincial Health Office (*Director do Gabinete Provincial da Saude*) | Provincial Health Office of LUNDA SUL |
| Domingos Chinguenji | Chief of Provincial Public Health Department | Provincial Health Office of LUNDA SUL |
| Ana Celestina | Malaria Provincial Supervisor | Provincial Health Office of LUNDA SUL |
| Madalena Angelina Diogo | Director of Provincial Health Office (*Director do Gabinete Provincial da Saude*) | Provincial Health Office of UIGE |
| Ntima Eduardo | Chief of Provincial Public Health Department | Provincial Health Office of UIGE |
| David António Fieca Sunda | HFA Provincial Coordinator /Lunda Sul | Provincial Health Office of UIGE |
| Manuel Messo | Malaria Provincial Supervisor | Provincial Health Office of UIGE |
| João Miguel Paulo | Director of Provincial Health Office (*Director do Gabinete Provincial da Saude*) | Provincial Health Office of ZAIRE |
| Fonseca João Lemos Milla | Chief of Provincial Public Health Department | Provincial Health Office of ZAIRE |
| Maria Augusto Nkuku | Malaria Provincial Supervisor | Provincial Health Office of ZAIRE |
| Avantino Helder Sebastiao | Director of Provincial Health Office (*Director do Gabinete Provincial da Saude*) | Provincial Health Office of MALANGE |
| Luis Demba | Malaria Provincial Supervisor | Provincial Health Office of MALANGE |
| Domingas Alexandre | Family Planning Provincial Supervisor | Provincial Health Office of Luanda |
| Adelina Bonga | Family Planning Provincial Supervisor | Provincial Health Office of Huambo |
| Ladi Stephen | USAID Implementing Partner - Supply & Procurement in-Country Representative | GHSC-PSM - Global Health Supply Chain - Procurement Supply Management |
| Joshua Galjour | Angola Portfolio Manager | Global Fund |
| Serena Brusamento | PHME | Global Fund |
| Evaristo Waya | Community Development Senior Officer, Previous President of Malaria Forum (funded through HFA) | ADPP |
| Paulo Máquina | SADC E8 Angola Focal Point | Elimination 8 |

| | | |
|---|---|---|
| Alfredo Francisco | World Vison/GF Project Chief of Party | World Vision |
| Fernanda Alves | Malaria Program Manager | WHO |
| Renato Pinto | Health Manager | UNICEF |
| Hirondina Cucubica | Health Manager | UNICEF |
| Sachi Fukushima | Expert Team | Japanese International Cooperation Agency |
| Marina Coelho | Representative Assistant | UNFPA |
| Ana Leitao | Medical Doctor/Assessor | World Bank Angola Office |
| Cecilia Fernandes | Head of UNITEL Social Responsibility Office | UNITEL |
| Henrique Costa | Innovation and Technology | UNITEL |
| Amiralis Machado | Community Relations Advisor - Public & Government Affairs Department | ExxonMobil Foundation |

# ANNEX 4. ASSESSMENT DESIGN MATRIX

This Assessment Design Matrix connects the assessment methods to questions, and to the data collection and analysis methods.

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| I | **DESIGN**<br>**To what extent has the HFA project design *effective to achieve the desired results*?**<br>**a. To what extents are the underlying assumptions still valid?**<br>i. MOH timely approves HFA activities: How timely and effective has the partnership with the MOH been?<br>ii. Medicines and contraceptives are available: How has the supply chain worked in life of the project (LOP)?<br>iii. Health facilities have required personnel and supplies: What % of the project-supported facilities meet the required standards of personnel?<br>**b. Are the current causal pathways producing the required outcomes?** | • MOH's Governance: reported degree of leadership, approval process of HFA activities and number and types of approvals processed in the LOP<br>• Alignment of HFA with MOH programs and MOH engagement and other partners to co-diagnose and co-design interventions to strengthen the health system in selected provinces<br>• Supply system performance nationally and in HFA supported facilities<br>• Staffing in HFA supported facilities<br>• Partnerships developed or strengthened<br>• M&E data of the HFA project to show how it managed the implementation of the Theories of Change and mitigated changes in underlying assumptions.<br>**Result 1**: 30% increases coverage of LLIN -<br>• Reported design process used for interventions under R1<br>• List of interventions and their coverage either co-designed and/or project led to expand coverage<br>• Interventions to improve LLIN supply chain co-designed at national, provincial, municipal and | The assessment has a qualitative focus that makes use of the experiences and observations of those involved in the HFA project. The goal is to inform the creation of a new and integrated TOC that will strengthen the next project design process and advances Angola in its journey towards Self-reliance.<br>The data will include:<br>• Document review<br>• Assessment and rating of tools and training materials<br>• Key informant interviews<br>• Review of DHIS data<br>• Review of HFA M&E data<br>• Site observations in selected sites identified for being top and low performers | Qualitative analysis of key informant interviews and documents and tools available.<br>Quantitative analysis of secondary data if available and of online survey responses.<br>In addition to descriptive statistics, if possible, patterns and clusters of data will be identified; outliers will be analyzed that may be explained through other sources of data. |

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| | Causal pathways will be assessed by result area: R1, R2, R4 and R5 | facility levels to expand coverage in project-supported areas.<br>● Intervention to improve demand and use of LLIN<br>● Reported views and evidence of the effectiveness of the TOC and sequence of interventions to achieve outcomes under Result 1.<br>**Result 2:** Improved malaria services in 60 municipalities<br>● Reported design process used for interventions under R2<br>● Reported views and evidence of the effectiveness of the TOC and sequence of interventions to achieve outcomes under Result 2.<br>● Data on reported improved quality and QI processes by outcome: e.g. Rapid tests prescribed and performed, trends in # of cases diagnosed, % of lab-confirmed cases that received treatment, data on completeness of medical records of a sample of malaria cases, audit of malaria death certificates, etc.<br>● Mortality and Morbidity data trends, comparison in HFA and non HFA-supported municipalities<br>● Stockout of Malaria medicines and testing supplies in the last 12 months and or by PY<br>**Result 4**: Strengthened and expanded integrated FP/RH services at provincial and municipal levels<br>● Reported design process used for interventions under R4 | ● Online survey of all the HFA staff and selected counterparts and stakeholders<br>The document review will include:<br>Program Description (PD) with goals and results, work plans, PMP, quarterly reports,<br>Key Informants will include:<br>● USAID/Angola<br>● HFA Team<br>● MOH authorities at national, provincial and municipal levels<br>● PMI US<br>● PMI Angola<br>● PSI<br>● Rede Mulher Angola<br>● Tropical Health LLP<br>● MSH<br>● Mentor Initiative<br>● NMCP | Causal pathways to each project outcome and to top and low-performing facilities and municipalities will be defined based on quantitative and qualitative data available. Graphic as well as narrative analysis will be presented if quality data are available for this purpose. |

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| | | • Reported views and evidence of the effectiveness of the TOC and sequence of interventions to achieve outcomes under Result 4.<br>• Reported design of patient flow chart of the HFA's FP/RH integrated service delivery model<br>• Reported quality of FP/RH services provided in project supported-provinces and municipalities<br>• Coverage of FP/RH services in project-supported provinces and municipalities: new FP acceptors and continuing users by method, and numbers of facilities that provide integrated FP/RH services<br>**Result 5.** DHIS2 capacity improved in six provinces and 60 municipalities<br>• Reported design process used for interventions under R5<br>• Reported effectiveness of TOC and sequence of interventions to achieve outcomes under R5<br>• Design of the Angolan Health Information System<br>• Alignment with Nation HIS program<br>• Harmonization with other partners and stakeholders (LMIS, etc.) | • Ministry of Terrestrial Administration<br>• SADC/FAA<br>• Global Fund CCM and Secretariat<br>• WHO<br>• UNICEF (IMCI and cIMCI)<br>• UNDP<br>• UNFPA<br>• ADECOS<br>• Civil Society Stakeholders<br>• Private Sector Stakeholders | |
| 2 | **IMPLEMENTATION**<br>**To what extent is the project's plan of implementation effective in achieving the desired results?** | • Reported perceptions on the degree of co-implementation process and the effectiveness of the management of HFA project<br>• Determine the breadth and depth of the HFA interventions in the supported municipalities | Selection of three or more products, activities, and tools across health elements (FP/RH and malaria).<br>Review SOPs, | Rating of HFA tools using assessment checklist against Angolan or international standards. |

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| | a. To what extent is the HFA project managed effectively (internal and external; nationally and provincially)?<br>b. What are the enabling factors critical to success and the barriers that impede implementation?<br>c. What are the key strategic, programmatic, technical and managerial features of the project that should be taken into account when designing and implementing the next project in Angola? | • Evidence of HFA best practices<br>• Views on how well HFA coordinated its activities with other stakeholders<br>• Views on how well the HFA project was managed in the US and Angola<br>• Reported degree of decentralization to provincial and municipal levels achieved<br>• Reported effectiveness of the capacity building, training, mentoring and coaching activities of HFA<br>**Result 1**: 30% increases coverage of LLIN -<br>1. Coverage and effectiveness of LLIN supply chain: co-design at national, provincial, municipal and facility levels to expand coverage in project-supported areas.<br>2. How and how much the LLIN volume has increased and improvement co-designed to the LLIN supply system?<br>3. Has distribution of LLIN, and consequently, their coverage and use improved? How?<br>4. How have partners been involved to co-implement R1?<br>5. Reported perceived enabling factors and barriers to sustainable and effective LLIN supply, coverage expansion and increased use<br>**Result 2:** Improved malaria services in 60 municipalities | Project documents (organogram, management functions, financial records, HR records, process documents, meeting minutes and notes, etc.) | Rating of implementation tool.<br>Site observation checklist will be analyzed to uncover causal pathways and barriers and enabling factors<br>Review of malaria and FP records, malaria death certificates, may help to discover patterns and opportunities for improvement to be included in the new theory.<br>Qualitative analysis of key informant interviews will help identify opportunities to design the new activity. |

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| | | 6. Reported co-implementation process used for interventions under R2<br>7. Data on coverage in terms of numbers of health facilities that provide services according to MOH/HFA standards<br>8. Data on reported improved health worker performance from supervision records, and data on numbers and distribution of trained health workers<br>9. Mortality and Morbidity data trends, comparison in HFA and non HFA-supported municipalities<br>10. Stockout of Malaria medicines and testing supplies in the last 12 months and or by PY<br>**Result 4**: Strengthened and expanded integrated FP/RH services at provincial and municipal levels<br>11. Reported and observed patient flow chart of the HFA's FP/RH integrated service delivery model<br>12. Data on contraceptive supply chain in HFA facilities and stockouts by method<br>13. Reported unmet need: % of facilities the provide short and long acting methods<br>14. Reported quality of FP/RH services provided in project supported-provinces and municipalities, # of facilities that meet supervision standards<br>15. Coverage of FP/RH services in project-supported provinces and municipalities in terms of new FP acceptors and continuing users by method, number of HW that successfully completed FP training, numbers of facilities that provide integrated FP/RH services, number of ADECOS providing FP | | |

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| | | information, referrals, and/or services during the year, and number of persons who received FP and HIV counseling services by IPC agents<br>**Result 5**. DHIS2 capacity improved in six provinces and 60 municipalities<br>16. Estimate number of reporting units<br>17. Reported data quality or studies available<br>18. Reported use of data to manage malaria and FP/RH services<br>19. Reported enabling factors and barriers to an effective HIS and scale up of DHIS2 | | |
| 3 | **OPPORTUNITIES**<br>**What are the current opportunities faced by the project?** | • Identification of opportunities in the current MOH activities and the 2021 work plan, and 2012-2025 PNDS<br>• Opportunities for Alignment with SDG3. Towards UHC by 2025 and 2030: What % of facilities will have been improved with assistance by USAID/Angola?<br>• Opportunities in the USAID portfolio of globally funded activities: synergy opportunities to complement and reinforce country strategy<br>• Contribution *from and* to other donors' initiatives: map donor presence and coverage and opportunities for collaboration<br>• PPP Opportunities | KIIs and Portfolio reviews, and stakeholders' reports | Rating and scoring based on perceived feasibility of various opportunities identified and analysis of themes that emerge in KIIs |
| 4 | **SUSTAINABILITY** | • Degree of implementation of HFA Sustainability Strategy | KIIs and portfolio reviews, stakeholder reports | Assessment of evidence of effective |

| | Assessment Question/ Sub-questions | Information Required and Data Source(s) | Data Collection Method | Data Analysis Method |
|---|---|---|---|---|
| | **What mechanisms are in place by USAID and/or implementing partners (IPs) to ensure the sustainability of the project's achievements?**<br>a. *What has HFA done to ensure the sustainability of its interventions and achievements?*<br>b. *What have other IPs done that can be sustained?*<br>c. *How much has the Angolan health information and LLIN and contractive supply systems been strengthened at national, provincial, municipal and facility levels to deliver quality malaria and FP/RH services?*<br>d. *How and how much has capacity building been institutionalized at national and provincial levels?* | • Reported mechanisms in existence to support ownership at national, provincial, municipal and facility levels<br>• Alignment mechanisms in existence with national policies and systems and other IPs and stakeholders<br>• Harmonization mechanisms with various stakeholders (UNDP, UNFPA, GF, etc.) views of various stakeholders and partnerships regarding the sustainability of HFA interventions.<br>• What mechanisms are in place to sustain the training investment made by HFA?<br>• Accountability mechanisms: assess the HFA's M&E in terms of its ability to account for its contribution to expanding and improving coverage of DHIS2, malaria and FP/RH programs, especially FP contraceptive prevalence | Assessment and rating of HFA sustainability plan | mechanisms in place and the factors that determine the likelihood that they will deliver the desired sustainable result for malaria, FP and DHIS2. |

# ANNEX 5. SCHEDULE OF DATA COLLECTION IN SELECTED PROVINCES

PROGRAMA DE VISITAS ÁS PROVÍNCIAS DE CUANZA NORTE, MALANJE, HUAMBO E ZAIRE - AVALAIÇÃO QUALITATIVA DO PROJECTO SAÚDE PARA TODOS

| | 4 April | 5 April | 6 April | 7 April | 8 April | 9 April | Membro da equipa |
|---|---|---|---|---|---|---|---|
| | | | | Luanda Maternidade Lucrecia Paim | | Luanda: CS Bairro Operario | Anna, Miguel and Zepherin (Consultores) |
| | 10 April | 11 April | 12 April | 13 April | 14 April | 15 April | |
| | | Luanda: CS Rangel | | | Luanda: HM Cacuaco | | |
| | Domingo | Segunda-feira | Terça-feira | Quarta-feira | Quinta-feira | Sexta-feira | Membro da equipa |
| | 18 Abril | 19 Abril | 20 Abril | 21 Abril | 22 Abril | 23 Abril | |
| COVID TESTE COVID ANTES DA VIAGEM | Viagem para Cuanza Norte | 1-Cuanza Norte: Kitapa CS, Cazengo<br>2-Cuanza Norte: Cazengo, CS Sassa | 3- Cuanza Norte: Cazengo, HP Kwanza Norte (HMI)<br>4- Cuanza Norte, Golungo Alto, HM Golungo Alto | Viagem para Malanje | 1-Malange: Caculama, CS Muquixe<br>2-Malange: Caculama, HM Caculama | 3-Malange: Cambundi ,Catembo HM Cambundi Catembo<br>4- Malanje: Malanje, HM Malanje | Zephirin e Miguel (Consultores)<br>Dra Fernanda Guimarães (PNCM)<br>Dra Joana De Rosario (USAID) |
| | 25 Abril | 26 Abril | 27 Abril | 28 Abril | 29 Abril | 30 Abril | |
| | COVID TESTE COVID ANTES DA VIAGEM | Viagem para Zaire | 1-Zaire: Mbanza Congo, HM Mbanza Congo<br>2- Zaire: Mbanza Congo, CS Kianganga | 3- Zaire: Kuimba HM Cuimba;<br>4- Zaire: Kuimba CS Luvaka | Viagem de regresso para Luanda | | Zephirin (Consultor) Dra Sarah Labuda (CDC)<br>Técnico do PNCM (A indicar) |
| | 2 Maio | 3 Maio | 4 Maio | 5 Maio | 6 Maio | 7 Maio | |
| | COVID TESTE COVID ANTES DA VIAGEM | Viagem aérea para Huambo | 1-Hospital do Cambiote;<br>2- Hospital Geral do Huambo | 3- CMI Caála;<br>4- CMI Mineira | Viagem aérea de regresso para Luanda | | Zephirin Meya (Consultor)<br>Sra Joana Bunga (PNCM) |

# ANNEX 6. HFA INDICATORS

| Indicator Level | Indicators | Baseline | Results | | %change |
|---|---|---|---|---|---|
| | | | 2019 | 2020 | |
| | | | | | |
| Objective 4: Strengthened, expanded, and integrated FP/RH services at provincial and municipal levels | | | | | |
| | **Family Planning and HIV Integration** | | | | |
| A4.1 | Percentage of USG-assisted service delivery points offering FP/RH counseling or services (+) ( ^) | 59.5 | 100 | 100 | 68% |
| A4.2 | Percent of USG-assisted service delivery points that experience a stockout at any time during the reporting period of a contraceptive method that service delivery point is expected to provide (+) ( ^) | 7% | 98% | 79% | 1079.00% |
| A4.3 | Couple years protection (CYPs) in USG-supported programs ( ^) ( ^) | 50,054 | 85,279 | 47,669 | -5% |
| A4.4 | Percent of health facilities whose providers reported a Quality of Care score >= 80% for management of FP services (+) | / | 45.2% | 45.2% | |
| A4.5 | Number of health workers who successfully completed an in-service training program | 192 | 339 | 101 | -47% |
| A4.6 | Number of protocols finalized and approved | 4 | 2 | 1 | |
| A4.7 | Number of people trained with USG funds (u) | 307 | 413 | 160 | -48% |
| A4.8 | Number of USG-assisted community workers providing FP information, referrals, and/or services during the year (+) | N/A | 83 | 84 | |
| **Activity** | **Family Planning and HIV integration** | | | | |
| A4.9 | Number of persons that received counselling in FP and HIV | N/A | 94,670 | 72,808 | |
| A4.10 | Number of persons successfully referred to FP services | N/A | 64,099 | 66,815 | |
| A4.11 | Number of persons successfully referred to HIV services | N/A | 8,633 | 16,668 | |
| **Activity** | **Gender integration indicators**** | | | | |
| A4.12 | GNDR-8 Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations (NEW indicator to be discussed with donor) | N/A | / | / | |
| **Activity** | **Funding indicator (FP2020)**** | | | | |
| A.13 | Percent of total spent on procurement of FP commodities for public sector services by the national government, USG, UNFPA, or other sources (NEW indicator to be discussed with donor) | N/A | / | / | |

| Indicator Level | Indicators | Baseline Values (*) | Results | | % change |
|---|---|---|---|---|---|
| | | | 2019 | 2020 | |
| **Long-term Result 5: Increased effective use of Health Information Systems for decision making by health managers at central, provincial, and municipal levels** | | | | | |
| **Activity** | | | | | |
| **Objective 5:** | | | | | |
| A5.1 | Percent of health units updated in DHIS2 organizational tree (new indicator in FY19) (DISCONTINUED IN FY20) | N/A | 89.7% | N/A | |
| A5.2 | Number of DHIS2 users trained within MINSA with USG assistance (DISCONTINUED IN FY19) | N/A | N/A | N/A | |
| A5.3.a | Percent of quarterly reports submitted in DHIS2 (Completion Rate) | N/A | 87.1% | 86.6% | |
| A5.3.b | Percent of quarterly reports submitted on time in DHIS2 (Timeliness) (NEW INDICATOR IN FY20) | / | / | 75.2% | |
| A5.4 | Percent of historical data (2017 and backwards) entered in DHIS2 for 6 PMI provinces (+) | N/A | 44.6% | 100.0% | |
| A5.5 | Number of data consolidation / revision meetings | N/A | 21 | 24 | |
| A5.6 | Number of municipalities represented in quarterly meetings to review HMIS/DHIS2 data and incorporate feedback in reports | N/A | 57 | 50 | |
| A5.7.a | Number of quarterly meetings in which NMCP lead (or provide remotely support starting FY20) DHIS2 analyses for decision making | N/A | 14 | 1 | |
| A5.7.b | Number of quarterly meetings in which municipal / provincial officials lead DHIS2 analyses for decision making ( +++) (NEW INDICATOR in FY20) | / | / | 23 | |
| A5.8 | Number of routine supervision visits / meetings implemented to DMS by HFA/MINSA personnel | N/A | 528 | 488 | |
| A5.9 | Number of MINSA staff trained or refreshed (at national and provincial level) | N/A | 96 | 90 | |
| A5.10 | # of provincial and municipal staff trained on DHIS2 (data insertion to provincial staff and data analyses and decision making to both, provincial and municipal hospital staff) [ NEW INDICATOR IN 2020 ] | / | / | 211 | |
| A5.11 | # of Research Studies Implemented (New Indicator in FY21) | / | / | / | |
| A5.12 | % of DHIS2 malaria reports matching HUs aggregate reports sent to DMS (difference between DHIS2 and HUs reports is no more than 10 percentage points) (New indicator in FY21) | / | / | / | |
| A5.13 | % of HUs visited with data in aggregate reports matching registry books data (difference between registry books and reports submitted to DMS is no more than 10 percentage points ) (New Indicator in FY21) | / | / | / | |

# ANNEX 7. CONFLICT OF INTEREST FORMS

PART III – APPENDICES

**APPENDIX D: CONFLICT OF INTEREST (COI)** ***(please fill/sign/date the form below)***

| | |
|---|---|
| **Name** | Dr. Elvira Beracochea |
| **Title** | Consultant |
| **Organization** | ME&A, Inc. |
| **Evaluation Position** | Team Lead |
| **Evaluation Award Number** *(or RFTOP or other appropriate instrument number)* | GH EvaLS - GS-10F- 154BA/7200AA20M00003 |
| **Project(s) Evaluated***(Include project name(s), implementer name(s) and award number(s), if applicable)* | Angola Health for All (HFA) Assessment |
| **I have real or potential conflict of interest to disclose.** | ☒ Yes ☐ No ☐ N/A |
| **If yes answered above, I disclose the following facts:** *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.* | I was subcontracted to Chemonics in a previous project (2006-2014) and worked for MSH on a previous project (2003-2005). |

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| **Signature** | E Beracochea |
| **Date** | 11/30/2020 |

## APPENDIX D: CONFLICT OF INTEREST (COI) *(please fill/sign/date the form below)*

| | |
|---|---|
| **Name** | Anna Pena |
| **Title** | Consultant – |
| **Organization** | ME&A, Inc. |
| **Evaluation Position** | Local Family Planning and Reproductive Health Specialist |
| **Evaluation Award Number** *(or RFTOP or other appropriate instrument number)* | GH EvaLS - GS-10F- 154BA/7200AA20M00003 |
| **Project(s) Evaluated** *(Include project name(s), implementer name(s) and award number(s), if applicable)* | Design and Implementation Assessment of the Angola Health for All Project<br>Population Services International (PSI)<br>AID-654-A-17-00003 |
| **I have real or potential conflict of interest to disclose.** | ☐ Yes ☐ xNo ☐ N/A |
| **If yes answered above, I disclose the following facts:**<br>*Real or potential conflicts of interest may include, but are not limited to:*<br>*1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.*<br>*2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.*<br>*3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.*<br>*4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.*<br>*5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.*<br>*6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.* | N/A |

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| **Signature** | |
| **Date** | 12/ 05/ 2020 |

| | |
|---|---|
| **Name** | Dr. Xiomara Brown |
| **Title** | Consultant |
| **Organization** | ME&A, Inc. |
| **Evaluation Position** | Senior Malaria Specialist |
| **Evaluation Award Number** *(or RFTOP or other appropriate instrument number)* | GH EvaLS - GS-10F- 154BA/7200AA20M00003 |
| **Project(s) Evaluated***(Include project name(s), implementer name(s) and award number(s), if applicable)* | Angola Health for All (HFA) Assessment |
| **I have real or potential conflict of interest to disclose.** | ☐ Yes ☑ No ☐ N/A |
| **If yes answered above, I disclose the following facts:** *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.* | |

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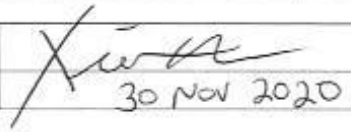
| **Signature** |  |
| **Date** | 30 NOV 2020 |

ME&A

## APPENDIX D: CONFLICT OF INTEREST (COI) *(please fill/sign/date the form below)*

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|---|---|
| **Name** | Miguel Antonio da Cruz |
| **Title** | Consultant – |
| **Organization** | ME&A, Inc. |
| **Evaluation Position** | Local Monitoring and Evalution Specialist |
| **Evaluation Award Number** *(or RFTOP or other appropriate instrument number)* | GH EvaLS - GS-10F- 154BA/7200AA20M00003 |
| **Project(s) Evaluated***(Include project name(s), implementer name(s) and award number(s), if applicable)* | Design and Implementation Assessment of the Angola Health for All Project<br>Population Services International (PSI)<br>AID-654-A-17-00003 |
| **I have real or potential conflict of interest to disclose.** | ☐ Yes ☒ No ☐ N/A |
| **If yes answered above, I disclose the following facts:**<br>*Real or potential conflicts of interest may include, but are not limited to:*<br>*1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.*<br>*2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.*<br>*3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.*<br>*4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.*<br>*5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.*<br>*6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.* | |

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| **Signature** | Miguel Antonio da Cruz |
| **Date** | December 28, 2020 |



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## APPENDIX D: CONFLICT OF INTEREST (COI) *(please fill/sign/date the form below)*

| | |
|---|---|
| **Name** | Dr. Zephirin Meya Mpambu |
| **Title** | Consultant – |
| **Organization** | ME&A, Inc. |
| **Evaluation Position** | Local Malaria Specialist |
| **Evaluation Award Number** *(or RFTOP or other appropriate instrument number)* | GH EvaLS - GS-10F- 154BA/7200AA20M00003 |
| **Project(s) Evaluated** *(Include project name(s), implementer name(s) and award number(s), if applicable)* | Design and Implementation Assessment of the Angola Health for All Project |
| **I have real or potential conflict of interest to disclose.** | ☐ Yes ☒ No ☐ N/A |
| **If yes answered above, I disclose the following facts:** *Real or potential conflicts of interest may include, but are not limited to:*<br>*1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.*<br>*2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.*<br>*3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.*<br>*4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.*<br>*5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.*<br>*6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.* | |

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| **Signature** | Zephirin Meya Mpambu |
| **Date** | 02/08/2021 |

# ANNEX 8. ASSESSMENT TEAM MEMBERS

**Dr. Elvira Beracochea – Team Lead**

Dr. Elvira Beracochea is a senior global health expert with over 25 years of international experience in health systems management, M&E, and global health project management. Dr. Beracochea has served on multiple USAID evaluations, including the USAID/Zimbabwe Improving Family Planning Project; USAID/Nepal Health for Life Project, USAID/Malawi Community Based Management of Acute Malnutrition Program, and the USAID/Nigeria Targeted States High Impact Project, among others.

Dr. Beracochea has managed, implemented, monitored, and evaluated projects in HIV/AIDS and TB, maternal and child health, nutrition, FP, malaria, PHC, and pharmaceutical management in over 60 countries. She has conducted research to improve healthcare delivery and improve the use of HIS to solve health system problems. Additionally, Dr. Beracochea has developed innovative training and coaching programs to help health professionals deliver quality healthcare efficiently and consistently and has improved the performance of health systems.

Beyond her health experience, Dr. Beracochea is a highly experienced evaluator. While serving as the Team Leader of the USAID/Zimbabwe Improving Family Planning Project, Dr. Beracochea was responsible for overseeing the entire evaluation, including the tool and methodology design, data collection and analysis, and report writing. The evaluation utilized a mixed methods approach and included focus groups, key informant interviews, and quantitative user surveys. Similarly, while serving as the Team Leader of the USAID/Nepal Health for Life Project (a health systems strengthening activity), Dr. Beracochea conducted key informant interviews, focus groups, and a quantitative user survey.

In addition to performance evaluations, Dr. Beracochea has extensive experience assessing health systems. While serving as a subject matter expert on the USAID/Ethiopia HIV/AIDS Multisectoral Mid-term Strategic Review, she worked with stakeholders to review progress made in Ethiopia's HIV/AIDS strategy. She particularly assessed the progress of the supply chain component of the strategy. She also recently completed a Review of the Digital Health Information System for USAID/Tanzania where she reviewed current investments in digital health information system and proposed recommendations to improve data collection, compilation, and use.

**Dr. Xiomara Brown – Senior Malaria Specialist**

Dr. Xiomara Brown served for more than 20 years on active U.S federal service as a public health clinician and epidemiologist working domestically and globally under the Department of State, Department of Health and Human Services, Department of Homeland Security, Department of Defense, and USAID. She championed collaborative, multidiscipline, and interagency processes to successfully implement and actively promote global health, recognizing that public health challenges do not respect geopolitical borders. Over the past 10 years, she has directed and managed programs funded under USG Global Health initiatives, mainly PEPFAR, PMI, and Global Health Security.

Under these initiatives, she served as the senior technical expert with responsibility for conceiving, planning, directing, and conducting broad and specific applied, clinical, and public health research pertaining to endemic and emerging infectious diseases. In her technical, clinical, senior management and executive positions that included Director of Clinical Services, Chief Medical Officer, Country Director, and Country Resident Advisor, her responsibilities and authorities related to execution and oversight of advanced level public health programs and science projects that typically had broad scope, were technically difficult, and had national public health and policy impact. She effectively developed de novo public health proposals, and successfully solicited funding from other sources to support USG public health mission objectives in

Africa. As the principal advisor on the planning, coordination and implementation of HIV/AIDS, Malaria, Ebola, and pandemic influenza global activities, she led the development of programs for populations at risk, and coordinated with other federally supported health program activities to bolster impact, leverage resources and enhance accountability of USG investments.

**Anna Pena – Local FP/RH Specialist**

Ms. Anna Pena is an Angolan FP/RH specialist with over 10 years of experience working in various FP/RH activities and capacities. Ms. Pena previously served as a legal officer for the United Nations addressing gender-based violence issues in the region. She recently conducted an assessment of sexual and reproductive health rights in Angola. The assessment looked at gender-based violence issues in the adolescent population of Angola.

**Miguel da Cruz – Local Evaluation Specialist**

Miguel da Cruz is an Angolan M&E specialist with over 13 years of experience working in M&E. Mr. Cruz previously served as a Senior M&E Advisor at MSH where he was responsible for conducting data collection, collation, and analysis for reporting and managed the data system using DATIM and other tools. Mr. Cruz is currently an M&E consultant working with donor projects to design M&E systems and assess and evaluate projects.

**Dr. Zephirin Meya Mpambu – Local Malaria Specialist**

Dr. Mpambu is a Congolese doctor residing in Angola with over 20 years of experience as a physician treating malaria in Angola. Dr. Mpambu previously served as a Provincial Malaria Program Officer in Cunene Province where he was responsible for supporting the NMCP. In this role, he trained staff on malaria diagnosis and treatment, supervised health workers, collected and analyzed incoming malaria data, and provided technical support for indoor residual spraying campaigns, larviciding, and LLIN distribution.